NEW MEXICO DEPARTMENT OF HEALTH

Legislative Health and Human Services Committee

October 20, 2015

NMDOH Highlights

FY17-19 Strategic Plan

- The strategic plan articulates NMDOH's focus on Results, reflects our Values, and creates a line of sight between the work of every employee and our Vision: A Healthier New Mexico

Public Health Accreditation

- Accreditation serves to ensure NMDOH delivers excellence in public health services

Health System Innovation

- Stakeholder engaged Design process to improve public health and health care delivery and outcomes

NMDOH Highlights

Public Health Surveillance

- Essential to identify and address health issues
- Assessment is a core public health function to understand the health of our communities

Special surveys are an important means of periodically gathering information on specific health issues in New Mexico

- Chronic pain is an issue that may lend itself to a special survey

How can we leverage existing data sources?

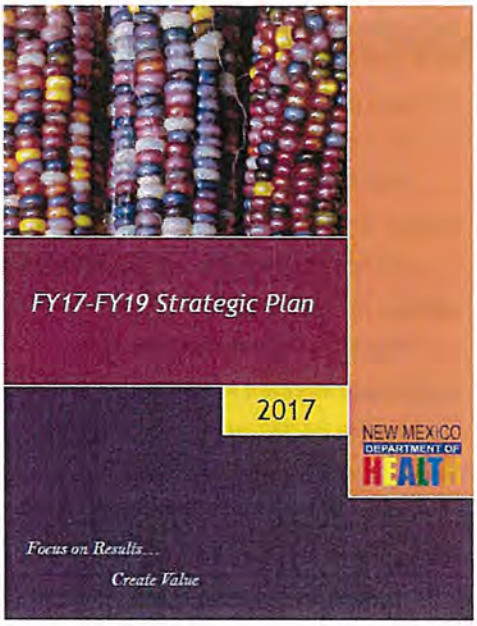
- Opportunities and challenges in Health Information Exchange

NMDOH Highlights

Updates to Hospital Quality and Transparency Efforts

- NMDOH Division of Health Improvement supports safe facilities that provide high-quality care
- Senate Bill 323, passed during the 2015 legislative session, updates the Health Information System Act to promote public access to hospital quality data.
- Other important opportunities for NMDOH
  - Hepatitis C
  - Childhood immunizations
  - Medical Cannabis

FY17-19 NMDOH Strategic Plan



NMDOH Strategic Plan

- Strategic planning is a process for defining our roles, priorities, and directions over three to five years
- The strategic plan sets forth what NMDOH plans to achieve, how we will achieve it, and how we will know we have succeeded
- The strategic plan provides a guide for decisions on taking actions to pursue priorities
- The strategic plan articulates NMDOH's focus on Results
- The strategic plan reflects our Values
- The strategic plan creates a line of sight between the work of every employee and our Vision:

A healthier New Mexico!

NMDOH Strategic Plan Continued

- Three-year plan
  - FY17-FY19
  - Annual updates based on progress
- Informed by State Health Assessment (SHA) and State Health Improvement Plan (SHIP)
  - Describes NMDOH contribution to the health of New Mexicans
- Considers Alternative Futures
  - Ambitious plan to pursue our desired future
- In accordance with Public Health Accreditation Board (PHAB)
  - Standards and Measures 1.5
- Adheres to Results Based Accountability
  - Simple, data-driven strategy development framework
- Aligned with Strategy Execution Plans (SEP)
  - Action-oriented implementation plans

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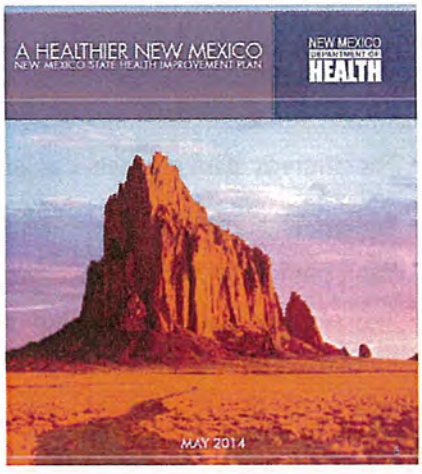
NMDOH Strategic Plan Continued

Informed by State Health Assessment and State Health Improvement Plan



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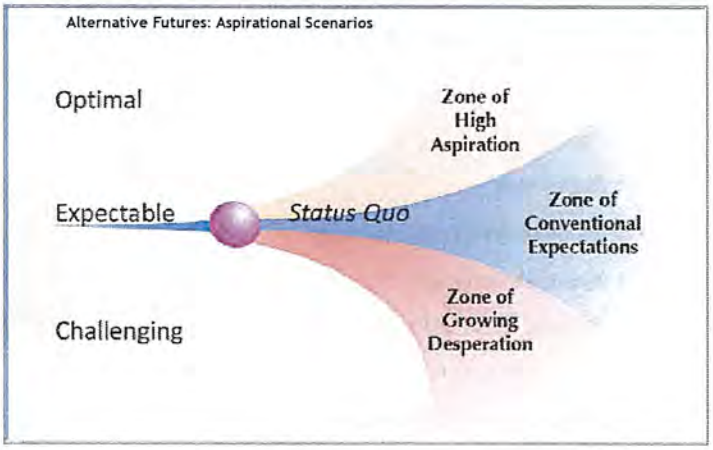
NMDOH Strategic Plan Continued

Considers Alternative Futures



NMDOH Strategic Plan Continued

PHAB Standards and Measures 1.5

- Robust planning process
- Considers opinions and knowledge from across the department
- Assesses the environment in which the department operates
- Uses organizational strengths, addresses challenges
- Links to the SHIP
- Must include:
  - Strategic priorities
  - Goals and objectives with measurable and time-framed targets

NMDOH Strategic Plan Continued

Strategy Development

Results Based Accountability

- 2 kinds of accountability
  - Population
  - Performance
- 3 kinds of performance measures
  - How much did we do?
  - How well did we do it?
  - Is anyone better off?
- 7 questions from Ends to Means

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NMDOH Strategic Plan Continued

Results Based Accountability: 7 Population Questions

1. What are the quality of life conditions we want for our stakeholders?
2. What would these conditions look like if we could see them?
3. How can we measure these conditions?
4. How are we doing on the most important of these measures?
5. Who are the partners that have a role to play in doing better?
6. What works to do better?
7. What do we propose to do?

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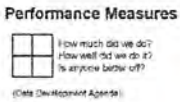
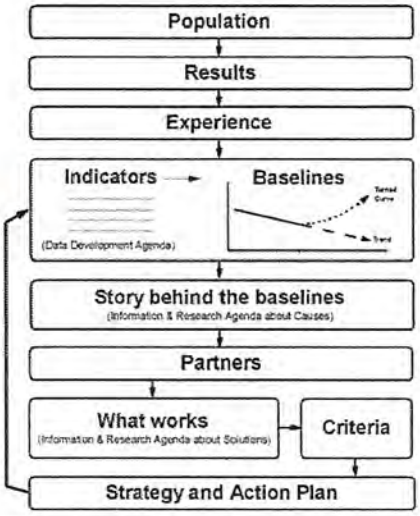
NMDOH Strategic Plan Continued

"Turn the Curve"

- Results Based Accountability:
  Population Accountability



- Results Based Accountability:
  Performance Accountability



NMDOH Strategic Plan Continued

Strategy Execution

- Strategy Execution Plans (SEP)
  - Vast majority of Fortune 500 CEO's indicate their organization is effective at strategic planning
  - Small minority also agree that they effectively implement the plan
- Simple, easy to use, effective
- Achieve greater results faster
- Validated as a best practice among national role model organizations
- Top priorities
- Biased toward action

NMDOH Strategic Plan Continued

Strategic Plan Structure

1. Results

Indicators

1.1 Priorities

Indicators

NMDOH Strategic Plan Continued

Three Results

1. Improved health status for New Mexicans
2. An engaged, empowered, and high-performing workforce that supports health status improvement
3. Simple and effective administrative processes that support health status improvement

NMDOH Strategic Plan Continued

Result 1: Improved health status for New Mexicans

Indicator	Baseline	Target
Percent of adults reporting good or better health status	79.9% (CY 2013)	82.5%

Result 2: An engaged, empowered, and high-performing workforce that supports health status improvement

Indicator	Baseline	Target
Percent of employees engaged	Under Development	Under Development
Percent of employees who trust their immediate supervisor, their organization, and their co-workers	Under Development	Under Development

Result 3: Simple and effective administrative processes that support health status improvement

Indicator	Baseline	Target
Percent of employees who believe that NMDOH administrative processes help rather than hinder their productivity	Under Development	Under Development
Number of completed agency-wide quality improvement initiatives that resulted in the improvement of an administrative process (including reductions in cycle time)	Under Development	Under Development

NMDOH Strategic Plan Continued

Result 1: Improved health status for New Mexicans

- Priority 1.1: Focus on the SHIP indicators with the super-priorities of diabetes, obesity, and substance misuse in health policies and across programs

Indicator	Baseline	Target
Percent of 3rd grade children who are considered obese	18.1% (CY 2014)	17.1%
Percent of adults who are considered obese	26.6% (CY 2013)	25.4%
Percent of adults who smoke	19.2% (CY 2013)	18.5%
Percent of adolescents who smoke	14.4% (CY 2013)	13.5%
Drug overdose death rate per 100,000 population	26.4 (CY 2014)	25.9
Alcohol-related death rate per 100,000 population	59.7 (CY 2014)	58.5
Diabetes hospitalization rate per 10,000 population	15.4 (CY 2013)	17.3

NMDOH Strategic Plan Continued

Result 1: Improved health status for New Mexicans

- Priority 1.1 continued

Indicator	Baseline	Target
Percent of adults who have visited a dentist in the past year	60.9% (CY 2012)	67.0%
Percent of adults aged 65+ who have ever received pneumonia vaccination	68.7% (CY 2013)	90.0%
Fall-related death rate per 100,000 adults aged 65+	102.2 (CY 2014)	96.1
Births to teens aged 15-19 per 1,000 females aged 15-19	35.0 (CY 2014)	25.5
Heart disease and stroke death rate per 100,000 population	108.1 (CY 2014)	108.1
Sexual assault rate per 100,000 population	500 (CY 2005)	475
Suicide rate per 100,000 population	21.1 (CY 2014)	20.7
Invasive pneumococcal disease rate per 100,000 population	16.6 (CY 2014)	15.0
Pneumonia and Influenza death rate per 100,000 population	17.1 (CY 2014)	15.0

NMDOH Strategic Plan Continued

Result 1: Improved health status for New Mexicans

- Priority 1.2: Access to an integrated outcome-based health system

Indicator	Baseline	Target
Hospitalization rate for ambulatory care sensitive conditions per 100,000 population	Under Development	↓ 900 per 100,000
Percent of discharges with readmission for any cause within 30 days	Under Development	↓ 20%

NMDOH Strategic Plan Continued

Result 1: Improved health status for New Mexicans

- Priority 1.3: Improve the health of special populations including persons with developmental disabilities and persons in long-term care

Indicator	Baseline	Target
Improvements in health status for the super-priority indicators under Priority 1.1 among persons with developmental disabilities	Under Development	Under Development
Improvements in health status for the super-priority indicators under Priority 1.1 among persons in long-term care	Under Development	Under Development

NMDOH Strategic Plan Continued

Result 1: Improved health status for New Mexicans

- Priority 1.4: Focus on subpopulations having the greatest opportunity for improved health status

Indicator	Baseline	Target
Reduction in health status disparities for indicators under Priority 1.1	Under Development	Under Development

NMDOH Strategic Plan Continued

Result 2: An engaged, empowered, and high-performing workforce that supports health status improvement

- Priority 2.1: Recruit, develop, recognize, and retain employees

Indicator	Baseline	Target
Percent of employees that continue employment with NMDOH for one, three, five, and 10 or more years	Under Development	Under Development
Employee turnover rate	Under Development	Under Development

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NMDOH Strategic Plan Continued

Result 2: An engaged, empowered, and high-performing workforce that supports health status improvement

- Priority 2.2: Promote and support optimal employee health and wellness

Indicator	Baseline	Target
Percent of employees reporting good or better health status	Under Development	Under Development
Percent of employees who participated in a NMDOH-recognized wellness program (e.g., nutrition, physical activity, stress reduction, mental resilience)	Under Development	Under Development

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NMDOH Strategic Plan Continued

Result 3: Simple and effective administrative processes that support health status improvement

- Priority 3.1: Ensure the consistent use of effective administrative processes

Indicator	Baseline	Target
Among targeted processes, the percent of process-deliverables that are delivered after pre-determined due dates (i.e., overdue processes)	Under Development	Under Development

NMDOH Strategic Plan Continued

Result 3: Simple and effective administrative processes that support health status improvement

- Priority 3.2: Supportive administrative infrastructure

Indicator	Baseline	Target
Percent of employees who agree that targeted processes are improved	Under Development	Under Development

Public Health Accreditation

A way to ensure the provision of excellence for the Department of Health

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What is Public Health Accreditation?

Public Health Accreditation Board (PHAB)

- Launched in 2011
- National accrediting body
- Composed of peer public health professionals

Public Health Accreditation is:

- Multi-step, multi-year process requiring plans, documented proficiency in the 10 essential services of public health and a commitment to ongoing quality improvement
- Set of standards developed by peers
- Process to assess performance; identify strengths and areas for improvement
- Recognizes Departments that meet the standards

PHAB

Advancing public health performance

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What does Accreditation mean to NMDOH?

