TITLE 7: HEALTH

CHAPTER 1: HEALTH GENERAL PROVISIONS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: ADJUDICATORY HEARINGS FOR LICENSED FACILITIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.2 NMAC.]

PART 3: HEALTH RECORDS

7.1.3.1 ISSUING AGENCY:

New Mexico Department of Health.

[10/31/96; Recompiled 10/31/01]

7.1.3.2 SCOPE:

All divisions, facilities and agencies within the department.

[10/31/96; Recompiled 10/31/01]

7.1.3.3 STATUTORY AUTHORITY:

Sections 9-7-6 and 14-2-1 through 14-2-12 NMSA 1978.

[10/31/96; Recompiled 10/31/01]

7.1.3.4 DURATION:

Permanent.

[10/31/96; Recompiled 10/31/01]

7.1.3.5 EFFECTIVE DATE:

October 31, 1996 [unless a later date is cited at the end of a section].

[10/31/96; Recompiled 10/31/01]

7.1.3.6 OBJECTIVE:

The objective of this part of Chapter 1, General Provisions, under Title 7, Health [now 7.1.3 NMAC], is to furnish guidance to the public and to employees of the New Mexico department of health in providing access to public records in the department's possession in accordance with the Inspection of Public Records Act, Section 14-2-1 to 14-2-12 NMSA 1978. This regulation establishes copying fees and supplies guidelines for determining whether an item is a public record. It also sets forth the procedures for allowing or denying access to requested records.

[10/31/96; Recompiled 10/31/01]

7.1.3.7 DEFINITIONS:

A. "Custodian" means the person or persons designated by the secretary as responsible for the maintenance, care or keeping of the department's public records for purposes of the Inspection of Public Records Act, regardless whether the records are in such person's actual physical custody and control.

B. "Department" means the New Mexico department of health.

C. "Inspect" means to review public records of the department.

D. "Mail" or "Mailed" as used in these regulations in connection with determining the running of a time period, is the date on which the letter or document was placed in the U.S. mail, and is evidenced by the date of the postmark.

E. "Person" means any individual, corporation, partnership, firm, association or entity.

F. "Public records" means all documents, papers, letters, books, maps, tapes, photographs, recordings, and other materials, regardless of physical form or characteristics, that are used, created, received, maintained or held by or on behalf of the department and relate to public business, whether or not the records are required by law to be created or maintained.

G. "Secretary" means the secretary, or his/her designee, for the department.

[10/31/96; Recompiled 10/31/01]

7.1.3.8 DESIGNATION OF CUSTODIAN:

The employee in charge of the department's office of public information is designated as custodian of the department's public records for purposes of responding to requests for inspection of department records.

A. Departmental employees receiving requests to inspect public records shall promptly forward the request to the office of public information.

B. In response to specific situations, the secretary may designate other employees of the department as custodian for distinct parts of the department's public records.

C. Distinct parts of the department's records may include records actually located in specific offices, divisions, or facilities, or may be records of a distinct type, such as patient medical records, computer data records, or vital statistics.

D. Custodians designated by the secretary in specific situations for distinct parts of the department's public records are required to fulfill the duties of the custodian in responding to written requests.

[10/31/96; Recompiled 10/31/01]

7.1.3.9 REQUESTS FOR INSPECTION OF PUBLIC RECORDS:

Any person may request orally or in writing to inspect the department's public records. However, the procedures in these regulations apply to written requests only. The failure to respond to an oral request is not actionable and is not subject to any penalty.

[10/31/96; Recompiled 10/31/01]

7.1.3.10 DUTIES OF CUSTODIAN:

The custodian is responsible for responding to written requests to inspect the department's public records. If the custodian permits inspection in response to the written request within three (3) business days of the custodian's receipt of the request, the custodian is not required to respond in writing. If inspection is not permitted in response to the written request within three (3) business days, the custodian must provide a written response to the person making the written request.

A. The written response shall set out the time, location and manner for inspection of the identified public records.

B. The time for review should be immediately or as soon as practicable under the circumstances, but may not exceed fifteen (15) days. If the inspection is not permitted within three (3) business days from the day the custodian receives the request, the custodian shall explain in writing when the records will be available for inspection or when the department will otherwise respond to the request.

C. The custodian should identify or designate reasonable facilities to make or furnish copies of the public records requested during usual business hours.

[10/31/96; Recompiled 10/31/01]

7.1.3.11 WRITTEN REQUESTS FOR INSPECTION; REQUIREMENTS:

Persons making written requests to inspect public records of the department are required to direct such requests to the custodian.

A. The written request must set out (1) the name, (2) address, and (3) telephone number of the person seeking access to the public records.

B. The written request must identify the records sought with reasonable particularity.

[10/31/96; Recompiled 10/31/01]

7.1.3.12 REQUESTS MADE TO NON-CUSTODIAN:

If a written request is made to an employee of the department, the request should be promptly sent to the custodian in the office of public information. The employee forwarding the request to the department custodian must also respond to the person requesting the inspection of the records, stating the reason for the absence of the records from that person's custody or control, the records' location and the name and address of the custodian.

[10/31/96; Recompiled 10/31/01]

7.1.3.13 WRITTEN RESPONSE TO REQUESTS; CONTENTS:

When inspection of public records is not permitted within three (3) business days of the custodian's receipt of the written request, the custodian must prepare a written response to a written request to inspect the department's public records, as required by Section 14-2-8 NMSA 1978. The custodian may consult with other department employees concerning the records identified in the written request, and may authorize an appropriate person in the employment of the department, for example, an attorney, a computer data specialist, or a medical records administrator, to respond to a specific request.

[10/31/96; Recompiled 10/31/01]

7.1.3.14 PROCEDURE FOR INSPECTION; SEPARATION OF EXEMPT INFORMATION:

Requested public records containing information that is exempt and nonexempt from disclosure shall be separated by the custodian prior to inspection, and the nonexempt information shall be made available for inspection. If necessary to preserve the integrity of computer data or the confidentiality of exempt information contained in a database, a partial printout of data containing nonexempt public records or information may be furnished in lieu of an entire database.

[10/31/96; Recompiled 10/31/01]

7.1.3.15 LOCATION FOR INSPECTION; MAIL:

The inspection may take place at the location within the department where the records are actually maintained, or, in the discretion of the custodian, in any other location within the department that is reasonable and responsive to the needs of the department or the person making the written request. A person making the written request for copies of public information, and by following the fee payment procedures herein, may have a copy of the requested public records provided by mail or other reasonable delivery method, without first inspecting.

[10/31/96; Recompiled 10/31/01]

7.1.3.16 FEES:

The custodian may charge reasonable fees for copying public records, payable in advance, and, upon request, shall provide a receipt. Unless a different fee is otherwise prescribed by law or regulation, the following apply.

A. Where redacting is not required:

(1) for copies of twenty (20) or less documents, eleven by seventeen inches in size or smaller, fifty cents ($.50) per copy;

(2) for copies of twenty to one hundred (20 to 100) documents, eleven by seventeen inches in size or smaller, forty cents ($.40) per copy;

(3) for copies of one hundred one (101) or more documents, eleven by seventeen inches in size or smaller, thirty cents ($.30) per copy;

(4) for written copies of computer data, printed on paper larger than eight by eleven inches in size, fifty cents ($.50) per copy;

(5) for written copies of computer data, printed on paper eight by eleven inches in size, forty cents ($.40) per copy;

(6) for electronic or digital copies of computer data, twenty five cents ($.25) per page, plus two dollars ($2.00) for each standard 3- inch floppy disk required.

B. Where redacting is required, one dollar ($1.00) per page regardless of the number or size of copies and regardless of the medium.

C. No copies will be provided by digital transfer methods, other than by transfer to floppy disk from department computers, unless, in the discretion of the custodian, in consultation with department staff, such copying is technically safe, may be reasonably and efficiently accomplished with existing and available software and hardware, and with available department personnel, and is cost effective. In such case the fee is the same as for digital copies using floppy disks.

[10/31/96; Recompiled 10/31/01]

7.1.3.17 EXCESSIVELY BURDENSOME OR BROAD REQUESTS:

A written request for inspection may be determined by the custodian to be excessively burdensome or broad. An additional reasonable period of time is allowed to comply with such requests determined by the custodian to be excessively burdensome or broad. The length of this additional time is determined based upon whether negotiation occurs. A fifteen-day additional period is available to the custodian, without negotiation, upon written notification to the requester. A post-negotiation reasonable period of time is available to the custodian and is determined based on discussions with the requester.

A. The custodian shall provide written notification to the requester within fifteen days of the custodian's receipt of the written request. The notification must state that additional time will be needed to respond because the request is determined to be excessively burdensome or broad. This notification is required whether the custodian relies upon the "no negotiation" provision (fifteen days) of section 17.2 [now Subsection B of 7.1.3.17 NMAC], or the "negotiation" (reasonable time) provision of section 17.3 [now Subsection C of 7.1.3.17 NMAC]. The custodian may use this notification as an opportunity to confirm any negotiated agreement providing additional time or any agreement that modifies the request.

B. The "no negotiation" additional period of time allowed to respond to a request determined to be excessively burdensome or broad, without negotiation, shall not exceed fifteen (15) days.

C. The "negotiation" additional period of time is that period of additional time agreed to by the custodian and the requesting person, or, in the event no agreement is reached, as determined to be reasonable by the custodian after at least one good faith effort to negotiate with the person making the request. The custodian, as part of the good faith effort to negotiate, should describe the circumstances that cause the request to be excessively burdensome or broad, and suggest possible modifications to the request that would decrease the burdensome or broad nature of the request on the department, and should suggest an additional reasonable amount of time for responding to the request.

[10/31/96; Recompiled 10/31/01]

7.1.3.18 DENIED REQUESTS; PROCEDURE:

A written request for inspection may be denied by written response from the custodian. A written request for inspection also may be deemed denied, except in cases where a written request for inspection of public records determined to be excessively burdensome or broad, if inspection has not been permitted within fifteen days of receipt by the custodian.

A. When responding to deny a request for inspection, the custodian shall provide the requester with a written explanation of the denial. The written denial shall:

(1) provide a description of the records sought;

(2) provide the names and titles or positions of each person responsible for the denial; and

(3) be delivered or mailed to the person requesting the records within fifteen days after the request for inspection was received.

B. If the custodian does not deliver or mail a written explanation or denial within fifteen days after receipt of a written request for inspection, the requesting party may bring an enforcement action against the custodian in accordance with the provisions of the Inspection of Public Records Act.

[10/31/96; Recompiled 10/31/01]

7.1.3.19 EXEMPTED RECORDS:

All records of the department are public records unless the record is exempted under state or federal law or regulation. The following constitute a common listing of sources of exemptions which may pertain to a department record; it is not intended to be exclusive and failure to specifically list an otherwise applicable source of law establishing an exemption does not affect the applicability of the exemption. The following may not be included in the department's public records:

A. Medical or confidential records under:

(1) the Inspection of Public Records Act, Section 14-2-1(A) NMSA 1978;

(2) the Hospital Records Provisions of Section 14-6-1 NMSA 1978;

(3) the Community Mental Health Services Act, Section 23-7-12(E) NMSA 1978;

(4) the Drug Abuse Treatment Act, Section 26-2-12 and 14 NMSA 1978;

(5) the Mental Health and Developmental Disabilities Code, Section 43-1-19 NMSA 1978;

(6) the Alcohol Abuse Treatment Act, Section 43-2-11 NMSA 1978;

(7) the Children's Mental Health and Developmental Disabilities Act, Section 32A-6-15 NMSA 1978;

(8) the Review Organization Immunity Act, Section 41-9-5 NMSA 1978;

(9) the Public Health Act, Section 24-1-9.4 and 20 NMSA 1978;

(10) the Vital Records Act, Section 24-14-27 NMSA 1978;

(11) Confidentiality of Alcohol and Drug Abuse Patient Records, 42 U.S.C. Section 290dd-2 and 290ee-3; and 42 CFR 2.1 to 2.67;

(12) HIV Test Act, Section 24-2B-1 et seq. NMSA 1978;

(13) DWI Tests Results, Section 24-11-6 NMSA 1978;

(14) Health Information Systems Act, Section 24-14A-8 NMSA 1978;

(15) the Health Maintenance Organization Law, Section 59A-46-26 and 27 NMSA 1978.

B. Other sources of law which may affect whether a record is a public record include:

(1) Public Health Act, Section 24-1-5(M) NMSA 1978;

(2) Juvenile Records Provisions of Section 32A-2-32; 32A-3B-22; and 32A-4-33 NMSA 1978;

(3) Traffic Safety Act, Section 66-7-507 and 508 NMSA 1978;

(4) provisions of Medicaid Law and Regulation, including but not limited to, 42 U.S.C. Section 1396a (a) and 42 CFR Section 431.300.

C. Records subject to attorney-client privilege; or, records that are attorney work product; or, records to which privileges recognized under New Mexico law apply.

D. Letters of reference concerning employment, licensing or permits.

E. Letters or memorandums which are matters of opinion in personnel files or students' cumulative files.

F. Law enforcement records that reveal confidential sources, methods, information or individuals accused but not charged with a crime.

G. Documents covered by the Confidential Materials Act, Section 14-3A-1 to 2 NMSA 1978.

H. Documents not otherwise exempted under state or federal law or regulations and for which a strong public policy exists for nondisclosure under Newsome v. Alarid, 90 N.M. 790, 568 P.2d 1236 (1977).

I. Information or a record that comes into the possession of the department through the department's normal course of business or through its lawful operations, and which information or record would otherwise be exempt or confidential under applicable law, does not lose its exempt or confidential status because of the department's possession of such information or record.

[10/31/96; Recompiled 10/31/01]

PART 4: DATA REPORTING REQUIREMENTS FOR HEALTH CARE FACILITIES

7.1.4.1 ISSUING AGENCY:

New Mexico Health Policy Commission.

[7.1.4.1 NMAC - Rp, 7.1.4.1 NMAC, 11/14/2008]

7.1.4.2 SCOPE:

This rule applies to all licensed inpatient and outpatient general and specialty health care facilities located within New Mexico.

[7.1.4.2 NMAC - 7.1.4.2 NMAC, 11/14/2008]

7.1.4.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 24-14A-3D(5) and (6); 24-14A-5A through C; 24-14A-8A and B; and 24-14A-9 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.4.3 NMAC - Rp, 7.1.4.3 NMAC, 11/14/2008]

7.1.4.4 DURATION:

Permanent.

[7.1.4.4 NMAC - Rp, 7.1.4.4 NMAC, 11/14/2008]

7.1.4.5 EFFECTIVE DATE:

November 14, 2008, unless a later date is cited at the end of a section.

[7.1.4.5 NMAC - Rp, 7.1.4.5 NMAC, 11/14/2008]

7.1.4.6 OBJECTIVE:

The purpose of this rule is to specify the data reporting requirements for licensed inpatient and outpatient general and specialty health care facilities pursuant to the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.4.6 NMAC - Rp, 7.1.4.6 NMAC, 11/14/2008]

7.1.4.7 DEFINITIONS:

In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following terms have the following meaning for purposes of this rule.

A. **Admission hour** coded in military time (e.g., 2:45 p.m. is represented as 1445).

B. **Attending physician NPI** the national provider identifier (NPI), a unique, government-issued, standard identification 10-digit number for individual health care providers and provider organizations like clinics, hospitals, schools and group practices.

C. **Birth weight** coded in grams.

D. **Data provider** means a data source that has provided data to the health information system on a regular basis.

E. **Data source** has the meaning given in Section 24-14A-2 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and includes those categories of persons or entities that possess health information, including any public or private sector licensed hospital, health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, pharmacy, third-party payer and any public entity that has health information

F. **Discharge hour** coded in military time (e.g., 2:45 p.m. is represented as 1445).

G. **1st E-code** means the first code for external causes of injury, poisoning, or adverse effect. If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, e-codes are required.

H. **2nd E-code** means the second code for external causes of injury, poisoning, or adverse effect. If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, e-codes are required.

I. **3rd E-code** means the third code for external causes of injury, poisoning, or adverse effect. If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, e-codes are required.

J. **Health care** means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

K. **Health information system or HIS** means the health information system established by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

L. **Inpatient health care facility** means a hospital or other health facility which admits patients for overnight or longer (and therefore is responsible for patients' room and board) for the purpose of providing diagnostic treatment or other health services.