Benefits of Accreditation

- High performance and Quality Improvement (QI)
- Recognition, validation, and accountability
- Potential increased access to resources
- Eliminating silos and building bridges across programs
- Vehicle to drive organizational change
- Create a quality improvement infrastructure
- Increased visibility and credibility

Accreditation Process Overview

1. Pre-application
   Submit a Statement of Interest (SOI)
2. Application
   Application form with pre-requisites
3. Document Selection and Submission
   Applicant selects documentation and submits it to ePHAB for review
4. Site Visit
   Site visit is conducted by a team of peers and report developed
5. Accreditation Decision
   PHAB Board will award accreditation status for 5 years if successful

Achieve

6. Reports - department submits annual reports
7. Reaccreditation (5 years)

Maintain

NMDOH Accreditation Process Overview

1. Pre-application
   Submitted August 2012
2. Application
   Submitted May 2013
3. Document Selection and Submission
   Selection occurred from July 2013-May 2014. Submission was May 2014
4. Site Visit
   Conducted December 2014
5. Accreditation Decision
   Decision to be provided November 2015

Achieve

6. Reports - department submits annual reports
7. Reaccreditation (5 years)

Maintain

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The 12 Domains of Accreditation

Domains include the 10 Essential Public Health Services, plus two:

1. Administrative Capacity
2. Governance

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Accreditation Structure

12 Domains

- Group standards pertaining to broad public health services

32 Standards

- Required level of achievement a health Department is expected to meet

105 Measures of Quality

- Evaluate if standards are met via Departmental documentation to demonstrate evidence of conformity

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New Mexico Health System Innovation

A Model Design to Achieve the Triple Aim

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State Innovation Model (SIM) Initiative

- Created by the Affordable Care Act (ACA) and administered by the Centers for Medicare and Medicaid Services Innovation Center (CMMI)
- SIM was developed to test innovative health delivery and payment models that:
  - Reduce Spending
  - Enhance the Quality of Care
  - Improve Population Health
- Since 2012 more than $1 billion has been awarded to 34 States, 3 territories, and the District of Columbia
- SIM is a two phase initiative
  - Design Phase (1-2 years to develop proposed design model)
  - Test Phase (3 years to test approved design model)

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State Innovation Model

- The Department of Health in partnership with the Human Services Department, was awarded funds from CMMI to develop a design to innovate the state's health system
- The foundation of the Health System Innovation is strong partnerships and collaboration efforts to achieve transformation
- We seek to achieve the triple aim:
  - Improved Population Health and Health Outcomes
  - Reduced health care costs and investment in health promotion
  - Enhanced experience of care for the person (quality and satisfaction)

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Objectives of the Model Design

- Aligning health care delivery with community activities that promote healthy behaviors and environments
- Slowing the rate of health care inflation by bending the cost curve over time
- Increasing the number of New Mexicans who have health insurance
- Re-envisioning and building the state's healthcare workforce and infrastructure
- Using health information technology to fill critical information gaps and support transparency and delivery system reform

Priority Measures

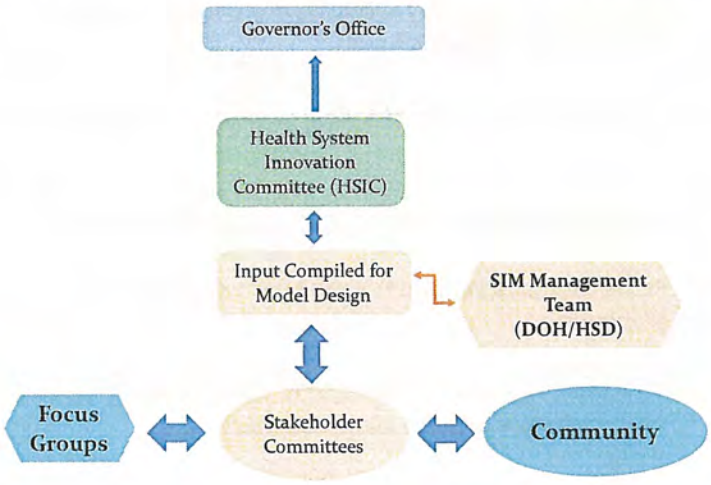
Quality and Performance Measures for delivery system transformation will focus on:

- Obesity
- Diabetes
- Tobacco Use

Measures will be considered for each part of the triple aim:

- The health of the population as a whole
- The quality of care provided to individual patient panels
- The cost of care

The Process of Design Development



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Engagement Structure

Seven Stakeholder Committees

- Population Health
- Healthcare
- Alignment and Integration of Public Health and Primary Care
- Workforce and Training Needs
- Payment Models
- Tribal
- Health Information Systems

Ongoing Community Engagement in local communities

- County Health Councils (33 around the state)
- Tribal Health Councils (5 around the state)

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The Design Vision

- Build on and innovate current transformation initiatives that exist within the state
  - Develop an enhanced version of the patient center medical home approach to move further into communities towards wellness
- Form a robust system of stakeholder engagement to obtain input and feedback to the proposed design
- Develop a sustainability plan for implementation in the future

Questions?

Public Health Surveillance Health Assessment Chronic Pain Study

A Presentation to the Legislative Health and Human Services Committee by the New Mexico Department of Health

October 20, 2015

Outline

- Public Health Surveillance
  - Surveillance 101
  - Key Public Health Surveillance Datasets
- Health Assessment
  - Assessment Role of Government
  - Indicators of New Mexico Health Status
- Pain Study

Public Health Surveillance

David Selvage, MHS, PA-C
Infectious Disease Epidemiology Bureau

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Surveillance Definition

Ongoing & systematic collection, analysis & interpretation of data, and dissemination

for.....

planning, implementation, and evaluation of public health practice.

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Simplified Steps in a Surveillance System

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Uses of Infectious Disease Surveillance

- Estimate magnitude of the problem
- Determine geographic distribution of illness
- Portray the natural history of a disease
- Detect epidemics/define a problem
- Generate hypotheses, stimulate research
- Evaluate control measures
- Monitor changes in infectious agents
- Detect changes in health practices
- Facilitate planning

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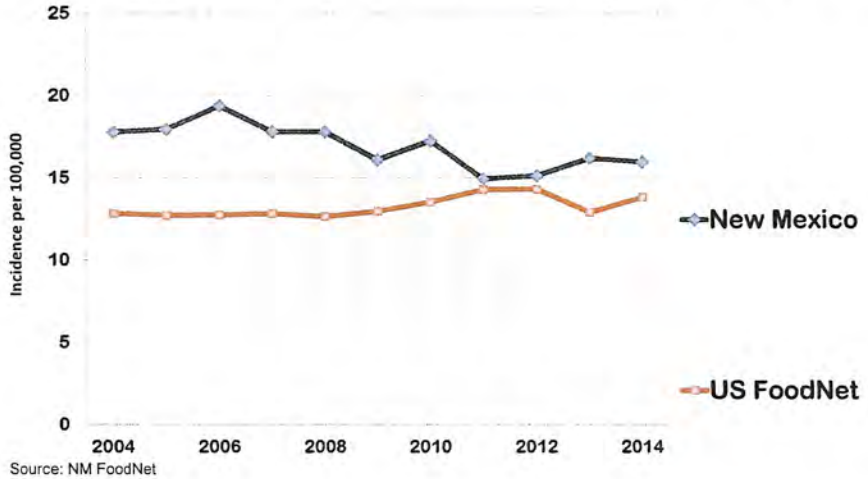
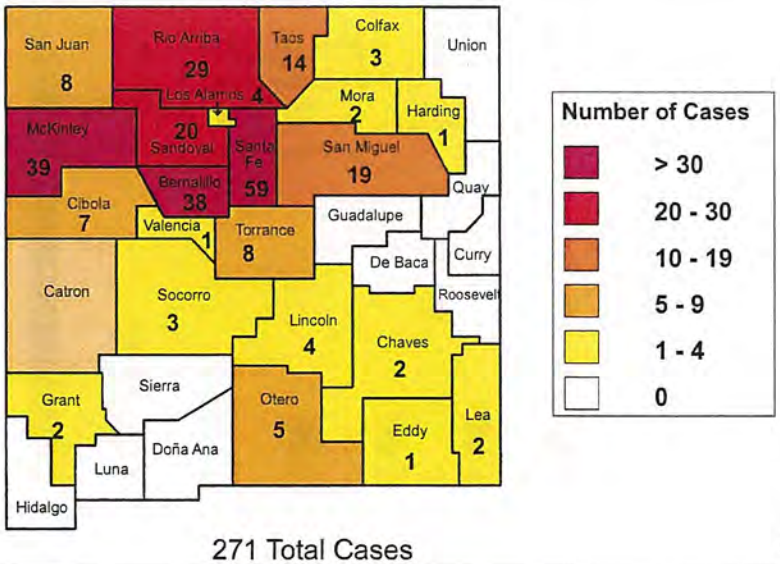
Campylobacteriosis Rates by Year, New Mexico and US FoodNet, 2004-2014



Source: NM FoodNet

Human Plague in New Mexico, Cases by County, 1949–2014



271 Total Cases

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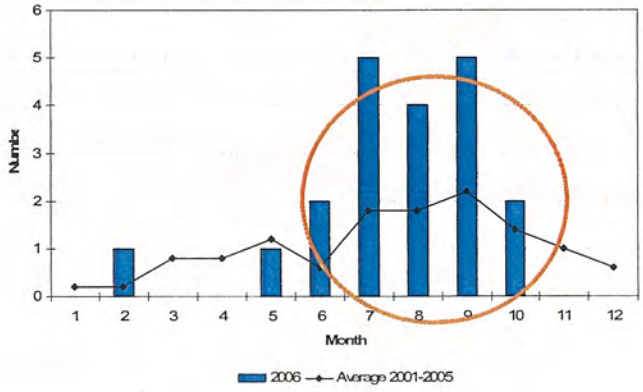
E. coli O157 Outbreak Associated with Baby Spinach, New Mexico, 2006



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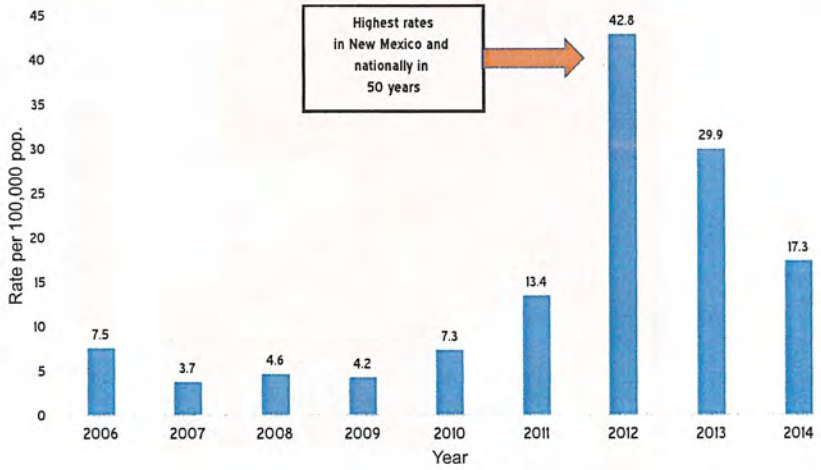
Pertussis Rates by Year, New Mexico, 2006-2014



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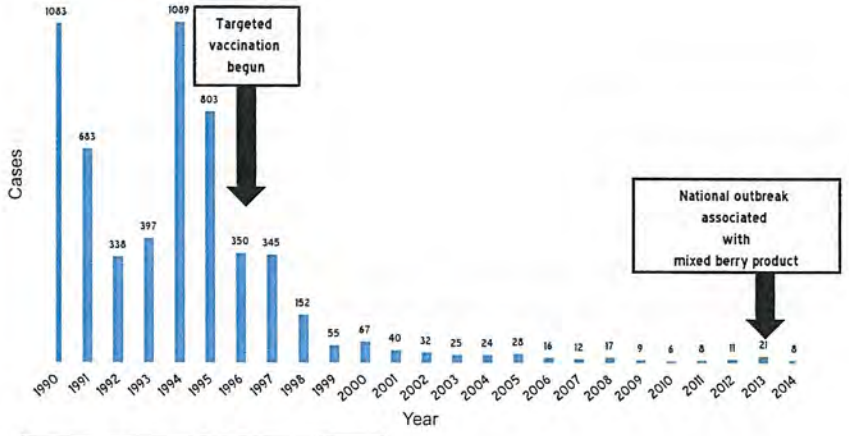
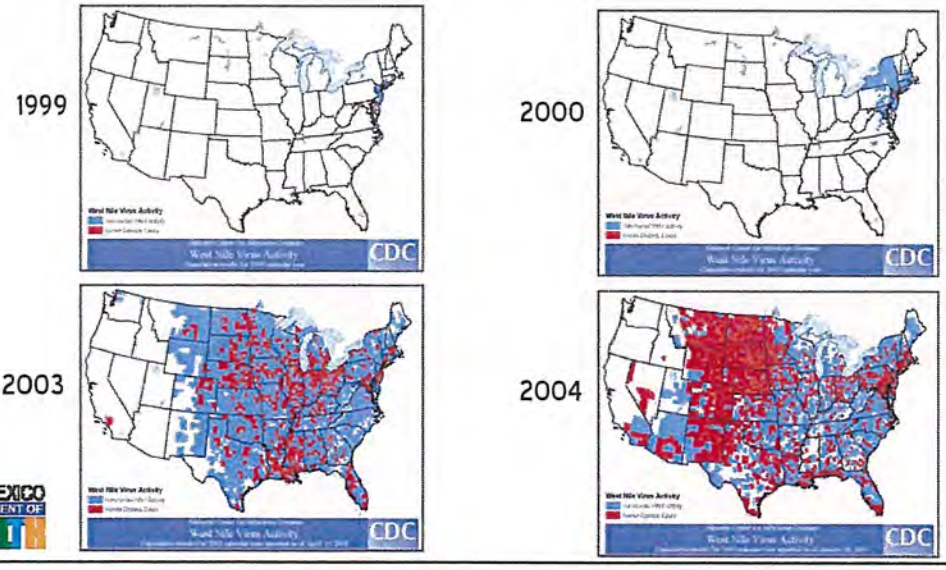
Hepatitis A Cases by Year, New Mexico, 1990-2014



Source: NETSS and NMEDSS

U.S. West Nile Virus Cases by Year, 1999-2004



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New Mexico Emerging Infections Program (NM EIP)

- Centers for Disease Control and Prevention funded
- New Mexico participation since 2004
- National network of 10 sites performing active, population-based surveillance for multiple conditions including foodborne illness, influenza, pneumococcal disease, *C.difficile*, to name a few
- Program results inform national public health policy
  - Pneumococcal vaccine; Group B Streptococcal screening during pregnancy