M. **Medicare provider number** means the six digit number assigned by Medicare to the data source providing the reported service(s).

N. **National provider identifier (NPI)** means the ten digit NPI from the national plan and provider enumeration system (NPPES).

O. **New Mexico state license number** means the four to eight digit license number issued by the New Mexico health department for the data source providing the reported service(s).

P. **Operating physician NPI** the national provider identifier (NPI), a unique, government-issued, standard identification 10-digit number for individual health care providers and provider organizations like clinics, hospitals, schools and group practices.

Q. **Outpatient health care facility** means a hospital or other health facility that provides ambulatory care to a patient without admitting the patient to the facility or providing lodging services.

R. **Patient** means a person who has received or is receiving health care.

S. **Patient admission date** means the date the patient was admitted by the provider for inpatient care. Format as "MMDDYYYY". For example, if the admission date was July 1, 1983, "07011983" would be coded.

T. **Patient street address** means the mailing address of the patient at the time of discharge including street name and number or post office box number or rural route number.

U. **Patient city** means the city of the patient's residence at the time of discharge.

V. **Patient county** means the county of the patient's residence at the time of discharge.

W. **Patient state** means the state of the patient's residence at the time of discharge.

X. **Patient zip code** means the zip code of the patient's residence at the time of discharge. Use either five or nine digits, e.g. 87501 or 875010968.

Y. **Patient control number** means the patient's unique alpha-numeric number assigned by the provider.

Z. **Patient date of birth** means the date of birth of the patient. Required format is "MMDDYYYY". Note that all four digits of year are required, e.g., "08191898" is for August 19, 1898.

AA. **Patient discharge date** means the date the patient was discharged by the provider from the inpatient health care facility. Formatted as "MMDDYYYY".

BB. **Patient diagnosis related group (DRG) code** means the diagnostic related group code.

CC. **Patient EMS ambulance run number** means the emergency medical services ambulance run number.

DD. **Patient race** means 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.

(1) R1 - American Indian.

(2) R2 - Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean and Vietnamese).

(3) R3 - Black or African American.

(4) R4 - Native Hawaiian or Pacific Islander (including Chamorro and Samoan).

(5) R5 - White.

(6) R6 - patient refused.

(7) R7 - unknown.

(8) R9 - other race.

EE. **Patient ethnicity** means the gross classification of a patient's stated ethnicity, coded as follows:

(1) Y - Hispanic or Latino;

(2) N - not Hispanic or Latino.

FF. **Patient tribal affiliation** means the classification(s) of patient's stated New Mexico tribal affiliation. Up to five reported affiliations can be reported, coded as shown below. When reporting multiple affiliations do not use spaces or delimiters. For example, if a patient states that he or she has affiliations with both Acoma pueblo and the Navajo nation the tribal affiliation field would be T1T22:

(1) T1 - Acoma pueblo;

(2) T2 - Cochiti pueblo;

(3) T3 - Isleta pueblo;

(4) T4 - Jemez pueblo;

(5) T5 - Jicarilla Apache nation;

(6) T6 - Kewa/Santo Domingo pueblo;

(7) T7 - Laguna pueblo;

(8) T8 - Mescalero Apache nation;

(9) T9 - Nambe pueblo;

(10) T10 - Ohkay Owingeh pueblo;

(11) T11 - Picuris pueblo;

(12) T12 - Pojoaque pueblo;

(13) T13 - San Felipe pueblo;

(14) T14 - San Ildefonso pueblo;

(15) T15 - Sandia pueblo;

(16) T16 - Santa Ana pueblo;

(17) T17 - Santa Clara pueblo;

(18) T18 - Taos pueblo;

(19) T19 - Tesuque pueblo;

(20) T20 - Zia pueblo;

(21) T21 - Zuni pueblo;

(22) T22 - New Mexico Navajo nation;

(23) T100 - other tribal affiliation;

(24) T200 - patient refused;

(25) T300 - unknown.

GG. **Patient first name** means the first name of the patient.

HH. **Patient last name** means the last name of patient. Last name should not have a space between a prefix and a name (as in MacBeth), but hyphenated names retain the hyphen (as in Smith-Jones). Titles should not be recorded. If the last name has a suffix, put the last name, a space, and then the suffix (as in "Snyder III"). Last name does not include abbreviations of academic achievement or profession, such as "M.D.", "Ph.D." etc.

II. **Patient middle initial** means the middle initial of the patient.

JJ. **Patient medicaid number** means the patient's unique identification number assigned by medicaid.

KK. **Patient medical record number** means the medical record number used by the provider to identify the patient.

LL. **Patient principle diagnosis code, patient 2nd diagnosis code, patient 3rd diagnosis code, patient 4th diagnosis code, patient 5th diagnosis code, patient 6th diagnosis code, patient 7th diagnosis code, patient 8th diagnosis code, patient 9th diagnosis code, patient 10th diagnosis code, patient 11th diagnosis code, patient 12th diagnosis code, patient 13th diagnosis code patient 14th diagnosis code, patient 15th diagnosis code, patient 16th diagnosis code, patient 17th diagnosis code, patient 18th diagnosis code** means the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

MM. **Patient principle diagnosis code, present on admission; patient 2nd diagnosis code; present on admission; patient 3rd diagnosis code, present on admission; patient 4th diagnosis code, present on admission; patient 5th diagnosis code, present on admission; patient 6th diagnosis code, present on admission; patient 7th diagnosis code, present on admission; patient 8th diagnosis code, present on admission; patient 9th diagnosis code, present on**

admission; patient 10th diagnosis code, present on admission; patient 11th diagnosis code, present on admission; patient 12th diagnosis code, present on admission; patient 13th diagnosis code, present on admission; patient 14th diagnosis code, present on admission; patient 15th diagnosis code, present on admission; patient 16th diagnosis code, present on admission; patient 17th diagnosis code, present on admission; patient 18th diagnosis code, present on admission means diagnosis was present at the time the order for inpatient admission occurs - conditions that develop during an outpatient encounter, including emergency room, observation, or outpatient surgery are considered as present on admission.

(1) Y - yes

(2) N - no

(3) U - no information on the record

(4) W - clinically undetermined

(5) 1 - exempt

NN. Patient principal procedure code, patient 2nd procedure code, patient 3rd procedure code, patient 4th procedure code, patient 5th procedure code, patient 6th procedure code means the codes identifying the significant procedures, performed during the patient stay.

OO. Procedure date for patient principal procedure code, procedure date for 2nd procedure code, procedure date for 3rd procedure code, procedure date for 4th procedure code, procedure date for 5th procedure code, procedure date for 6th procedure code, means the date of the procedure that is reported as it coincides with the procedure code that was performed (mmddyyyy).

PP. Patient social security number means the nine digit social security number provided by the patient, without section separating characters like dashes, hyphens or slashes, for example, "585940323".

QQ. Patient status means the code indicating patient disposition at time of discharge. The codes are:

(1) 01 - discharged to home or self care (routine discharge);

(2) 02 - discharged/transferred to another general hospital;

(3) 03 - discharged/transferred to skilled nursing facility;

(4) 04 - discharged/transferred to intermediate care facility (ICF);

(5) 05 - discharged/transferred to another type of institution;

(6) 06 - discharged/transferred to home under care of organized home health service organization;

(7) 07 - left against medical advice;

(8) 08 - reserved for national assignment;

(9) 09 - admitted as an inpatient to this hospital;

(10) 10 - 19 reserved for national assignment;

(11) 20 - expired;

(12) 21 - discharged/transferred to court/law enforcement (covers patients sent to jail, prison or other detention facilities);

(13) 22 - 29 - reserved for national assignment;

(14) 30 - still patient or expected to return for outpatient services;

(15) 31 - 39 - reserved for national assignment;

(16) 40 - expired at home (hospice claims only);

(17) 41 - expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (hospice claims only);

(18) 42 - expired - place unknown (hospice claims only);

(19) 43 - discharged/transferred to a federal health care facility; (effective 03/31/2008) (usage note: discharges and transfers to a government operated health care facility such as a department of defense hospital, a veteran's administration (VA) hospital or VA hospital or a VA nursing facility; to be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not);

(20) 44 - 49 - reserved for national assignment;

(21) 50 - discharged/transferred to hospice - home;

(22) 51 - discharged/transferred to hospice - medical facility;

(23) 52 - 60 - reserved for national assignment;

(24) 61 - discharged/transferred within this institution to a hospital based medicare approved swing bed;

(25) 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital;

(26) 63 - discharged/transferred to long term care hospitals;

(27) 64 - discharged/transferred to a nursing facility certified under medicaid but not certified under medicare;

(28) 65 - discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital;

(29) 66 - discharged/transferred to a critical access hospital (CAH) (effective 03/31/2008);

(30) 67 - 69 reserved for national assignment;

(31) 70 - discharge/transfer to another type of health care institution not defined elsewhere in the code list (effective 03/31/2008);

(32) 71-99 - reserved for national assignment.