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New Mexico Healthcare-associated Infections Program (NM HAI)

- Infections acquired during treatment for other conditions
- NM HAI Program began in 2009
- Identify and reduce prevalence in New Mexico
- NM HAI Advisory Committee
- NM HAI Reporting Group Facilities
- Standardized reporting to National Healthcare Safety Network (NHSN)

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Ebola Virus Disease (EVD) Preparedness in New Mexico

- To date, completed 21 day contact monitoring on over 70 returned travelers
- Designated Ebola assessment hospitals
- Trained 2 EMS companies to transport Ebola suspect patients
- Ongoing EVD competency training for health care workers, clinical laboratories, EMS personnel and other partners

ENVIRONMENTAL PUBLIC HEALTH SURVEILLANCE

Heidi Krapfl, MS
Environmental Health Epidemiology Bureau

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Surveillance of Environmental Health Related Health Outcomes

- How can the environment potentially affect the health of New Mexico residents?
  - The Environmental Health Epidemiology Bureau (EHEB) is funded by several CDC grants to try and answer this question and then develop interventions.
  - Environmental Public Health Tracking (EPHT):
    - One-stop source that combines environmental exposure data with health data + maps
    - Track and understand how environment might affect the health of New Mexicans
    - https://nmtracking.org

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Surveillance of Environmental Health Related Health Outcomes

- Environmental Public Health Tracking
  - What kind of data are collected and analyzed?
    - Cancer data (examples: leukemia, brain cancer, bladder cancer)
    - Birth defects data: 12 birth defects (includes Down Syndrome)
    - Key hospitalization data: heart attacks, asthma, carbon monoxide poisoning
    - Exposure data: Particulate matter ($PM_{2.5}$) and ozone
    - Notifiable conditions: uranium concentrations in urine, mercury concentrations in blood, arsenic concentrations in urine

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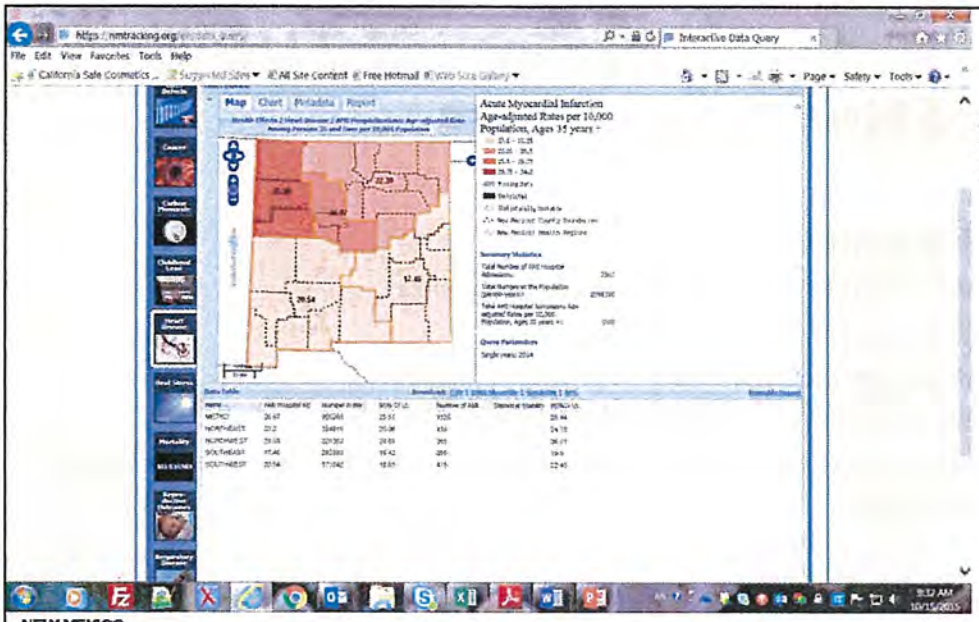

Age-adjusted Heart Attack Hospitalization Rates by Public Health Region, 2014

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Surveillance of Environmental Health Related Health Outcomes

- Environmental Public Health Tracking
  - How can these data be used?
    - Examine $PM_{2.5}$ concentrations and emergency department visits during wildfire events: Wallow Fire. Develop tools to reduce residents' exposures.
    - Work with physicians on poisonings, such as mercury poisoning
      - Blood mercury of 576 ug/L
      - Over 100 ug/L considered high exposure

Surveillance of Environmental Health Related Health Outcomes

- **Asthma Control Program**
  - Asthma hospitalizations and emergency department (ED) visits
  - Number of adults and children who have asthma
  - Environmental asthma triggers among New Mexicans with asthma
  - Percentage of residents with asthma that have well-controlled asthma
  - Intervention: use of promotoras in the homes of people with asthma to reduce asthma triggers and thus ED visits

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Surveillance of Environmental Health Related Health Outcomes

- **Four Corners States Biomonitoring Consortium**
  - Biomonitoring: directly assess exposure to chemicals through blood and urine (and sometimes hair)
  - Assessing exposure to heavy metals in urine and testing these metals in private well wells: arsenic, mercury, uranium, cadmium, manganese, and selenium
  - Exposure to insecticide 2,4 D (chronic exposure of expectant mothers may result in birth defects).

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Surveillance of Environmental Health Related Health Outcomes

- On Call
  - EHEB staff members take calls from physicians, public, and the Poison Control Center: Mon through Fri, 8 am to 5 pm
  - Types and examples of calls?
    - Private well drinking water—arsenic and source
    - Air quality—formaldehyde from flooring
    - Occupational injury—mining accident resulting in sulfuric acid and hydrogen sulfide exposure
    - Housing issues: mold, bed bugs

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Hospital and Emergency Department Data

- Inpatient Hospital Discharges
  - Chronic diseases
  - Acute conditions
  - Ambulatory care sensitive conditions
- Emergency Department Encounters
  - Injury and substance abuse
  - Mental health encounters

Vicky Dirmyer
Environmental Health Epidemiology Bureau

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Disease Registries

- Cancer (Tumor) Registry
- Violent Death Reporting System
- Child blood lead

Birth Certificate Data

- Birth and fertility rates
- Risk factors and health outcomes
  - Infant birth weight (high or low)
  - Preterm-births
  - Births to Teens
  - Births to single mothers
  - Late or no prenatal care
  - High-risk infants born at tertiary care facilities
  - Weight gain during pregnancy
  - Inter-pregnancy interval

Death Certificate Data

- Overall death rates
- Life expectancy
- Cause-specific deaths
  - Diabetes-related deaths
  - Alcohol-related motor vehicle crash deaths
  - Heart disease deaths
  - Chronic liver disease and cirrhosis
  - Suicide deaths
  - Chronic lower respiratory disease

Behavioral Risk Factor Surveillance System (BRFSS)

- Health Behaviors
  - Smoking, alcohol use
  - Physical activity, overweight
- Access to Health Care
  - Health insurance coverage
  - Unable to get needed care due to cost
- Clinical Preventive Services
  - Adult immunization
  - Cancer screening
- Chronic Diseases
- Mental and Physical Health Status

Pregnancy Risk Assessment and Monitoring System (PRAMS)

- Health care coverage for delivery and prenatal care
- Smoking and alcohol use before and during pregnancy
- Pregnancy intention and contraceptive use
- Breastfeeding
- Well baby care
- Infant sleep position
- Mother's post-partum depression
- Exposure to tobacco smoke in the home

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Youth Risk and Resiliency Survey (YRRS)

- Nutrition, overweight, physical activity
- Violence at school / in relationships
- Substance use
  - Drug & alcohol use
  - Tobacco use (cigarette and other)
- Mental health
  - Persistent feelings of sadness and hopelessness
  - Suicidal thoughts, suicide attempts
  - Caring and Supportive Relationship in the Family

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Data are Used for evidence-based decisions

- Disease surveillance and outbreak investigation
- Syndromic surveillance
- Healthcare acquired infection surveillance and prevention
- Public information, press releases (food borne, plague, Hanta virus, etc.)
- Emergency management and planning (Ebola, wildfires, etc.)
- Health promotion program planning
- Policy decision-making
- Community health assessment

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PUBLIC HEALTH ASSESSMENT

Lois M. Haggard, PhD
Community Health Assessment Program

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IOM on the Role of Government in Public Health

- The core functions of government in public health:
  - to develop policy that supports the health of populations,
  - to assure access to health care and the quality of that care, and
  - to assess the health status of the population, including public health surveillance

Institute of Medicine; Committee for the Study of the Future of Public Health; Division of Health Care Services (1988) The Future of Public Health. Washington, D.C.: National Academies Press.

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Assessment Function of Public Health

- Assessment is:
- regular and systematic
- collection, assembly, analysis, and dissemination
- of information about the health of a community.

Institute of Medicine (1988) The Future of Public Health, National Academies Press.

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The S.O.A.P. Model for Clinical and Community Health Assessment

	Clinical Assessment	Community Assessment
Subjective	Presenting complaint, symptoms, pain, medical interview	Community members, advisory boards, CBOs, focus groups, key informant interviews, qualitative surveys
Objective	Physical examination, Heart rate, BP, Blood test, X-ray	Morbidity, mortality rates, behavioral data, social determinants, quantitative surveys
Assessment	What is the diagnosis?	What are the priority health and safety issues?
Plan	What treatment will be most effective?	What interventions will be most effective?

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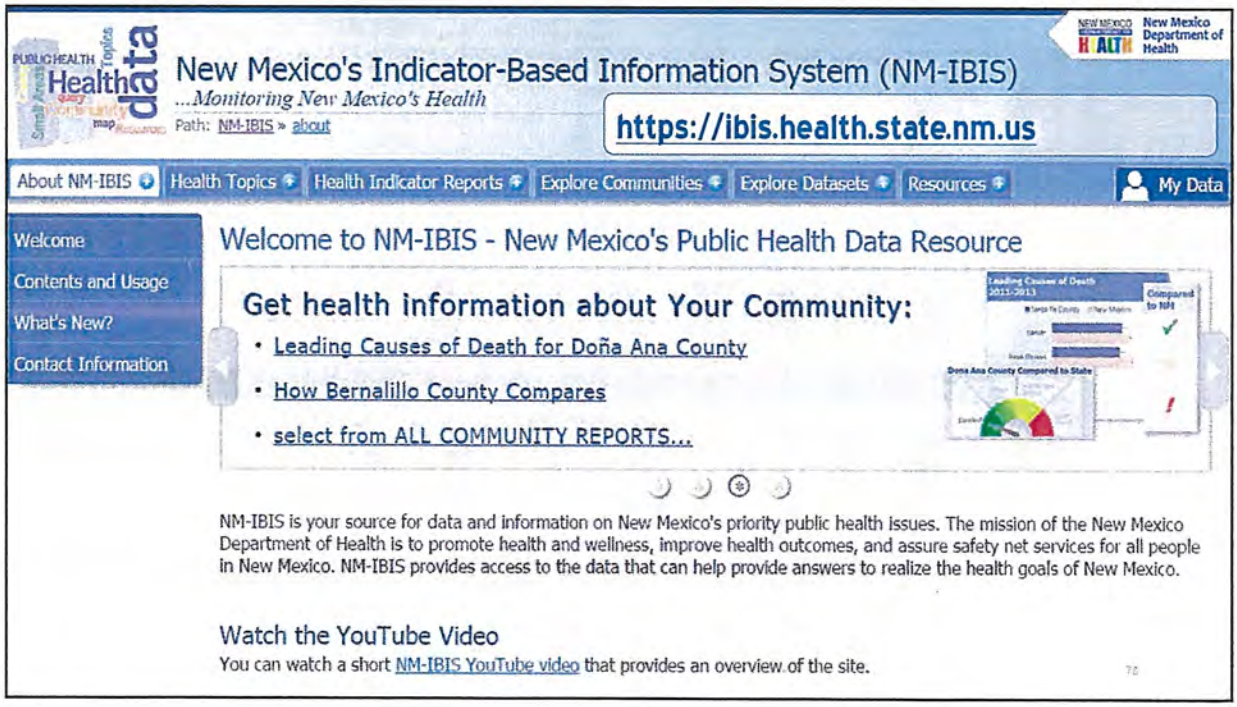

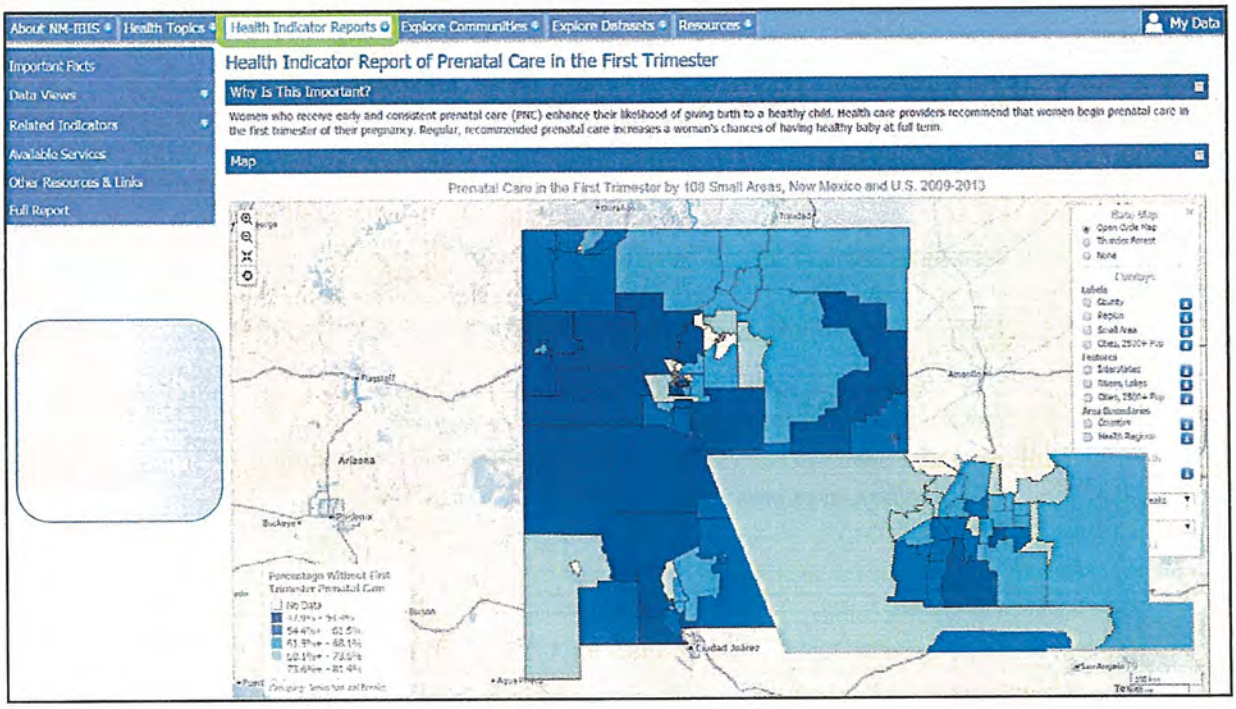
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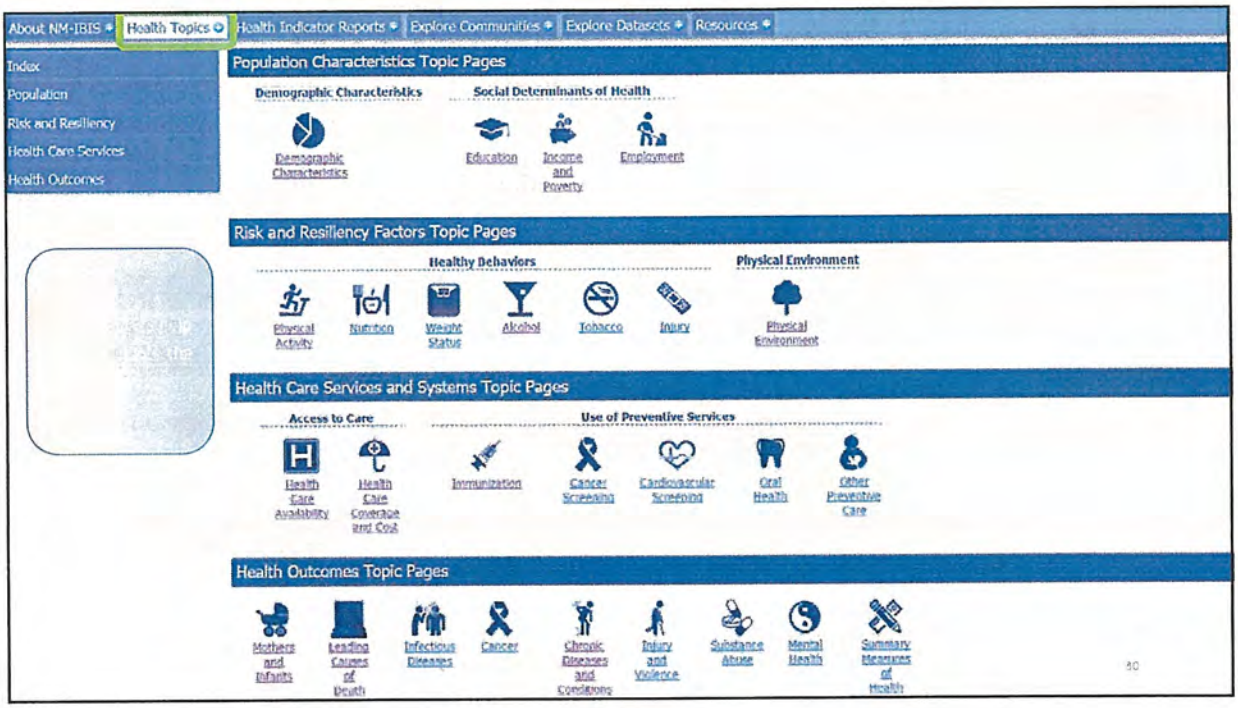
Related Indicators
Available Services
Other Resources & Links
Full Report
Health Indicator Report of Prenatal Care in the First Trimester
Why Is This Important?
Women who receive early and consistent prenatal care (PNC) enhance their likelihood of giving birth to a healthy child. Health care providers recommend that women begin prenatal care in the first trimester of their pregnancy. Regular, recommended prenatal care increases a woman's chances of having healthy baby at full term.
Map
Prenatal Care in the First Trimester by 100 Small Areas, New Mexico and U.S. 2009-2013
Arizona
Ciudad Juárez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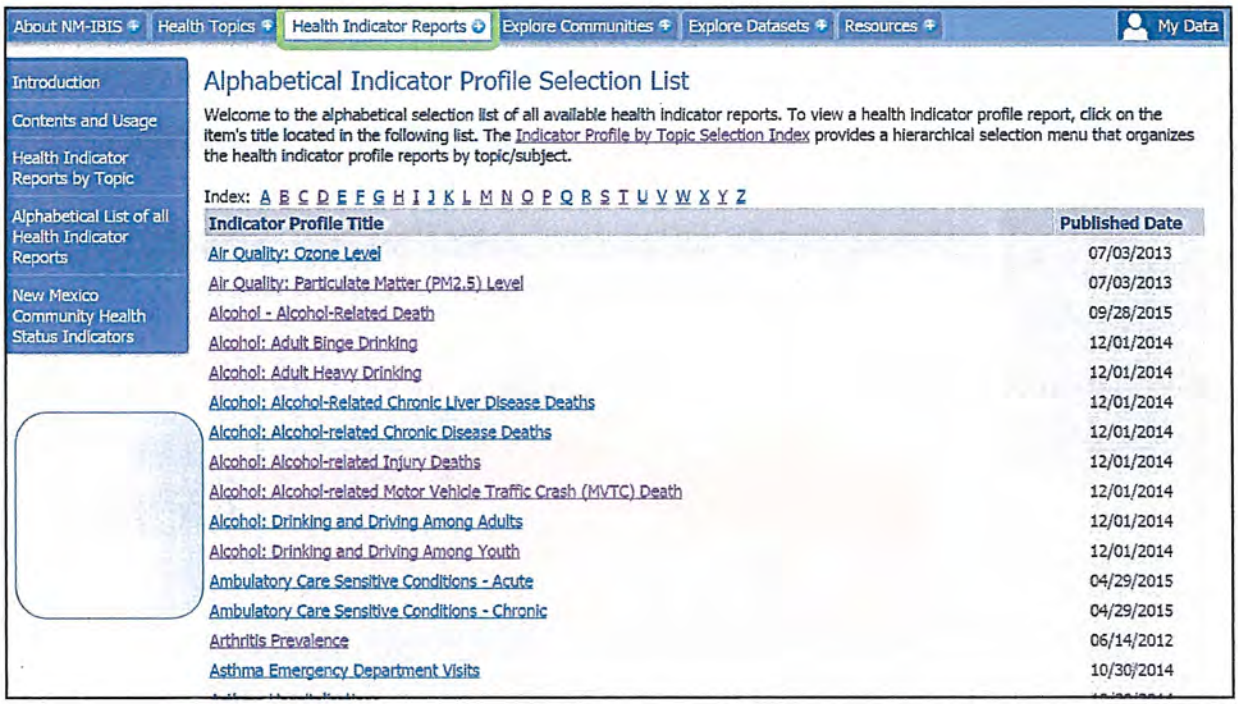
Injury and Violence
Substance Abuse
Mental Health
Summary Measures of Health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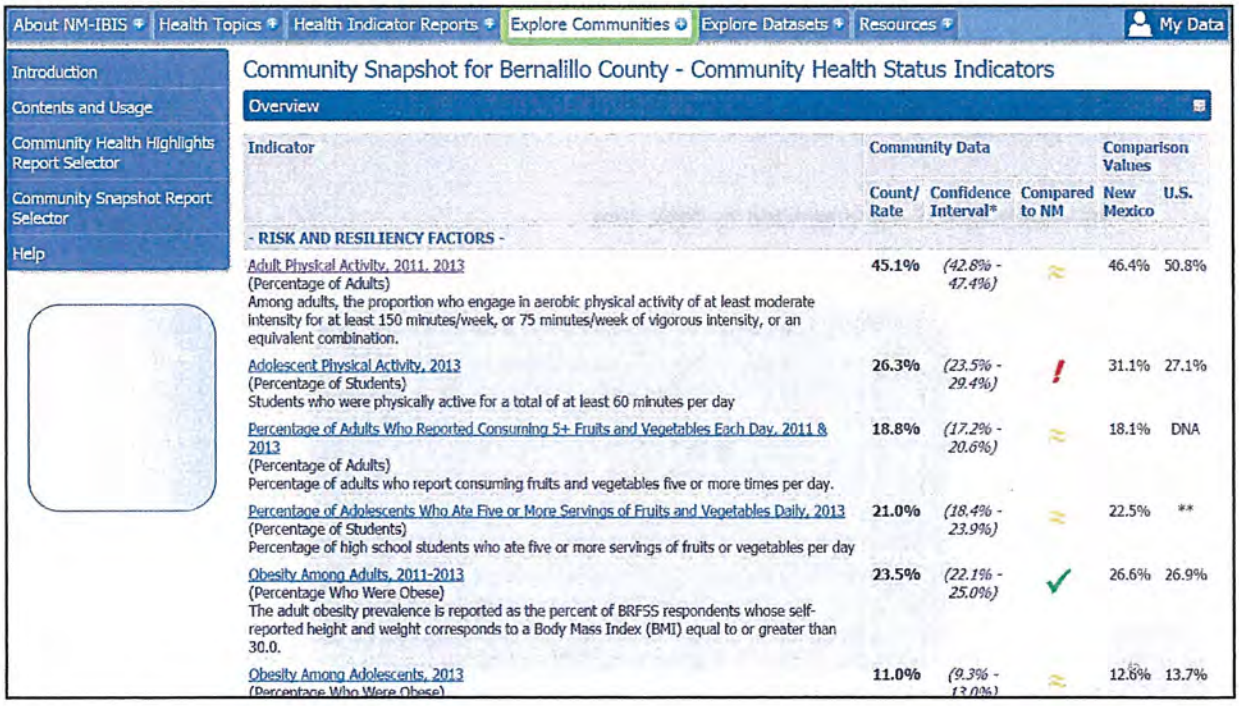
Health Indicator Reports by Topic
Alphabetical List of all Health Indicator Reports
New Mexico Community Health Status Indicators
Alphabetical Indicator Profile Selection List
Welcome to the alphabetical selection list of all available health indicator reports. To view a health indicator profile report, click on the item's title located in the following list. The Indicator Profile by Topic Selection Index provides a hierarchical selection menu that organizes the health indicator profile reports by topic/subject.
Index: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z
Indicator Profile Title
Published Date
Air Quality: Ozone Level 07/03/2013
Air Quality: Particulate Matter (PM2.5) Level 07/03/2013
Alcohol - Alcohol-Related Death 09/28/2015
Alcohol: Adult Binge Drinking 12/01/2014
Alcohol: Adult Heavy Drinking 12/01/2014
Alcohol: Alcohol-Related Chronic Liver Disease Deaths 12/01/2014
Alcohol: Alcohol-related Chronic Disease Deaths 12/01/2014
Alcohol: Alcohol-related Injury Deaths 12/01/2014
Alcohol: Alcohol-related Motor Vehicle Traffic Crash (MVTC) Death 12/01/2014
Alcohol: Drinking and Driving Among Adults 12/01/2014
Alcohol: Drinking and Driving Among Youth 12/01/2014
Ambulatory Care Sensitive Conditions - Acute 04/29/2015
Ambulatory Care Sensitive Conditions - Chronic 04/29/2015
Arthritis Prevalence 06/14/2012
Asthma Emergency Department Visits 10/30/2014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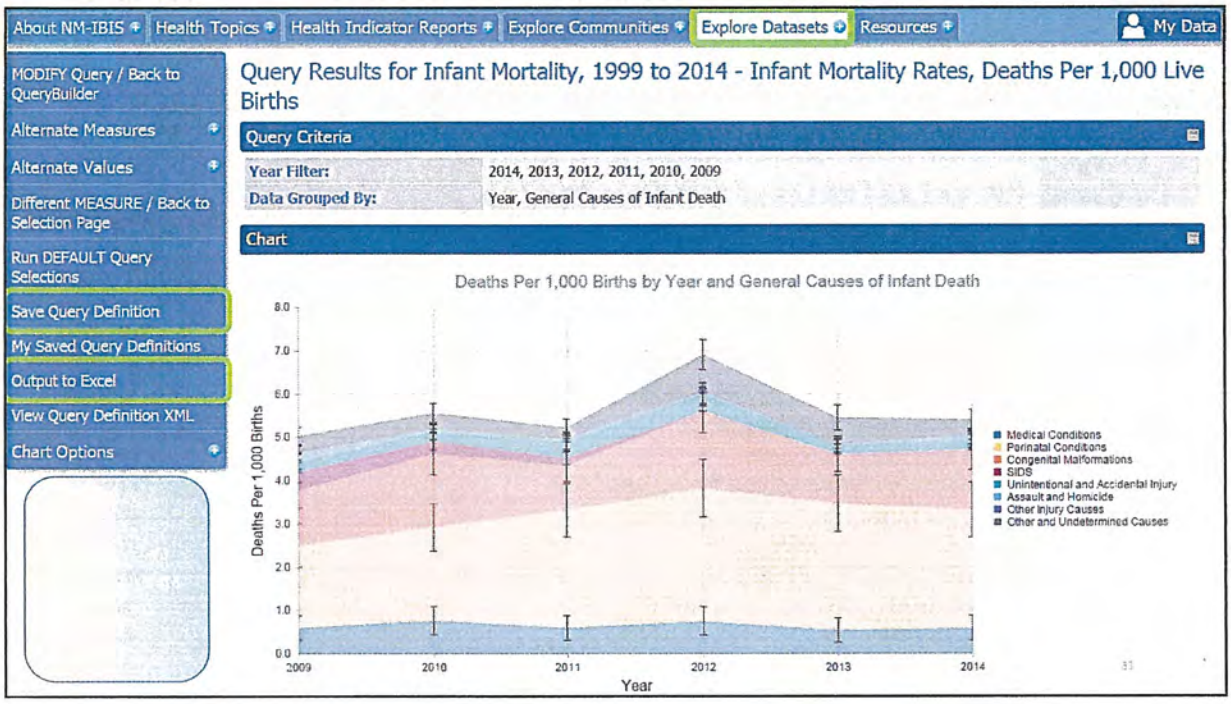
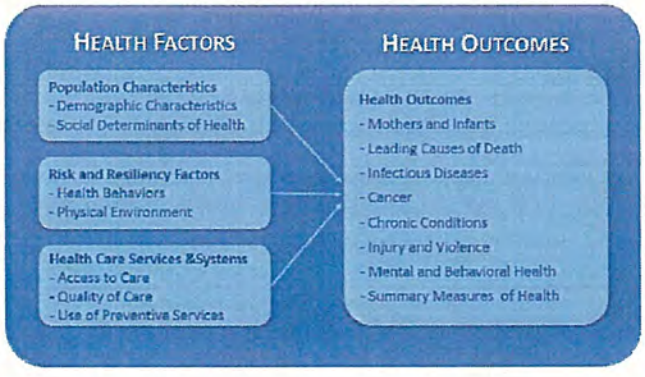
Community Snapshot for Bernalillo County - Community Health Status Indicators
Overview
Indicator
Community Data
Count/ Rate
Confidence Interval*
Compared to NM
Comparison Values
New Mexico
U.S.
- RISK AND RESILIENCY FACTORS -
Adult Physical Activity, 2011, 2013 (Percentage of Adults) Among adults, the proportion who engage in aerobic physical activity of at least moderate intensity for at least 150 minutes/week, or 75 minutes/week of vigorous intensity, or an equivalent combination. 45.1% (42.8% - 47.4%) ≈ 46.4% 50.8%
Adolescent Physical Activity, 2013 (Percentage of Students) Students who were physically active for a total of at least 60 minutes per day 26.3% (23.5% - 29.4%) ! 31.1% 27.1%
Percentage of Adults Who Reported Consuming 5+ Fruits and Vegetables Each Day, 2011 & 2013 (Percentage of Adults) Percentage of adults who report consuming fruits and vegetables five or more times per day. 18.8% (17.2% - 20.6%) ≈ 18.1% DNA
Percentage of Adolescents Who Ate Five or More Servings of Fruits and Vegetables Daily, 2013 (Percentage of Students) Percentage of high school students who ate five or more servings of fruits or vegetables per day 21.0% (18.4% - 23.9%) ≈ 22.5% **
Obesity Among Adults, 2011-2013 (Percentage Who Were Obese) The adult obesity prevalence is reported as the percent of BRFSS respondents whose self-reported height and weight corresponds to a Body Mass Index (BMI) equal to or greater than 30.0. 23.5% (22.1% - 25.0%) ✓ 26.6% 26.9%
Obesity Among Adolescents, 2013 (Percentage Who Were Obese) 11.0% (9.3% - 13.0%) ≈ 12.8% 13.7%