RR. **Primary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the primary payer identification name field.

(1) 1 **Medicare** is the primary payer from which the provider might expect some payment.

(2) 2 **Medicaid** is the primary payer from which the provider might expect some payment.

(3) 3 **CHAMPUS/military/VA** is the primary payer from which the provider might expect some payment.

(4) 4 **IHS/PHS** (Indian health service/public health service) is the primary payer from which the provider might expect some payment.

(5) 5 **Other government** (including corrections/research) is a government entity other than those specifically listed as the primary payer from which the provider might expect some payment.

(6) 6 **Private insurance** is the primary payer from which the provider might expect some payment.

(7) 7 **Workers compensation** is the primary payer from which the provider might expect some payment.

(8) 8 **Self pay/no insurance** means the patient (or the patient's family) is the primary payer from which the provider might expect some payment.

(9) 9 **County indigent funds** are the primary payer source from which the provider might expect some payment.

(10) 10 **Charity care** means the provider does not anticipate any payment from any source, including the patient.

(11) 88 **Unknown**.

SS. **Primary payer identification name** means the name identifying the primary payer from which the provider might expect some payment for the reported service(s).

TT.**Primary payer type** means the type of primary payer as defined below from which the provider might expect some payment for the reported services(s):

(1) 1 **HMO** - health maintenance organization;

(2) 2 **other managed care** - includes provider service networks;

(3) 3 **indemnity plan;**

(4) 88 **unknown.**

UU. **Provider zip code** means the zip code whose boundaries physically contain the facility where the reported service(s) were provided. Use either five or nine digits, e.g., 87501 or 875010968.

VV. **Secondary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the secondary payer identification name field.

(1) 1 - **Medicare** is the secondary payer from which the provider might expect some payment.

(2) 2 - **Medicaid** is the secondary payer from which the provider might expect some payment.

(3) 3 - **CHAMPUS/military/VA** is the secondary payer from which the provider might expect some payment.

(4) 4 - **IHS/PHS** (Indian health service/public health service) is the secondary payer from which the provider might expect some payment.

(5) 5 - **Other government** (including corrections/research) is a government entity other than those specifically listed as the secondary payer from which the provider might expect some payment.

(6) 6 - **Private insurance** is the secondary payer from which the provider might expect some payment.

(7) 7 - **Workers compensation** is the secondary payer from which the provider might expect some.

(8) 8 - **Self pay/no insurance** means the patient (or the patient's family) is the secondary payer from which the provider might expect some payment.

(9) 9 - **County indigent funds** are the secondary payer source from which the provider might expect some payment.

(10) 10 - **Charity care** means the provider does not anticipate any payment from any source, including the patient.

(11) 88 - **Unknown**.

WW. **Secondary payer identification name** means the name identifying a secondary payer from which the provider might expect some payment for the reported service(s).

XX. **Secondary payer type** means the type of secondary payer as defined below from which the provider might expect some payment for the reported service(s):

(1) 1 - **HMO** - health maintenance organization;

(2) 2 - **other managed care** - includes provider service networks;

(3) 3 - **indemnity plan;**

(4) 88 - **unknown**.

YY. **Sex of patient** means the sex of the patient as recorded at discharge. Enter the sex of the patient, coded as follows:

(1) female - F;

(2) male - M;

(3) unknown - U.

ZZ.**Point of origin for admission or visit** means the source of referral for this admission.

(1) **Adults and pediatrics:** source of admission codes for adults and pediatrics are:

(a) 1 - non-health care facility point of origin - the patient was admitted to this facility upon the recommendation of his or her personal physician if other than a clinic physician or a HMO physician (this includes patients coming from home, a physician's office or workplace;

(b) 2 - clinic referral - the patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic;

(c) 4 - transfer from a hospital - the patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient or outpatient (excludes transfers from hospital inpatient in the same facility);

(d) 5 - transfer from SNF or ICF - the patient was admitted to this facility as a transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF) where he or she was a resident;

(e) 6 - transfer from another health care facility - the patient was admitted to this facility as a transfer from a health care facility not defined elsewhere in this code list (i.e., other than an acute care facility or skilled nursing facility);

(f) 8 - court/law enforcement - the patient was admitted to this facility upon the direction of a court of law, or upon a request of a law enforcement agency representative (includes transfers from incarceration facilities);

(g) 9 - information not available - the means by which the patient was referred to this facility is not known;

(h) A - reserved for national assignment;

(i) D - transfer from hospital inpatient in the same facility resulting in a separate claim to the payer - the patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer;

(j) E - transfer from ambulatory surgery center - the patient was admitted to this facility from an ambulatory or same-day surgery center (does not include patients admitted from the same facilities' outpatient surgery department);

(k) F - transfer from hospice and is under a hospice plan of care or enrolled in a hospice program - the patient was admitted to this facility as acute inpatient status and was receiving hospice care;

(l) G-Z - reserved for national assignment.

(2) **Newborns:** Newborn codes must be used when the **type of admission** is code 4. The codes are:

(a) 5 - born inside this facility - a baby born inside this facility;

(b) 6 - born outside of this facility - a baby born outside of this facility;

AAA. **Total charges** means an 11 digit number rounded to the whole dollar for the total charges for all inpatient services reported.

BBB. **Traffic crash report number** means the six digit number of the traffic crash/accident report form.

CCC. **Type of admission** means an Inpatient code indicating the priority of the admission. Type of admission codes are:

(1) 1--emergency - the patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions; generally, the patient is admitted through the emergency room;

(2) 2--urgent - the patient requires immediate medical attention for the care and treatment of a physical or mental disorder; generally, the patient is admitted to the first available and suitable accommodation;

(3) 3--elective - the patient's condition permits adequate time to schedule the availability of a suitable accommodation;

(4) 4--newborn - a baby born within this facility; use of this code necessitates the use of special source of admission codes - see source of admission;

(5) 9--information not available.

[7.1.4.7 NMAC - Rp, 7.1.4.7 NMAC, 11/14/2008; A, 12/01/2010]

7.1.4.8 DATA:

[RESERVED]

7.1.4.9 STATUS OF DATA:

All data and health information collected from data sources shall become the property of the commission upon receipt.

[7.1.4.9 NMAC - Rp, 7.1.4.9 NMAC, 11/14/2008]

7.1.4.10 DATA REPORTING BY LICENSED NONFEDERAL GENERAL AND SPECIALTY INPATIENT HEALTH CARE FACILITIES:

A. **Schedule for reporting:** Beginning with the first quarter of 2011 (January 1-March 31), all licensed nonfederal general and specialty inpatient health care facilities in New Mexico shall submit to the commission on a quarterly basis the data required by this rule, in accordance with the following schedule:

Reporting period	**Report due to the commission**	**Commission returns integrity and validation errors**	**Final corrected report due to the commission**
January 1 - March 31	June 30	July 31	August 30
April 1 - June 30	September 30	October 30	November 30
July 1 - September 30	December 31	January 30 of the following year	February 28 of the following year
October 1 - December 31	March 31 of the following year	April 30 of the following year	May 31 of the following year

B. Pursuant to the electronic reporting requirements in 7.1.4.11 NMAC, submit the data as a fixed-width ASCII text (flat) file. Follow the record layout specifications, provided by the commission, for field placement and lengths (field lengths are maximum values).