New Mexico's Community Health Status Indicators

- 46 Health indicators, organized by topic area



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EXAMPLE NM-IBIS INDICATOR REPORT PAGES

Selected Community Health Status Indicators

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85

Teen Birth Rate

Why Is This Important?

Factors in New Mexico's high teen pregnancy rates are poverty, education, rural vs. urban population and access to services.

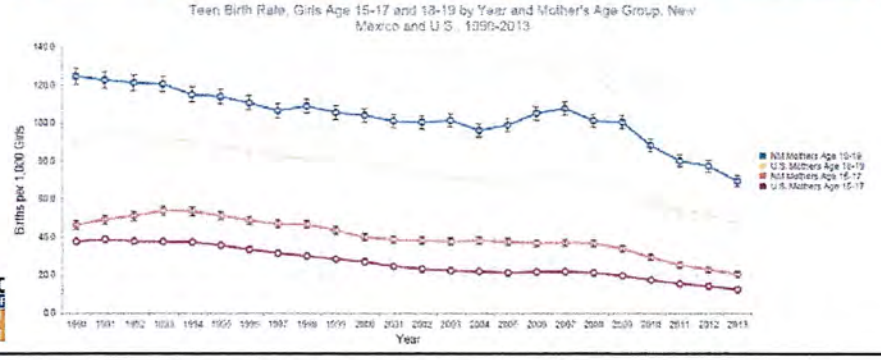
Poverty is one of the most important contributing factors to teenage pregnancy. In 2013, New Mexico ranked 2nd among all states and the District of Columbia in percentage of children living in poverty (30.1% of children age 0-17 in poverty).

Teens who have dropped out of school are more likely to become pregnant and have a child than their peers who stay in school. The NM high school dropout rate in 2012 was 29.6%, compared to 24.5% nationally.

Teen parenthood is most common in rural areas.

There is a lack of access to family planning services with all but one of NM counties classified as a health professional shortage area.

Chart



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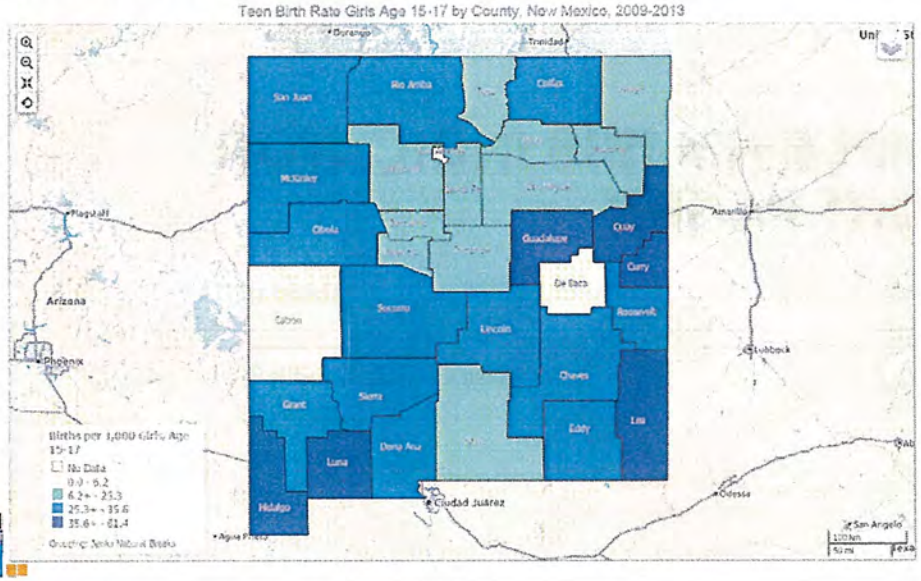
Teen Birth Rate

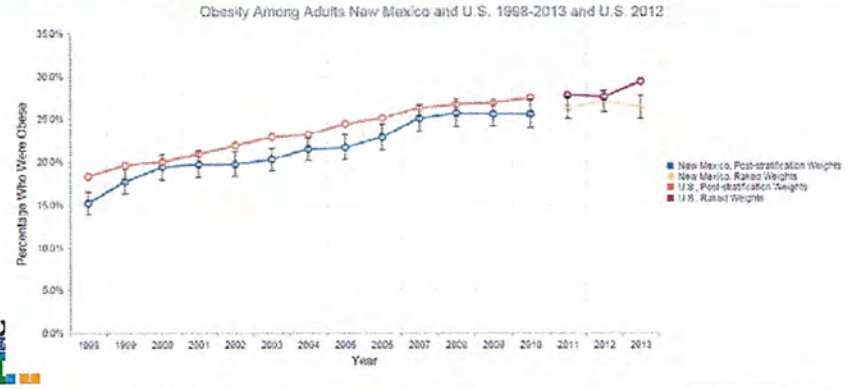


Obesity - Adult Prevalence

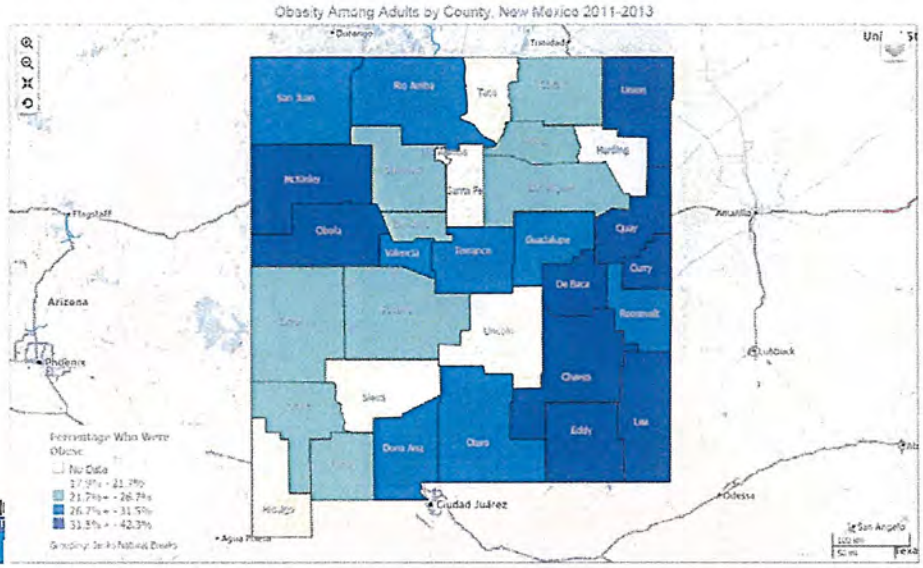
Why Is This Important?

Obesity is associated with an increased risk for a number of chronic diseases, including heart disease, stroke, diabetes, and some cancers (endometrial, colon, kidney, esophageal, and post-menopausal breast cancer.) In both New Mexico and the United States, the percentage of adults who are obese, based on telephone survey data, has more than doubled since 1990. Excess weight also contributes to the development of arthritis, a chronic disease that is the leading cause of disability amongst adults in the nation and the state.

Chart



Obesity - Adult Prevalence

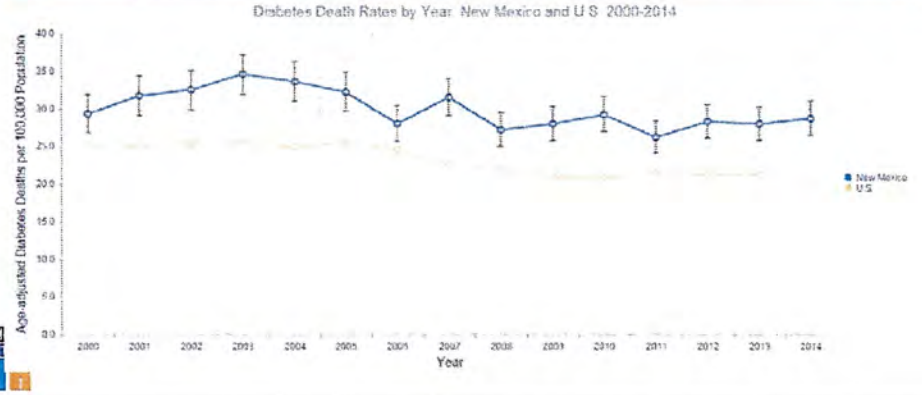


Diabetes Deaths

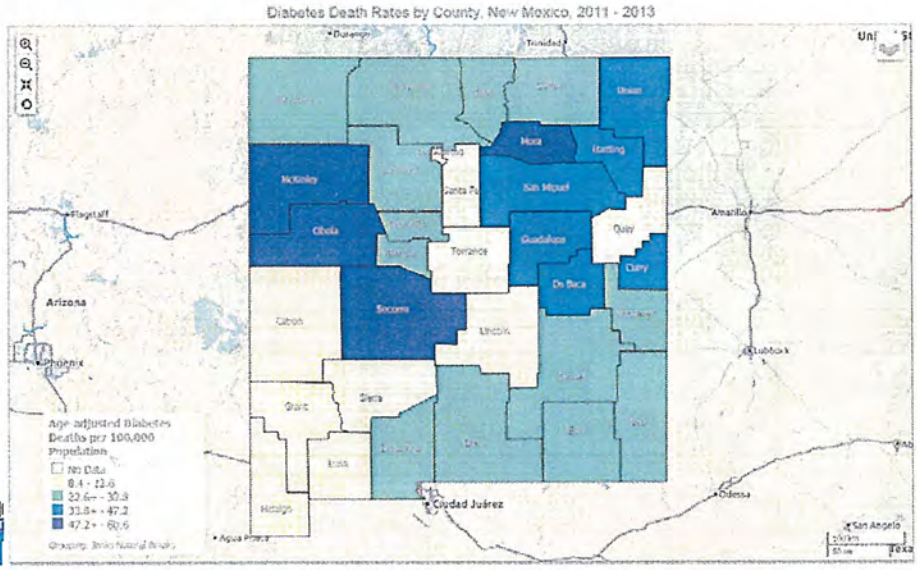
Why Is This Important?

Diabetes is the 6th leading cause of death for New Mexicans and the 7th leading cause in the U.S. Diabetes complications, which are costly to individuals, families and to society, include premature death, cardiovascular disease, blindness, end stage kidney disease, and lower extremity amputations. People with diabetes are two to four times more likely to develop cardiovascular disease and stroke; about 65% of deaths in people with diabetes nationwide are due to these conditions. Costs of diabetes extend beyond medical costs, such as costs due to lower productivity, disability and loss of productive life due to premature death, and care-taking by family members. Effective and accessible diabetes prevention and management programs and resources are necessary to reverse the increasing rates of diabetes in our communities.