C. Data required to be reported: All licensed nonfederal general and specialty inpatient health care facilities in New Mexico shall report to the commission the following data elements, in the record layout provided by the commission:

(1) admission hour;

(2) attending physician NPI;

(3) birth weight;

(4) discharge hour;

(5) 1st E-code, left justified;

(6) 2nd E-code, left justified;

(7) 3rd E-code, left justified;

(8) medicare provider number, left justified;

(9) New Mexico state license number left justified;

(10) operating physician NPI;

(11) patient principal diagnosis code (ICD-9-CM) left justified;

(12) patient 2nd diagnosis code (ICD-9-CM) left justified;

(13) patient 3rd diagnosis code (ICD-9-CM) left justified;

(14) patient 4th diagnosis code (ICD-9-CM) left justified;

(15) patient 5th diagnosis code (ICD-9-CM) left justified;

(16) patient 6th diagnosis code (ICD-9-CM) left justified;

(17) patient 7th diagnosis code (ICD-9-CM) left justified;

(18) patient 8th diagnosis code (ICD-9-CM) left justified;

(19) patient 9th diagnosis code (ICD-9-CM) left justified;

(20) patient 10th diagnosis code (ICD-9-CM) left justified;

(21) patient 11th diagnosis code (ICD-9-CM) left justified;

(22) patient 12th diagnosis code (ICD-9-CM) left justified;

(23) patient 13th diagnosis code (ICD-9-CM) left justified;

(24) patient 14th diagnosis code (ICD-9-CM) left justified;

(25) patient 15th diagnosis code (ICD-9-CM) left justified;

(26) patient 16th diagnosis code (ICD-9-CM) left justified;

(27) patient 17th diagnosis code (ICD-9-CM) left justified;

(28) patient 18th diagnosis code (ICD-9-CM) left justified;

(29) patient principal diagnosis code, present on admission, left justified;

(30) patient 2nd diagnosis code, present on admission, left justified;

(31) patient 3rd diagnosis code, present on admission, left justified;

(32) patient 4th diagnosis code, present on admission, left justified;

(33) patient 5th diagnosis code, present on admission, left justified;

(34) patient 6th diagnosis code, present on admission, left justified;

(35) patient 7th diagnosis code, present on admission, left justified;

(36) patient 8th diagnosis code, present on admission, left justified;

(37) patient 9th diagnosis code, present on admission, left justified;

(38) patient 10th diagnosis code, present on admission, left justified;

(39) patient 11th diagnosis code, present on admission, left justified;

(40) patient 12th diagnosis code, present on admission, left justified;

(41) patient 13th diagnosis code, present on admission, left justified;

(42) patient 14th diagnosis code, present on admission, left justified;

(43) patient 15th diagnosis code, present on admission, left justified;

(44) patient 16th diagnosis code, present on admission, left justified;

(45) patient 17th diagnosis code, present on admission, left justified;

(46) patient 18th diagnosis code, present on admission, left justified;

(47) patient principal procedure code, left justified;

(48) patient 2nd procedure code, left justified;

(49) patient 3rd procedure code, left justified;

(50) patient 4th procedure code, left justified;

(51) patient 5th procedure code, left justified;

(52) patient 6th procedure code, left justified;

(53) procedure date for patient principal procedure code (mmddyyyy);

(54) procedure date for patient 2nd procedure code (mmddyyyy);

(55) procedure date for patient 3rd procedure code (mmddyyyy);

(56) procedure date for patient 4th procedure code (mmddyyyy);

(57) procedure date for patient 5th procedure code (mmddyyyy);

(58) procedure date for patient 6th procedure code (mmddyyyy);

(59) patient admission date (mmddyyyy);

(60) patient street address, left justified;

(61) patient city, left justified;

(62) patient county, left justified;

(63) patient state, left justified;

(64) patient zip code, left justified;

(65) patient control number, left justified;

(66) patient date of birth (mmddyyyy);

(67) patient diagnosis related group (DRG) code;

(68) patient discharge date (mmddyyyy);

(69) patient EMS ambulance run number, left justified;

(70) patient race;

(71) patient ethnicity;

(72) patient tribal affiliation;

(73) patient first name, left justified;

(74) patient last name, left justified;

(75) patient middle initial;

(76) patient medicaid I.D. number;

(77) patient medical record number, left justified;

(78) patient social security number;

(79) patient status;

(80) primary payer category, right justified;

(81) primary payer identification name, left justified;

(82) primary payer type, right justified;

(83) provider zip code, left justified;

(84) secondary payer category, right justified;

(85) secondary payer identification name, left justified;

(86) secondary payer type;

(87) sex of patient;

(88) source of admission;

(89) total charges, right justified;

(90) traffic crash report number, left justified;

(91) type of admission.

D. **Data reporting requirements for New Mexico human services department's medicaid system:** The New Mexico human service department’s medicaid system shall provide all data listed by cooperative agreement between the commission and the human services department, pursuant to the reporting schedule contained in Subsection A of 7.1.4.10 NMAC.

E. **Data reporting requirements for the medicare (part A) fiscal intermediary:** The medicare (part A) fiscal intermediary shall provide all data mutually agreed upon in accordance with law between the commission and the fiscal intermediary, pursuant to the reporting schedule contained in Subsection A of 7.1.4.10 NMAC.

F. **Annual financial statements:** All licensed nonfederal general and specialty inpatient health care facilities shall submit annual audited financial statements to the

commission. If the owners of such facilities obtain one audit covering more than one facility, combined annual audited financial statements may be submitted in compliance with this section. Facilities reporting in combined annual audited financial statements must also submit annual unaudited, individual facility financial statements to the commission. These reports shall be submitted no later than the end of the calendar year following the statement year.

[7.1.4.10 NMAC - Rp, 7.1.4.10 NMAC, 11/14/2008; A, 12/01/2010]

7.1.4.11 ELECTRONIC REPORTING REQUIREMENTS:

Starting with 2011 data, all data providers shall submit the required quarterly discharge data pursuant to the reporting schedule contained in Subsection A of 7.1.4.10 NMAC and all final corrected reports, for the full year's worth of data, are due no later than May 31of the following year. Submit data by electronic media, which includes CD or DVD or by direct electronic transmission, in an ASCII file format, per the record layout and instruction provided by the commission. Label all data with the following information: type of data, hospital name and license number, year, file name, point of contact and telephone number. Please mail data to New Mexico Health Policy Commission, ATTN: State Reporting Data Steward, 1190 St. Francis Drive, Suite N3060, Santa Fe, NM 87505.

[7.1.4.11 NMAC - Rp, 7.1.4.11 NMAC, 11/14/2008; A, 12/01/2010]

7.1.4.12 REPORTING EXEMPTIONS:

Upon written application to the commission, the commission may grant a health care facility a temporary exemption, not to exceed two reporting quarters, from the schedule required by Subsection A of 7.1.4.10 NMAC. Temporary exemption from reporting does not excuse the health care facility from reporting the data from the exempted period. Upon resumption of the regular reporting schedule the health care facility shall promptly report data for the exempted period.

[7.1.4.12 NMAC - Rp, 7.1.4.12 NMAC, 11/14/2008]

7.1.4.13 PENALTIES FOR RULE VIOLATION:

Failure to comply with any of the reporting requirements in this rule may result in injunctive relief and a civil penalty not to exceed $1,000 per violation, as provided by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.4.13 NMAC - Rp, 7.1.4.13 NMAC, 11/14/2008]

PART 5: PROCUREMENT OF PROFESSIONAL SERVICES

7.1.5.1 ISSUING AGENCY:

NM Department of Health, Harold Runnels Building, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, NM 87502-6110.

[3/5/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.2 SCOPE:

General Public

[3/5/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.3 STATUTORY AUTHORITY:

The statutory authority for adopting these regulations is found in Section 9-7-6.F., NMSA 1978 of the Department of Health Act and Sections 13-1-28, *et seq*. NMSA 1978 of the Procurement Code.

[3/5/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.4 DURATION:

Permanent.

[3/5/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.5 EFFECTIVE DATE:

January 1, 1997, unless a later date is cited at the end of a section or paragraph.

[1/1/97; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.1.5.6 OBJECTIVE:

To implement the competitive sealed proposal procurement process mandated by the Procurement Code.

[3/5/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.7 DEFINITIONS:

A. "Central purchasing office" means an organizational unit within the department responsible for the control of procurement by competitive sealed proposals.