Chart



Diabetes Deaths

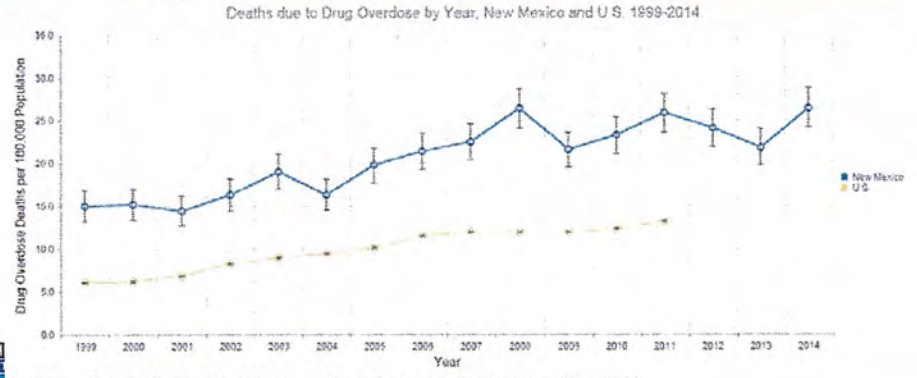


Drug Overdose Deaths

Why Is This Important?

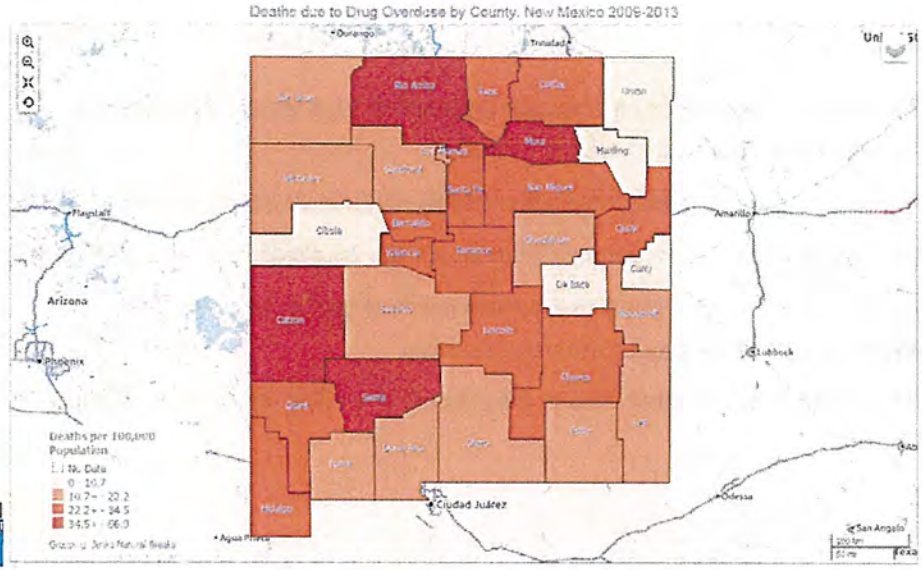
New Mexico's drug overdose death rate has been one of the highest in the nation for most of the last two decades. New Mexico's death rate has more than tripled since 1990. While deaths due to illicit drugs have remained steady during the past decade, deaths due to prescription drugs (particularly opioid pain relievers) have increased dramatically. In addition to the high death rates, drug abuse is one of the most costly health problems in the U. S. In 2007, it was estimated that prescription opioid abuse, dependence, and misuse cost New Mexico $890 million (based on a national methodology derived by Birnbaum et al. (2011). Societal costs of opioid abuse, dependence, and misuse in the United States. Pain Medicine, 12(4):657-667).

Chart



In 2013, New Mexico had the third highest total drug overdose death rate in the nation (most recent data available).

Drug Overdose Deaths



Chronic Pain Study

Background

- The NM Department of Health administers the Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council
- A pain management specialist and a consumer health advocate sit on the Advisory Council
- The Advisory Council adopted recommendation for a study on needs of chronic pain patients
- House Memorial 98 called for a study to ascertain needs of chronic pain patients
  - However, there was a lack of resources to conduct the study
- The Department of Health is committed to the concept of a study on needs of chronic pain patients

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Context of Chronic Pain

Several definitions of chronic pain

- Pain $\geq$ 3 months
- Pain $\geq$ 6 months
- Definitions may include duration and severity

Prevalence of chronic pain in previous studies

- 19% in 2014 US national study conducted by National Center for Health Statistics
- 26% in 2007 Kansas state Behavioral Risk Factor Surveillance System
- 30.7% in Internet-based national survey conducted by Research Triangle Institute Health Solutions

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Possible Sample Designs

Survey Methods

- Mailed questionnaire
- Telephone interview
- Computer-assisted telephone interview (CATI)

Survey Questions

- Screening questionnaire to estimate prevalence of chronic pain
- In-depth interviews to understand causes of pain, sites of pain, and treatments

Possible Instruments

Behavioral Risk Factors Surveillance System (Kansas questions)

- *Example: Do you suffer from any type of chronic pain, that is, pain that occurs constantly or flares up frequently?*

National Health Interview Survey Quality of Life Supplement

- *Example: Do you have frequent pain?*

Brief Pain Inventory

Short Form 36 (from the Danish Health Interview Survey)

Chronic Pain Grade Questionnaire

Resources & Costs

- Major investment of staff time and resources
- Survey development
- Four full-time equivalents for one year to conduct & analyze survey
- Resources for survey dissemination

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THANK YOU!

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Health Information Exchange: Using Data for Achieving Better Health Care

Terry Reusser, Chief Information Officer, Department of Health
Patricia Montoya, Director, New Mexico Coalition for Healthcare Value

Report to the Legislative Health and Human Services Committee
October 20, 2015

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NMDOH is a Rich Source of Data

- The department manages a wide variety of data about people, health, healthcare quality, and preventive and educational services
  - Vital Records (Birth and Death Certificates)
  - Vaccinations
  - Disease
  - Hospital Quality
  - Developmental Disabilities
  - Home Health Services
  - Nutritional Services
  - Family and Children Healthcare
  - Environmental
  - Outpatient
  - Emergency Medical Services
  - Aging and Long-Term Care
  - Electronic Health Records
  - Behavioral Health
  - Laboratory Results
  - Pharmacy / Prescription Management
  - Seven Divisions
  - Over 100 programs
  - Over 350 applications and databases

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Complexities of Managing this Data

- Redundant efforts to capture data
  - Collecting the same data multiple ways
  - Duplication of data in multiple systems affects infrastructure
  - Inconvenience to data providers to report multiple times
  - Inconvenience to patients filling out forms and answering questions
  - Difficulty in understanding the one "true source" of the data
- Timeliness of data collection
  - Collection of data is not timely enough to be useful
  - The ability to report on data is not frequent enough to provide value
- Inability to integrate meaningful related data sources
  - Lack of valuable standards across multiple sources of data
  - Inability to link sources of data for complete picture of healthcare
- Security
  - Strict guidelines from the Office of Civil Rights (OCR) to protect patient privacy according to the Healthcare Information Portability

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Driving Forces for Use of Data Innovation

- Centers for Medicaid and Medicare (CMS) incentive programs to use Electronic Healthcare Records (EHRs) in a meaningful way
- Health and Human Services (HHS), Office of the National Coordinator (ONC) for Health Information Technology initiative to build interoperable solutions
- State Innovation Model (SIM) awards to design and test models for the improvement of the healthcare delivery system
- Affordable Care Act (ACA) requirements to reduce costs
- Consumer demand for access to data
- Public demand for better quality data

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Opportunities

- Integration of current data systems
  - Identify the "dark data" that lies dormant and leverage or lose it
  - Consolidate and link data sources to bring more meaning
  - Develop common core set of data elements and standards that the allow all sources of data to be combined such that a complete picture of the continuum of care is easily accessible
  - Absent the lack of applicable universal standards, prepare to be flexible in collecting multiple forms of data and connect the data
- Collaboration
  - Exchange data with other entities (Human Services Division, Children Youth and Families, Public Education, Environment Department, Department of Workforce Solutions)
  - Extend collaboration to the community (Community wellness programs, City government, Rural Healthcare Providers)
  - Partner with local, state and regional exchanges

Opportunities

- Transparency
  - Multiple stakeholders are involved in collecting, managing and using data related to healthcare
  - Looked at in a collective manner, the data can become much more useful
  - The data has to be available, to the right people at the right time

Questions?

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Hospital Quality and Transparency

Statistics for Fiscal Year 2015

- DHI licensed 53 hospitals
  - 40 Acute Care (35 nationally accredited)
  - 4 Psychiatric (all nationally accredited)
  - 9 Critical Access (4 nationally accredited)
- DHI completed 41 hospital surveys
  - 4 Recertification
  - 1 Accreditation Validation
  - 36 Complaints (out of 546 received)
  - 3 Emergency Medical Treatment and Labor Act (EMTALA)

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Hospital Quality and Transparency

DHI Survey Process

- Centers for Medicare and Medicaid Services (CMS) Directed
- Includes Health/Program and Life Safety Code/Building
- Areas of Non-compliance Identified
  - Record Reviews - patient charts, administrative, personnel, policies and procedures
  - Direct Observations
  - Interviews - administration, care providers, patients
- Report of Findings (CMS form 2567) Issued
- Plans of Correction Required for serious infractions, DHI approves plans then monitors to verify compliance
- Sanctions Recommended by DHI to CMS, Action Taken by CMS

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Hospital Quality and Transparency

Top 5 Areas of Non Compliance Cited

- Patient Rights (18 times)
- Nursing Services (15 times)
- Infection Control Program (10 times)
- Pharmaceutical Services (9 times)
- Quality Assurance Program Improvement (QAPI) (8 times)

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Hospital Quality and Transparency
Other Actions to Improve Quality

- CMS Pilot - Patient Safety Indicator Survey (Infection Control, Quality Assurance (QA) and Performance Improvement (PI), Discharge Planning)
- Improved and Frequent Communication with the NM Hospital Association (HA)
- Presentation at Hospital Conferences - Emergency Preparedness
- Training on Complaint Process through HA October and November 2015

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Health Information Systems Act (SB 323)

Hospital Quality and Transparency Measures

A Presentation to the Legislative Health and Human Services Committee by the New Mexico Department of Health

October 20, 2015

Victoria F. Dirmyer, PhD
Health Systems Epidemiology Program
Epidemiology and Response Division

NEW MEXICO DEPARTMENT OF HEALTH

SB 323

52nd Legislature-2015

Health Information System Act (24-14A-1, et seq. NMSA 1978)

1989: The Health Information Systems Act officially is enacted.

1994 (SB 556): Changes to † 24-14A-2 - Definitions. Changes include removal of committee and addition of commission. Updated department to only include department of health (removal of environmental department).

Changes to † 24-14A-3 - Duties. Removal of department in catchline and replaced with commission.

Changes to † 24-14A-7 - Reports. Added subsection B regarding annual report.

New Sections: Annual Review of Data Needs, Investigatory Powers, Advisory Committee, and Health Information Alliance.

2009 (HB 293): Changes to † 24-14A-2 - Definitions. Changes include updates to data source and record level data.

Changes to † 24-14A-6 - Access. Changes include sharing of data between HPC and DOH and sharing of data with a federal entity.

Changes to † 24-14A-8 - Confidentiality. Changes include confidential parameters around record level data to the DOH.

2012 (HB 18): Changes to † 24-14A-2 - Definitions. Changes include the removal of commission.

Changes to † 24-14A-3 - Duties of Department.

Changes to † 24-14A-11 - Temporary Provision. Transfer of property, records, and contracts from HPC to DOH.

2015 (SB 323): Changes to † 24-14A-11 - Creation of Advisory Committee.

Changes to † 24-14A-6.1 - Website; Public Access; Data.

Changes to † 24-14A-8 - Confidentiality.

Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

1) § **24-14A-11 Advisory Committee**

"The secretary of health shall appoint a health information system advisory committee to advise the department in carrying out the provisions of the Health Information System Act. The secretary shall establish the membership and duties of the committee by rule."

NEW MEXICO DEPARTMENT OF HEALTH

Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

2) § **24-14A-8 Health Information System; Confidentiality**

"C. The individual forms, electronic information or other forms of data collected by and furnished for the health information system shall not be public records subject to inspection pursuant to Section 14-2-1 NMSA 1978. The department may release or disseminate aggregate data, **including those data that pertain to a specifically identified hospital or other type of health facility.** These data shall be public records if the release of these data does not violate state or federal law relating to the privacy and confidentiality of individually identifiable health information."

NEW MEXICO DEPARTMENT OF HEALTH

Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

3) § **24-14A-6.1 Website; Public Access; Data**

"By January 1, 2018, the department shall ensure that the public is provided with access, free of charge, to a user-friendly, searchable and easily accessible web site on which the department shall post and update on a regular basis cost, quality, and such other information it publishes pursuant to the Health Information System Act. The web site shall be accessible through the sunshine portal. The department shall adopt and promulgate rules to carry out the provisions of this section."

Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.

Additional section added to HIS Act

3) § **24-14A-6.1 Website; Public Access; Data**

Issues

a) Charge data in HIDD may not capture all charges (currently limited to 22 revenue line item charges per admission record).

b) A claims database is a better alternative for analyzing healthcare costs (All Payers Claims Database-APCD).

c) How will quality healthcare be defined? What measures will be used? Prevention Quality Indicators (PQIs)?

Progress Update

The Department of Health has been working to draft a set of rules governing the Advisory Committee—outlining membership, duties and responsibilities of committee members, and the setting for committee meetings.

Next Steps

Once the rules are outlined, then a public hearing will be held. This will be an opportunity for individual's outside of the Department of Health to comment on the drafted rules.

Once the rules become finalized, the Secretary of the Department of Health will appoint committee members.

HIDD 101

Hospital inpatient and discharge data in New Mexico

Health Information System Act (24-14A-1, et seq. NMSA 1978)

- Provides authority for the Department of Health to collect health data.
- NMDOH had this authority prior to the revision of this Act in 2012 based on authority in the Public Health Act.

New Mexico Administrative Code (7.1.27)

- Outlines the specific data reporting requirements for licensed inpatient and outpatient general and specialty health care facilities, pursuant to the HIS Act.