B. "Contract" means any agreement for the procurement of professional services.

C. "Department" means the New Mexico department of health.

D. "Offeror" means a person or business which submits a proposal to provide professional services in response to a request for proposals.

E. "Professional services" means the services of architects, archeologists, engineers, land surveyors, landscape architects, medical arts practitioners, scientists, management and systems analysts, certified public accountants, registered public accountants, lawyers, psychologists, planners, researchers and persons or businesses providing similar services.

F. "Procurement" means purchasing or otherwise acquiring professional services.

G. "Secretary" means the secretary of the New Mexico department of health.

[8/12/85, 7/7/87, 1/1/97, 12/1/98; Recompiled 10/31/01]

7.1.5.8 APPLICABILITY:

A. The secretary shall designate an organizational unit within the department as the central purchasing office. The central purchasing office shall assist the various units of the department in the procurement process but the award selection shall be made by the unit of the department requesting sealed proposals, unless otherwise directed by the secretary.

B. The department shall procure professional services having a value exceeding twenty thousand dollars ($20,000) by competitive sealed proposals.

C. The central purchasing office, in consultation with the procuring department unit, may determine that procurement should be effected by competitive sealed proposals when the use of competitive sealed bidding is either not practicable or advantageous to the department.

(1) Competitive sealed bidding is not practicable unless the nature of the procurement permits award to a low bidder which agrees by its bid to perform without condition or reservation in accordance with the purchase description, delivery or performance schedule, and all other terms and conditions of the invitation for bids. Factors to be considered in determining whether competitive sealed bidding is not practicable include:

(a) whether the contract needs to be other than a fixed-price type;

(b) whether oral or written discussions may need to be conducted with offerors concerning technical and price aspects of their proposals;

(c) whether offerors may need to be afforded the opportunity to revise their proposals, including price;

(d) whether award may need to be based upon a comparative evaluation as stated in the request for proposals of differing price, quality, and contractual factors in order to determine the most advantageous offering to the department. Quality factors include technical and performance capability and the content of the technical proposal; and

(e) whether the primary consideration in determining award may not be price.

(2) A determination may be made to use competitive sealed proposals if it is determined that it is not advantageous to the department, even though practicable, to use competitive sealed bidding. Factors to be considered in determining whether competitive sealed bidding is not advantageous include:

(a) if prior procurements indicate that competitive sealed proposals may result in a more beneficial contract; and

(b) whether the factors listed in Paragraph 8.3.1.2 through Paragraph 8.3.1.4 [now Subparagraphs (b) through (d) of Paragraph (1) of Subsection C of 7.1.5.8 NMAC] of this regulation are desirable as opposed to being necessary in conducting a procurement; if they are, then such factors may be used to support a determination that competitive sealed bidding is not advantageous.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.9 PROCUREMENT PROCESS:

A. To initiate the process for procurement of professional services, a request for proposals shall be issued soliciting competitive sealed proposals which shall include the following:

(1) the specifications for the services or professional services to be procured;

(2) all contractual terms and conditions applicable to the procurement;

(3) the location where proposals are to be received;

(4) the date, time and place where proposals are to be received and reviewed;

(5) a statement of the relative weights to be given to the factors in evaluating proposals;

(6) a statement that offerors submitting proposals may be afforded an opportunity for discussion and revision of proposals. Revisions may be permitted after submission of proposals and prior to award for the purpose of obtaining best and final offers;

(7) a statement that the contents of any proposal shall not be disclosed so as to be available to competing offerors during the negotiations process.

(8) A statement which reads as follows: "The Procurement Code, Sections 13-1-23 through 13-1-199 NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities and kickbacks."

B. Public notice of the request for proposals shall be given by publishing a notice not less than ten (10) calendar days prior to the date set for the receipt of the proposals. The notice shall be published at least once in a newspaper of general circulation in New Mexico. Other procedures may be adopted to notify prospective offerors as is commercially reasonable, including publication in trade journals. For all expenditures over twenty thousand dollars ($20,000), copies of the notice shall also be sent to interested persons and businesses who have signified in writing an interest in submitting proposals for particular categories of services.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.10 PRE-PROPOSAL CONFERENCES:

Pre-proposal conferences may be held to explain the procurement process and requirements. Conferences shall be held long enough after the request for proposals has been published to allow offerors to become familiar with it, but sufficiently before the deadline for submission of sealed proposals to allow consideration of the conference results in preparing their sealed proposals.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.11 RECEIPT OF PROPOSALS:

A. Completed proposals shall be returned to the department as specified in the notice of the request for proposals. The organizational unit of the department receiving the completed proposal shall establish a log of all proposals received which shall include the date and time the proposal was received, the name of the offeror and a description of the proposal sufficient to identify the service(s) offered.

B. The log shall be maintained by the procuring unit of the department in its procurement file.

[8/12/85, 1/1/97, 1/1/97; Recompiled 10/31/01]

7.1.5.12 NEGOTIATIONS:

A. Negotiations may be conducted by the central purchasing office or the department unit for whom the services or professional services are to be provided with responsible offerors who submit proposals found to be reasonably likely to be selected for the award.

B. The above provision does not apply to architects, engineers, landscape architects and land surveyors.

[8/12/85, 1/1/97; Recompiled 10/31/01]

7.1.5.13 EVALUATION OF PROPOSALS:

A. The evaluation of submitted competitive sealed proposals shall be conducted by the department unit which caused the request for proposals to be issued. The evaluation shall be based on the evaluation factors and relative weights set forth in the request for proposals.

B. At least one written evaluation shall be prepared for every responsive proposal.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.14 AWARD:

A. The award shall be made to the responsible offeror or offerors whose proposal is most advantageous to the department, taking into consideration the evaluation factors set forth in the request for proposals.

B. If, upon evaluation of all submitted proposals, a determination is made that none of the proposals submitted is most advantageous to the department, the central purchasing office, or procuring unit, may extend the deadline for submission of proposals or may reject any or all proposals, in whole or in part, when it is in the best interest of the department.

C. The central purchasing office or procuring unit of the department shall notify in writing each offeror of the outcome of the awards process.

D. All contracts for professional services with the department shall be reviewed:

(1) as to form and legal sufficiency by the office of general counsel of the department,

(2) for budget sufficiency by the administrative services division of the department; and

(3) by the department of finance and administration for form, legal sufficiency and budget requirements pursuant to Section 13-1-118 NMSA 1978.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.5.15 SMALL PURCHASES OF PROFESSIONAL SERVICES:

A. The central purchasing office or procuring unit of the department may procure professional services having a value not exceeding twenty thousand dollars ($20,000) excluding applicable state and local gross receipts taxes, except for the services of architects, landscape architects, engineers or land surveyors for state capital projects, as provided in this section.

B. Before contracting with any person or business to provide professional services, the central purchasing office is encouraged to examine the state purchasing agent's current list of potential offerors.

C. The central purchasing office or procuring unit of the department shall negotiate a contract for the required services at a fair and reasonable price to the department. The central purchasing office or department unit is encouraged, but not required, to contact at least three (3) persons or businesses for written or oral offers before selecting a contractor. A record of those contacts shall be included in the procurement file maintained by the central purchasing office or procuring unit of the department.

D. If more than one person or business is contacted, the contents of the written or oral offer of one business shall not be disclosed to another person or business during the negotiation process.

[8/12/85, 1/1/97; Recompiled 10/31/01]

7.1.5.16 LATE PAYMENT CLAUSE:

Department contracts shall include a clause imposing late payment charges against the department in the amount and under the conditions stated in Section 13-1-158 NMSA 1978.

[12/1/98; Recompiled 10/31/01]

PART 6: PROTEST PROCEDURE UNDER THE PROCUREMENT CODE

7.1.6.1 ISSUING AGENCY:

NM Department of Health, Harolds Runnels Building, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, NM 87502-6110.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.2 SCOPE:

General Public

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.3 STATUTORY AUTHORITY:

The statutory authority for adopting these regulations is found in Section 9-7-6.F., NMSA 1978 of the Department of Health Act and Section 13-1-174, NMSA 1978 of the Procurement Code.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.4 DURATION:

Permanent

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.5 EFFECTIVE DATE:

January 1, 1997, unless a later date is cited at the end of a section or paragraph.