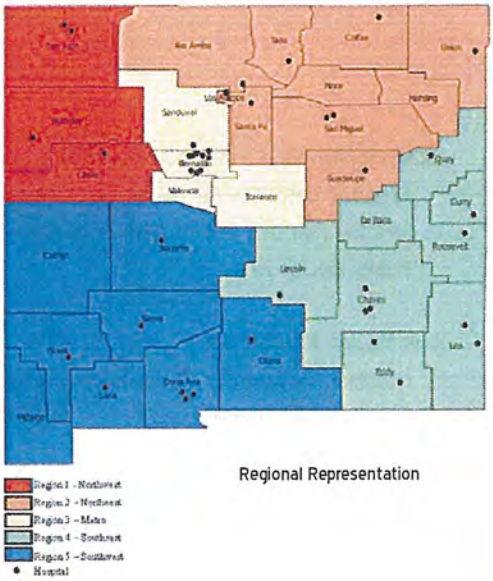
Reporting

- Hospitals are required to report inpatient hospitalization data quarterly.
- Information includes admission information, discharge information, diagnoses, procedures, demographics, and hospital stay costs (revenues).

Data Elements

- In 2015, currently collecting 268 data elements.

- Specialty Hospitals: 13
- General Hospitals: 37



Regional Representation

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How to Improve New Mexico's Hospitalization Data

- Currently the hospitalization dataset is limited to non-federal hospitals.
  - Missing
    - Veteran's Affairs Data (VA)
    - Indian Health Services Data (IHS)
    - Neighboring States Data (TX, CO, AZ)
- Improvements
  - IHS data is available for 2010-2014 (Enhanced HIDD)
  - De-identified data from CO, AZ, and TX has been obtained (looking to gather 2010-2014 data)
  - Discussions with VA have been occurring for several years
- Overall Goal: Population-based surveillance of health conditions affecting New Mexicans

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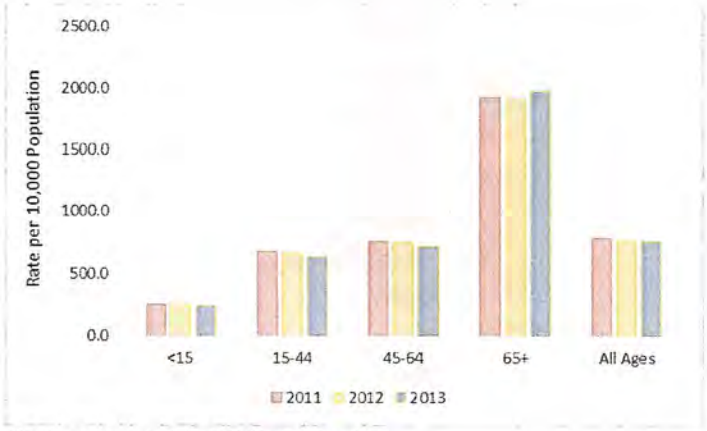
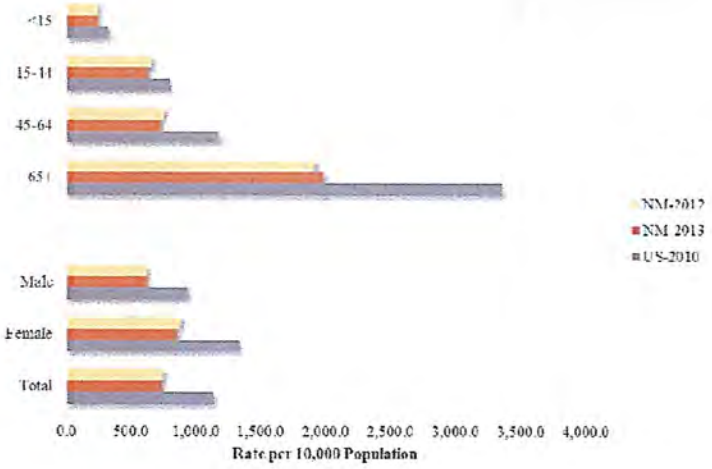
Discharge Rates by Age and Gender, NM, 2011-2013



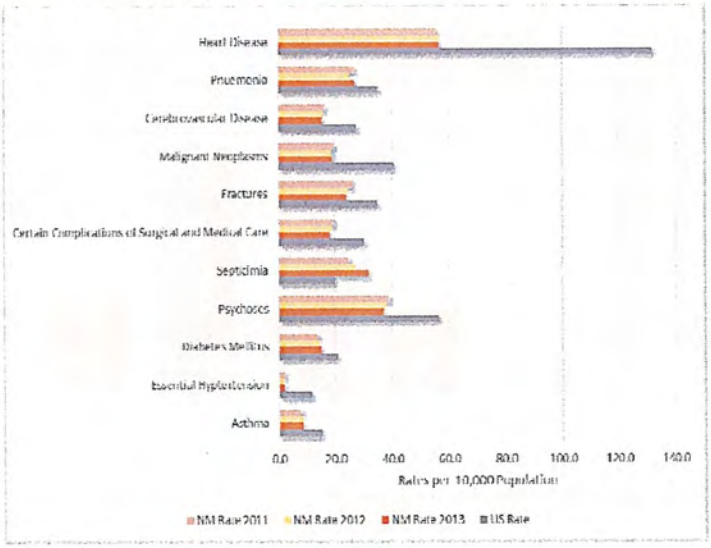
*All rates are age-adjusted to the 2000 U.S. standard population

Discharge Rates by Age and Gender, NM (2012-2013) and United State (2010)



*All rates are age-adjusted to the 2000 U.S. standard population

Discharge Rates by NCHS Category, NM, 2011-2013, and United States, 2010



*All rates are age-adjusted to the 2000 U.S. standard population

Data Integrity

Top five concerns

1. Timeliness of Data Submission

Reporting Period	Report Due to the division (95% of discharges)	Division returns integrity and validation errors	Final corrected report due to division (100% of discharges)
January 1 - March 31 (Q1)	May 31	June 15	June 30
April 1 - June 30 (Q2)	August 30	September 15	September 30
July 1 - September 30 (Q3)	November 30	December 15	December 31
October 1- December 31 (Q4)	February 28 (of the following year)	March 15 (of the following year)	March 31 (of the following year)

http://164.64.110.239/nmac/parts/title07/07.001.0027.pdf

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1. Timeliness of Data Submission

- If timeline was followed, NMDOH would be able to finalize a dataset by the beginning of May.
- Typically the annual dataset is available in September/October (2014 HIDD was put onto IBIS at the end of September).
- Issues Encountered in 2014 HIDD
  - Revenue Codes not formatted as outlined in NMAC 7.1.27
  - Duplication of records due to more than 22 revenue codes
  - Admission and Discharge Hours and Dates the same.
- Annual 2014 HIDD report will be available November 2015.

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2. Data Formatting for Submission

- In 2011, NMDOH received a grant from the Agency for Healthcare Research & Quality (AHRQ) to improve the collection of race and ethnicity data.
- In 2011 HIDD, the following was the status of race and ethnicity data in HIDD.

	Pre-DOH Intervention	Year 1/Flux (Q1/Q2 2011)	Year 1.5 (Q3 2011)	Current Year (2014)
% of general hospitals reporting	100% (37)	100% (37)	100% (36)*	100% (50)
% of general hospitals reporting race and ethnicity values	0	81.1% (30)	91.6% (33)	100% (50)
% of general hospitals reporting valid race and ethnicity values	0	78.4% (29)	88.9% (32)	100% (50)**
% of general hospitals reporting tribal identifiers	0	75.7% (28)	88.9% (32)	100% (50)
% of general hospitals reporting valid tribal identifiers	0	2.7% (1)	2.8% (1)	100% (50)†
% of general hospitals reporting multiple race	0	2.7%(1)	0	100% (50)
% of general hospitals reporting multiple tribe	0	0	0	18% (9)

*Year 1.5 only has a total of 36 hospitals because Heart Hospital was bought by Lovelace.
**288 records had an invalid race value (11 facilities).
† 266 records had an invalid tribal value (15 facilities).

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2. Data Formatting for Submission

PATIENT ETHNICITY

Name: ETHNICITY Type: Character Length: 2 Format: $ETHNIC

DEFINITION: The gross classification of patient's self-reported ethnicity.

Codes:
E1 -- Hispanic or Latino
E2 - Non-Hispanic or Non-Latino
E6 - Declined
E7-- Unknown

Source: Input record, location 1766.

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2. Data Formatting for Submission

PATIENT RACE

Name: RACE1-RACE5 Type: Character Format: $RACE
Length: 12

DEFINITION: The classification(s) of a patient's stated race to include one or multiple reported classifications, coded as shown below. When reporting multiple classifications do not use spaces or delimiters. For example, if a patient states that he or she is both Asian and other the race field would be R1R5.

Codes:
R1 - American Indian or Alaska Native
R2 - Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean and Vietnamese)
R3 - Black or African American
R4 - Native Hawaiian or Pacific Islander (including Chamorro and Samoan)
R5 - White
R6 - declined
R7 - unknown
R9 - other race

Source: Input record, location 1754.

3. Records with Missing Diagnoses

- In 2013, 577 records were missing a primary diagnosis (←1%).
- In 2014, 753 records were missing a primary diagnosis (←1%).
- Diagnosis codes are **imperative** for surveillance.

4. Communication between NMDOH and Hospitals

- Vendor Changes
- Changes in Staff Members
- Formatting/Coding Questions
- File Submission Formatting (Fixed Length File)

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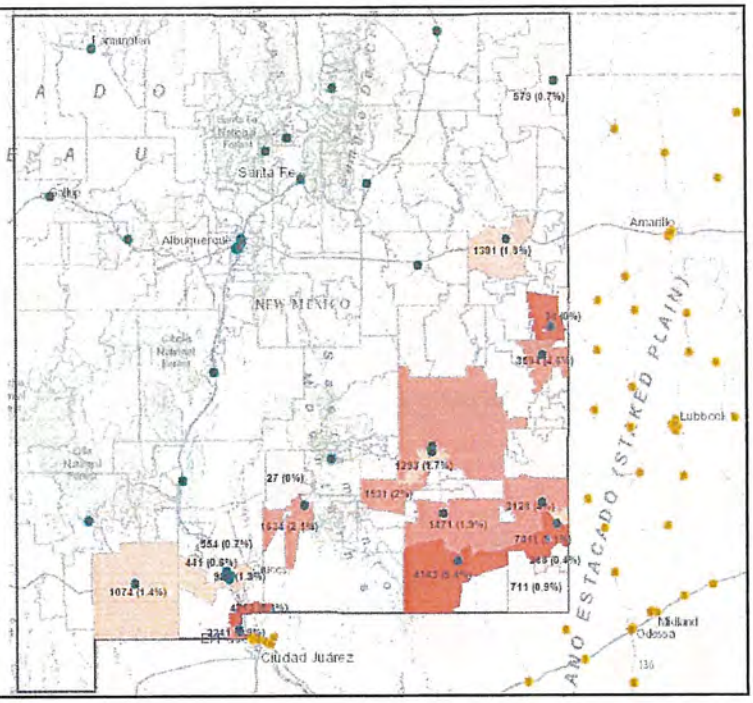
5. Data Validity

- Does HIDD capture all New Mexicans?
- Texas data from 2005-2010 shows that 77,399 hospitalizations occurred in Texas hospitals for New Mexico residents.
- Major Texas cities include Amarillo, Lubbock, Midland/Odessa, and El Paso.



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Data Usage

Hospitals and general public

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New Mexico Epidemiology

July 4, 2014 Volume 2014, Number 4

Ambulatory Care Sensitive Condition Hospitalization Rates in New Mexico

Chronic ACSC Include:

- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Angina
- Asthma (pediatric & adult)
- Hypertension
- Diabetes

Acute ACSC Include:

- Pneumonia
- Dehydration
- Urinary Tract Infection (UTI)

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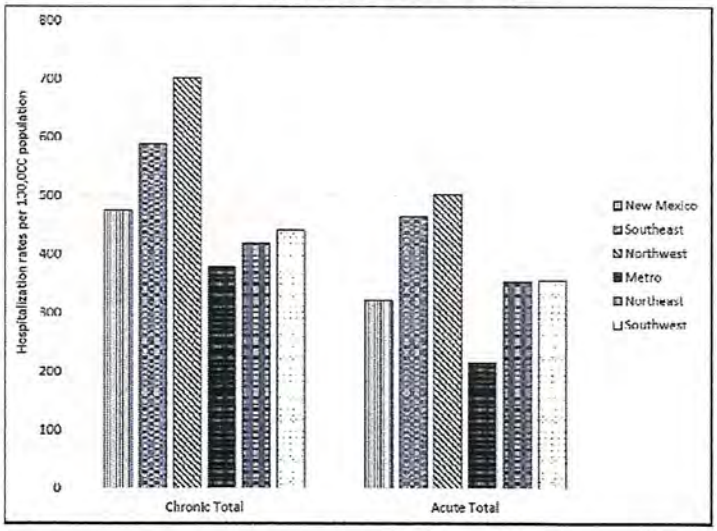
Chronic and Acute Ambulatory Care Sensitive Conditions Hospitalization Rates per 100,000 population in Five Regions of New Mexico, 2012



Ambulatory Care Sensitive Condition Hospitalization Rates in New Mexico

- High rates of ACSCs are an indication of a lack of access, availability or quality of primary care services.[1]
- In New Mexico, the Southeast and Northwest health regions had the highest ACSC rates.
- Other factors that may contribute to high ACSC rates include poor patient education, lack of patient compliance, lack of primary care providers, poor disease management by primary care providers, and socioeconomic factors like income.[2]
- High ACSC rates in the Southeast and Northwest health regions parallel a primary care physician shortage as indicated by a gap analysis performed by the New Mexico Health Workforce Committee in 2012.

[1]Saha, S., et al., Are preventable hospitalizations sensitive to changes in access to primary care? The case of the Oregon Health Plan. Med Care, 2007. 45(8): p. 712-9.
[2]Siegrist, R.B., Jr. and N.M. Kane, Exploring the relationship between inpatient hospital costs and quality of care. Am J Manag Care, 2003. 9 Spec No 1: p. SP43-9.
[3]Sanchez, M., et al., Variations in Canadian rates of hospitalization for ambulatory care sensitive conditions. Healthc Q, 2008. 11(4): p. 20-2.

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New Mexico Epidemiology

April 15, 2015 Volume 2015, Number 3

Hospital Readmissions among the Homeless Population in Albuquerque

30- Day Readmission Rates by Year for Homeless Patients, Bernalillo County, 2010-2013

Calendar Year	Number of Patients with a 30-Day Readmission	Total Number of Homeless Patients	% of Patients with a 30-Day Readmission
2010	107	368	29.1
2011	82	253	32.4
2012	93	317	29.3
Overall*	256	850	30.1
Number of Records	720	2,068	34.8
Bernalillo County Residents			
Overall*	17,798	144,710+	12.3

*Overall combines all 3 years.
+ Total number of patients.

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Hospital Readmission among the Homeless Population in Albuquerque

- Homeless patients who visited an Albuquerque hospital at least once had a higher 30-day readmission rate compared to Bernalillo county residents. This rate was also higher than the estimated readmission rate of ~20% among Medicare and Medicaid beneficiaries (CMS: Centers for Medicaid and Medicare Services).[1]
- With a readmission rate of 19%, CMS estimated the cost of these readmissions to be around $17 billion.[1]
- Homelessness impacts all age groups, including children. Children are the most vulnerable as homelessness is associated with multiple stressors, including loss of property, disruption of school and community relationships, and dramatic changes in family routine.[2]
- Readmission rates are a direct means of capturing and measuring quality of care.

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[1]Centers for Medicare & Medicaid Services. National medicare readmission findings: Recent data and trends. 2012.
[2]Grant R, Gracy D, Goldsmith G, Shapiro A, Redlener IE. Twenty-five years of child and family homelessness: Where are we now? Am J Public Health. 2013; 103 Suppl 2:e1-10

Summary/Key Points

1. Major improvements in HIDD data collection have occurred since NMDOH became the co-data stewards for the HIDD in 2009.
   - Inclusion of more variables: revenue codes.
   - Formatting of variables for better analysis.

2. The collection of patient demographics has improved since the NMDOH intervention in 2011, improving the collection of race, ethnicity, and tribal affiliation.

3. Timeliness of data submission by hospitals will benefit the timeliness of the HIDD annual report, HIDD data on NM-IBIS, and fulfillment of data requests.

4. Communication between NMDOH and hospitals is needed to keep the data flow moving and to ensure that hospitalization data is of highest quality.

5. Hospitalization data has been used for high level analysis and will continue to be used for future analyses.

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Update on Comprehensive Planning for Hepatitis C Virus (HCV) and Hepatitis C Coalition

Andrew Gans, MPH
HIV, STD and Hepatitis Section Manager

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New Mexico Hepatitis C Coalition

- Formed in August 2013.
- First invitational meeting for the community on May 14, 2014.
- Partnership of New Mexico Department of Health (NMDOH) and community organizations.
- Follows prior planning groups, including the New Mexico Hepatitis C Alliance.

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New Mexico Hepatitis C Coalition

- Meets monthly (first Thursday of the month) via the "ZOOM" telehealth system.
- Co-chairs from three organizations:
  1) NMDOH: Laine Snow
  2) UNM ECHO Institute: Miranda Sedillo
  3) Southwest CARE Center: Rosie Brandenberger
- Will create the state's first comprehensive plan for HCV since 2004's "Vision and Strategy."

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Coalition - Expansion

- After passage of House Memorial 26 (HM26): Hepatitis Task Force (Trujillo), the Coalition was expanded to invite perspectives noted in the bill.
- Invitations from Public Health Division Director Mark Williams sent in first week of June 2015.
- Greater participation from:
  Human Services Department (HSD)
  Medicaid Managed Care Organizations (MCOs)
  Corrections Department
  Community health councils from some areas.

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Comprehensive Planning – Basis for Work

Uses established hepatitis C plans.

- Framework for the 2016-2020 DVH Strategic Plan – from Centers for Disease Control and Prevention (CDC), Division of Viral Hepatitis (DVH)

- Health and Human Services (HHS) Action Plan for the Prevention, Care and Treatment of Viral Hepatitis

Also modeled on the National HIV/AIDS Strategy (NHAS).

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Comprehensive Planning

Group established a process with four phases to develop a comprehensive plan.

1) Develop vision/mission and goals. complete
2) Assess available resources for HCV. complete
3) Identify unmet needs and gaps across New Mexico. In process – prioritizing gaps
4) Create specific objectives for each goal.

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Mission/Vision

- New Mexico will prioritize the prevention, testing and treatment of infection with hepatitis C virus (HCV) in order to reduce the number of new infections as well as cure the infection in those currently living with HCV, thereby reducing the negative health impacts of this disease.

Goals

1. **Prevention**: Reduce the transmission of HCV by providing harm reduction education and interventions.
2. **Access to Testing and Care**: Cure HCV and reduce negative health impacts by improving access to testing, counseling, support, treatment and comprehensive medical care.
3. **Education and Training**: Reduce stigma, increase awareness and expand resources by providing education and training to at-risk populations, persons with HCV, providers and policy makers.
4. **Health Disparities**: Reduce health disparities related to HCV by advocating for increased resources and appropriate policies for surveillance, prevention and medical services.

Thank you.

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Vaccine Purchase Act

Department of Health (DOH) presentation to LHHS

October 20, 2015

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Vaccine Purchase Act – summary

- Purpose: expand access to vaccines, improve vaccine coverage rates, and facilitate providers getting vaccines.
- Non-reverting fund created - only for vaccine purchase (no administration expenses)
- DOH purchases vaccines for all NM children, invoices insurers and group health plans for the cost, and reports non-payment to Attorney General
- DOH estimates vaccine costs for all privately insured children, plus 10%
- Office of Superintendent of Insurance (OSI) requires insurers to report number of insured children
- DOH invoices insurers/health plans quarterly for their proportion of insured children

ACCOMPLISHMENTS

1) DOH drafted regulations, held a hearing and finalized regulations. DOH's rules became effective on August 28, 2015. (NMAC 7.5.4.)

2) DOH met with officials at the Office of Superintendent of Insurance in April and again in October to coordinate and align regulations and procedures.

3) DOH estimated the cost of vaccines for all insured children for **FY16, plus a 10% reserve**, as required by statute.

Total cost estimate = **$20,226,256**

ACCOMPLISHMENTS

4) OSI set up a data collection survey to determine the number of covered children 0-18 for all insurers and employee health groups doing business in New Mexico

- Due date for reporting was July 15, 2015.
- Extensions were granted for companies that requested them.

5) DOH received data on August 7, 2015

- **871 self insured and 237 fully insured plans** reported.
- **54,080 privately insured children** were reported.
- Many problems with addresses, contacts, etc. were found and corrected.
- Number of covered childhood lives continue to be updated and reported.

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DOH INVOICED ALL COMPANIES WHO REPORTED

832 invoices sent out **September 1, 2015**, as required by statute.

Total of $5,056,564 was invoiced

Questions and complaints were received.

- Many issues were fixed – invoices were adjusted, and invoices for those who claimed no covered child lives were voided.
- Immunization Program Manager talked with many companies to address their questions.
- Additional meetings/conference calls held with BC/BS, Cigna and others
- Meeting held with OSI to discuss how to improve the process next year.

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PAYMENTS RECEIVED TO DATE

$3,475,998 received out of $5,056,564 = 68.7%

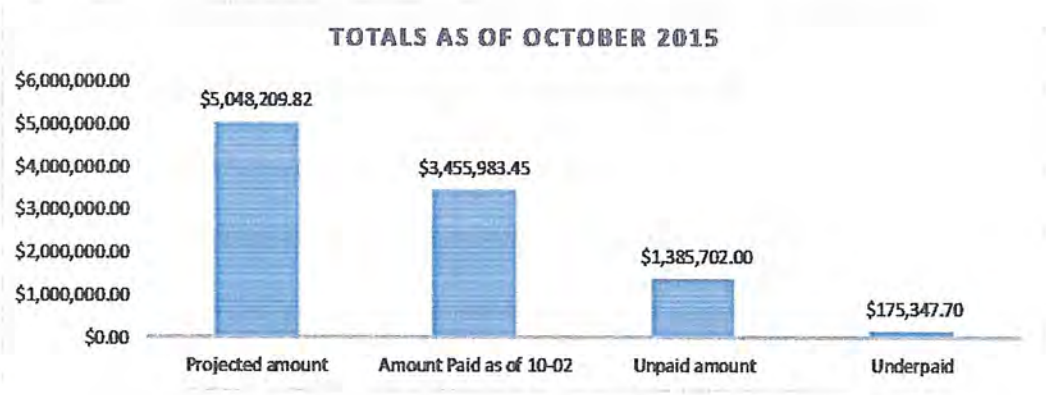
- Immunization Program is working on the receivables
- Due date has been moved back to October 31 due to start-up issues.

Major companies already paid include:

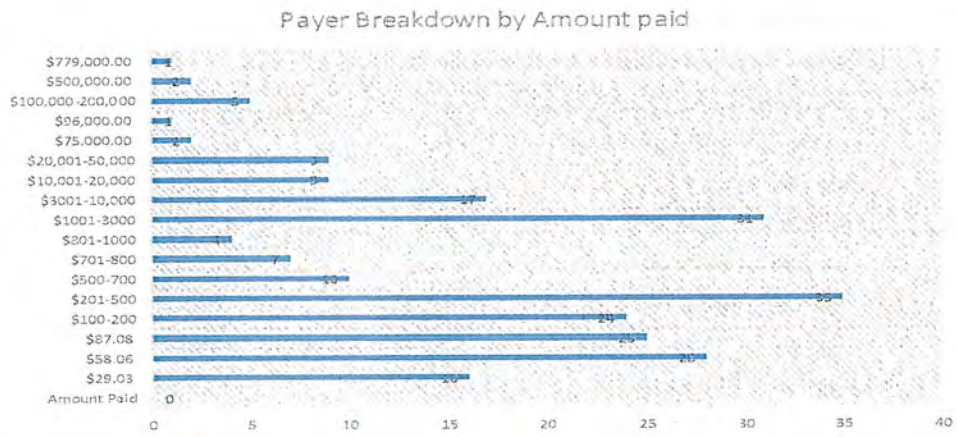
- Blue Cross Blue Shield
- United Healthcare Services
- Presbyterian Health Plan
- State of NM (partial)
- LANL Security
- Albuquerque Public Schools
- UNM

Still due: include Cigna; NM Public Schools Insurance Authority; United HC Insurance; and others.

PAYMENTS RECEIVED TO DATE



PAYERS BY AMOUNT PAID



ISSUES WITH REPORTING AND INVOICING

- Insurers don't have information to exclude Native American children from the counts.
  - We expect this **will affect all payers** and should not result in additional burden on any particular entity.
- Confusion over who should report – third party administrators or employer health groups?
  - One or the other, **but not both**. They need to coordinate and decide which one will report.
  - As duplicate reporting is found, it is fixed immediately and will be correct in the 2nd quarter.
  - DOH and OSI have discussed ways to give clearer instructions for next year to prevent confusion in reporting.
- The invoice had some errors, which will be corrected in the 2nd quarter

ISSUES WITH SELF-INSURED PLANS

- A handful of self-insured plans are raising preemption issues, arguing that federal regulations preempt state regulation and laws, so they don't have to pay
- Other self-insured plans are paying the department and are not raising preemption
- DOH will work with OSI and the AG's office to evaluate this possible legal issue.

NEXT STEPS

- Continue working with our sister agency, OSI, on streamlining the process and working out reporting issues.
- Continue working the receivables, addressing complaints, looking at possible duplicates.
- Determine which companies are refusing to pay vs. which simply haven't paid yet, or have questions.
- Evaluate process and procedures at the end of one year.

Medical Cannabis Program

Andrea Sundberg, Program Coordinator

NEW MEXICO DEPARTMENT OF HEALTH

Current Statistics

- 18,343 Active Patients
- 3,983 Have Personal Production License (PPL)
- This number represents an increase in 6,757 active enrollees over the same time last year (October 2014)

Condition	Applicants	Percentage
PTSD	8,338	45.4%
Chronic Pain	5,120	27.9%
Cancer	1,553	8.5%

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Regulation Changes

- February 2015 - new rule changes adopted, primarily to producer rule, including:
  - Increase in the number of plants that non-profit producers can possess (from 150 to 450);
  - New testing and labeling requirements for cannabis products;
  - New provisions for approval of manufacturers, laboratories and couriers; and
  - Changes to licensing fees for non-profit producers.
- Last year the program also added Parkinson's disease, Huntington's Disease, and Ulcerative Colitis to the list of conditions approved for enrollment.
- New rule changes anticipated soon. Removal of non-profit producer confidentiality provision; amendment to patient rule to remove requirement of attestation that "standard treatments have failed to bring adequate relief"; and removal of certain restrictions on who can diagnose certain medical conditions (PTSD, chronic pain, inflammatory autoimmune-mediated arthritis).

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New Tracking System

- Program held an open RFP for the selection of a new database.
- BioTrack THC was selected. BioTrack is used by three other states (Washington, Illinois, and New York), and is also used by producers in 19 additional states.
- This system will enable the Department to gather better statistics on producer inventory and sales, as well as purchases.
- System will provide better tracking of available product, and will track plants from seed to sale.
- System will allow for better assessment of patient purchases, and will help the Department to better assess supply and demand within the program.

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Producer Licensure

- The Department recently completed a review of 86 applications for licensed producers.
- Applications were scored by a committee of four employees, which issued recommendations to the Secretary.
- The Secretary provisionally approved 12 applicants for licensure as producers, and denied all other applications. The 12 applicants are working with the Program to obtain final licensure.
- The 12 applications selected displayed a strong knowledge of the growth process, strong distribution plans to reach underserved communities, and offered a variety of products to meet enrollees needs.

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Outreach efforts

- Presentations to medical providers around the State of New Mexico.
- 13 presentations conducted with the past year, with eight being to medical providers. The remaining presentations were to various support groups.
- Program staff working on development of materials for enrollees and the community to create more awareness on enrollment process.
- Medical directors are reaching out to individual medical providers to educate about the use of cannabis and enrollments requirements.

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