[1/1/97; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.1.6.6 OBJECTIVE:

To implement the protest process mandated by the Procurement Code.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.7 DEFINITIONS:

A. "Central purchasing office" means an organizational unit within the department responsible for the control of procurement by competitive sealed proposals.

B. "Contract" means any agreement for the procurement of professional services.

C. "Department" means the New Mexico department of health.

D. "Offeror" means a person or business which submits a proposal to provide professional services in response to a request for proposals.

E. "Professional services" means the services of architects, archeologists, engineers, land surveyors, landscape architects, medical arts practitioners, scientists, management and systems analysts, certified public accountants, registered public accountants, lawyers, psychologists, planners, researchers and persons or businesses providing similar services.

F. "Procurement" means purchasing or otherwise acquiring professional services.

G. "Secretary" means the secretary of the New Mexico department of health.

[8/12/85, 7/7/87, 1/1/97, 12/1/98; Recompiled 10/31/01]

7.1.6.8 APPLICABILITY:

A. The provisions of this regulation apply to all protests filed with the central purchasing office of the department.

B. All definitions as stated in 7 NMAC 1.5 [now 7.1.5 NMAC], "Procurement of Professional Services," shall apply to these regulations.

C. When computing time under these regulations, the first day shall be excluded and the last day included unless the last day falls on Sunday, in which case, the time prescribed shall be extended to include the following Monday.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.9 RIGHT TO PROTEST:

A. Who may file: Any offeror who is aggrieved in connection with a solicitation or award of a professional services contract initiated by the department may protest to the central purchasing office of the department.

B. What may be protested: Protestants may protest any procurement function in connection with a solicitation or award of a contract.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.10 FILING OF PROTEST:

A. Protest must be written: Protests must be in writing and addressed to the contracts officer, administrative services division, department of health, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, New Mexico 87502-6110.

B. Contents: The protest shall:

(1) include the name and address of the protestant;

(2) identify the contracting activity and the number of the solicitation, if any, and, if a contract has been awarded, the contract number;

(3) contain a statement of the grounds for protest;

(4) include supporting exhibits, evidence or documents to substantiate any claim unless not available within the filing time in which case the expected available date shall be indicated; and

(5) specify the ruling requested from the central purchasing office or procuring unit of the department.

C. Pleadings: No formal briefs or other technical forms of pleadings or motion are required, but protests and other submissions should be concise, logically arranged, and direct.

D. Time limit: Protests shall be submitted within fifteen (15) calendar days after the facts or occurrences giving rise thereto.

E. Appointment of hearing officer: Upon the filing of a timely protest, the department shall designate a hearing officer. The hearing officer shall not have been directly involved in the protested procurement and, to the extent possible, be disinterested and impartial.

F. Additional information: If additional information is required by the hearing officer from the protestant, the department, or from interested parties, such information shall be submitted within the time period established by the hearing officer. Failure to timely comply may result in consideration and resolution of the protest without the untimely-filed information.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.11 PROCUREMENT AFTER PROTEST:

In the event of a timely protest, as defined in Paragraph 10.4 [now Subsection D of 7.1.6.10 NMAC] of this regulation, the central purchasing office or procuring unit of the department shall not proceed further with the procurement unless the central purchasing office or procuring unit of the department makes a written determination that the award of the contract is necessary to protect substantial interests of the department. Such written determination should set forth the basis for the determination.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.12 NOTICE OF PROTEST:

Notice to offerors: The hearing officer shall give notice of the protest to the contractor if award has been made or, if no award has been made, to all offerors who appear to have a substantial and reasonable prospect of receiving an award if the protest or appeal is denied.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.13 FURNISHING OF INFORMATION ON PROTESTS:

A. Information generally available: The hearing officer shall, upon written request, make available to any party information bearing on the substance of the protest which has been submitted by the parties, except to the extent that withholding of information is permitted or required by law.

B. Confidentiality of information: If a party considers that information submitted contains material which should be withheld, a statement advising of this fact must be affixed to the front page of the document, and the information requested to be kept confidential must be so identified wherever it appears. Upon such written request, material submitted by a party shall be made available except to the extent that the withholding of information is permitted or required by law.

C. Comments on information. Any party may file comments on the information, provided such comments are filed within ten (10) days of receipt of the information.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.14 CONFERENCE OR HEARING:

A. When held: A conference or hearing on the merits of the protest may be held at the discretion of the hearing officer, with or without the request of the protestant, interested parties or the department. The hearing officer shall establish any necessary procedures for a conference or hearing. Requests for conferences or hearings should be made within ten (10) days of the filing of the protest.

B. Comments on conference or hearing: Any written comments to be submitted as a result of the conference or hearing must be received by the hearing officer within five (5) days of the date on which the conference or hearing was held, unless the hearing officer provides otherwise.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.15 RESOLUTION:

A. Written recommendation: The hearing officer shall make a written recommendation on the merits of the protest within ten (10) days or as expeditiously as possible after the receipt of all information or the date of any conference or hearing held

on the matter, whichever is later, and shall furnish a copy of the recommendation to the protestant, the department, and other interested parties. Such recommendation should include:

(1) a copy of the protest to interested parties if any;

(2) a statement setting forth findings and conclusions in the matter, together with any additional evidence or information deemed necessary in determining the validity of the protest. The statement shall be fully responsive to the allegations of the protest. If the award was made after receipt of the protest, the statement shall include the determination required under Paragraph 11 [now 7.1.6.11 NMAC] of this regulation;

(3) a statement of the relief granted; and

(4) notice to the protestant of the right to judicial review of the final determination, pursuant to Section 13-1-183 NMSA 1978.

B. Notice of Recommendation. A copy of the recommendation shall be transmitted to the protestant, the department, and other interested parties involved in the procurement.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.16 RELIEF:

A. Prior to award: If, prior to award, the hearing officer makes a recommendation and the department division director or his/her designee makes a determination that a solicitation or proposed award of a contract is in violation of law, then the solicitation or proposed award shall be cancelled.

B. After Award:

(1) No fraud or bad faith. If, after an award, the hearing officer makes a recommendation and the department division director or his/her designee makes a determination that solicitation or award of a contract is in violation of law and that the business awarded the contract has not acted fraudulently or in bad faith:

(2) the contract may be ratified, affirmed and revised to comply with law, provided that a determination is made that doing so is in the best interest of the department; or

(a) the contract may be terminated, and the business awarded the contract shall be compensated for the actual expenses reasonably incurred under the contract plus a reasonable profit or equivalent thereto prior to termination.

(b) Fraud or bad faith: If, after an award, the hearing officer makes a recommendation and department division director or his/ her designee whose organizational unit initiated the procurement makes a determination that a solicitation or award of a contract is in violation of law and that the business awarded the contract has acted fraudulently or in bad faith, the contract shall be cancelled.

C. Relief not allowed: Except as provided in Paragraph 16.2.2.1 [now Subparagraph (a) of Paragraph (2) of Subsection B of 7.1.6.16 NMAC], above, the hearing officer shall not award money damages or attorneys' fees.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

7.1.6.17 FINAL DETERMINATION:

A. The hearing officer shall prepare a recommended written decision in the format required by Section 39-3-1.1 NMSA 1978. The recommended written decision shall be approved or disapproved by the department division director or designee within ten days or as expeditiously as possible after the issuance of the hearing officers written recommendation.

B. The decision by the department division director or designee is subject to review by the secretary at the secretary’s discretion and is the final determination for purpose of judicial review.

C. The department shall issue a final decision that includes an order granting or denying relief. The final decision may incorporate the hearing officer’s recommended decision or the department may render any other final decision supported by law. The final decision shall include a statement of the factual and legal basis for the order.

[8/12/85, 7/7/87, 1/1/97, 12/1/98; Recompiled 10/31/01]

7.1.6.18 EX PARTE COMMUNICATION:

The hearing officer shall not receive, nor shall any person directly or indirectly involved in a protest submit to the hearing officer, ex parte, any evidence explanation, analysis, or advice, when written or oral, regarding any matter at issue in a protest.

[8/12/85, 7/7/87, 1/1/97; Recompiled 10/31/01]

PART 7: HEALTH FACILITY LICENSURE FEES AND PROCEDURES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.3 NMAC.]

PART 8: HEALTH FACILITY SANCTIONS AND CIVIL MONETARY PENALTIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.4 NMAC.]

PART 9: CAREGIVERS CRIMINAL HISTORY SCREENING REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.5 NMAC.]

PART 10: ACCESS TO MEDICAL RECORDS BY DISABILITY APPLICANTS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.6 NMAC.]

PART 11: HEALTH FACILITY RECEIVERSHIP REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.7 NMAC.]

PART 12: EMPLOYEE ABUSE REGISTRY [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.8 NMAC.]

PART 13: INCIDENT REPORTING, INTAKE, PROCESSING AND TRAINING REQUIREMENTS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.9 NMAC.]

PART 14: ABUSE, NEGLECT, EXPLOITATION, AND DEATH REPORTING, TRAINING AND RELATED REQUIREMENTS FOR COMMUNITY PROVIDERS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.10 NMAC.]

PART 15-18: [RESERVED]

PART 19 VIOLENCE INTERVENTION PROGRAM FUND

7.1.19.1 ISSUING AGENCY:

New Mexico Department of Health, epidemiology and response division.

[7.1.19.1 NMAC - N, 4/25/2023]

7.1.19.2 SCOPE:

The violence intervention program fund shall apply to requests made for funds available pursuant to the Violence Intervention Fund Act, Sections 24-34-1, et seq, NMSA 1978.

[7.1.19.2 NMAC - N, 4/25/2023]

7.1.19.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to the following statutory authorities:

A. The Department of Health Act, Subsection E of Section 9-7-6, NMSA 1978, which authorizes the secretary of the department of health to "make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions".

B. The Violence Intervention Program Fund Act, Section 31-30-8, NMSA 1978, which authorizes the department of health to adopt rules to carry out the provisions of the act.

[7.1.19.3 NMAC - N, 4/25/2023]

7.1.19.4 DURATION:

Permanent.

[7.1.19.4 NMAC - N, 4/25/2023]

7.1.19.5 EFFECTIVE DATE:

April 25, 2023, unless a later date is cited at the end of a section.

[7.1.19.5 NMAC - N, 4/25/2023]

7.1.19.6 OBJECTIVE:

The objective of Part 19, Chapter 1 is to establish standards and procedures for funding programs under the Violence Intervention Program Fund Act. These standards and procedures are designed for the purpose of making funds available to administer the provisions of the Violence Intervention Program Act and award violence intervention program grants to state agencies, counties, municipalities or tribal governments that the department finds are disproportionately impacted by violent crimes, including homicides, shootings and aggravated assaults, and develop standards pertaining to the collection and sharing of data by grantees. This rule will inform eligible agencies and stakeholders of the procedures to access funds. The department of health through the injury and behavioral epidemiology bureau, will administer the fund pursuant to the Violence Intervention Program Fund Act and this rule.

[7.1.19.6 NMAC - N, 4/25/2023]

7.1.19.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) **"Accumulation"** defined as the prior approved expenditure or disposition in the current fiscal year of funds distributed in the fiscal year.

(2) **"Act"** defined as the Violence Intervention Program Fund Act, Section 24-34-1, et seq, NMSA 1978.

B. Definitions beginning with "B": "Bureau" defined as the injury and behavioral epidemiology bureau of the epidemiology and response division, New Mexico department of health.

C. Definitions beginning with "C":

(1) **"Chief"** defined as the bureau chief of the injury and behavioral epidemiology bureau.

(2) **"Commission"** defined as the New Mexico sentencing commission.

(3) **"Community-based service provider"** defined as an entity that is eligible to be awarded a contract to provide services that accomplish the purposes of the Violence Intervention Program Act.

D. Definitions beginning with "D":

(1) **"Department"** defined as the New Mexico department of health.

(2) **"Director"** defined as the director of the epidemiology and response division.

(3) **"Division"** defined as the epidemiology and response division.

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F":

(1) **"Fiscal year"** defined as the state fiscal year that runs from July 1 through June 30 each year.

(2) **"Fund"** defined as the violence intervention program fund.

G. Definitions beginning with "G": "Grantee" defined as a state agency, county, municipality or tribal government that has applied for and received funding pursuant to

the Violence Intervention Program Act for the purposes of addressing gun violence and aggravated assaults in a locally focused geographic area.

H. Definitions beginning with "H": [RESERVED]

I. Definitions beginning with "I": [RESERVED]

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": [RESERVED]

M. Definitions beginning with "M": [RESERVED]

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P": [RESERVED]

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R": [RESERVED]

S. Definitions beginning with "S": "Secretary" defined as the secretary of the New Mexico department of health.

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[7.1.19.7 NMAC - N, 4/25/2023]

7.1.19.8 DUTIES OF THE BUREAU:

The bureau shall administer the fund, administer the provisions of the Violence Intervention Program Act and pursuant to the Act and this rule receive and review applications for and award violence intervention program grants to state agencies, counties, municipalities or tribal governments that the department finds are disproportionately impacted by violent crimes, including homicides, shootings and aggravated assaults.

[7.1.19.8 NMAC - N, 4/25/2023]

7.1.19.9 DUTIES OF THE COMMISSION:

The commission shall:

A. provide state agencies, counties, municipalities and tribal governments with data relevant to grant applications pursuant to Subsection B of Section 31-30-5 NMSA 1978;

B. each year through 2027, with the department, the commission shall report to the legislature by December 1 regarding the awards and outcomes of each grantee pursuant to Subsection B of Section 31-30-9, NMSA 1978.

[7.1.19.9 NMAC - N, 4/25/2023]

7.1.19.10 ANNUAL REPORTS:

Each grantee shall report to the department and the commission by November 1 of each year regarding the:

A. purpose and amount of each grant received by the grantee for the previous fiscal year; and

B. processes, outputs and outcomes resulting from each grant approved by the department for the previous fiscal year, including relevant data as required by department rules.

[7.1.19.10 NMAC - N, 4/25/2023]

7.1.19.11 VIOLENCE INTERVENTION PROGRAM:

The purpose of the Violence Intervention Program Act is to create a non-reverting fund in the state treasury, the "violence intervention program fund", to consist of appropriations, gifts, grants and donations, to be administered by the department for awarding violence intervention program grants to state agencies, counties, municipalities or tribal governments that the department finds are disproportionately impacted by violent crimes, including homicides, shootings and aggravated assaults.

A. Eligibility: subject to the availability of the funds in the violence intervention fund, state agencies, counties, municipalities or tribal governments that the department finds are disproportionately impacted by violent crimes, including homicides, shootings and aggravated assaults may apply for funding under this rule.

B. Application process: In the first year of the program, within 60 days of the effective date of this rule, and thereafter, annually prior to the start of each state fiscal year, eligible state agencies, counties, municipalities, or tribal governments may apply to participate in the violence intervention fund program by submitting the application forms in a timely manner, as prescribed and distributed by the bureau. Such application forms will include, but not be limited to:

(1) Grant application form provided by the bureau including, but not limited to the following:

(a) budget form and narrative including a plan of expenditure for the amounts requested from the fund;

(b) project narrative which includes:

(i) need statement-provide a description of your agency and the constituents you serve. This narrative should describe the severity of violence and its impact on the community, as well as a description of the unmet need or problem that the grant project will address;

(ii) project description including identified high-risk target population and programs to address the problem.

(2) Violence prevention strategic plan - the strategic plan must include, at a minimum:

(a) an assessment of current violence prevention capacity and any current violence prevention activities and their effectiveness;

(b) description of selected evidence-based, evidence informed, or research-based programs and strategies to be implemented;

(c) action plans for program implementation and evaluation;

(d) statement of desired (measurable) outcomes and criteria with which to assess implementation success.

C. Funding amounts: Based upon the allocation decision by the authority in 7.27.9.12 NMAC, Funding amounts shall be determined by the department, will be based on criteria described in the grant application form, and will be dependent on availability of funds in the violence intervention fund.

D. Accumulation: It is anticipated that the entire amount of the annual award to each grantee will be spent during the fiscal year in which it is awarded. In the event that the entire amount cannot or will not be expended, the grantee must return the unexpended balance to the bureau unless it submits an accumulation and expenditure plan that is approved by the bureau prior to the close of the fiscal year in which it was awarded. The bureau may approve up to one additional fiscal year to expend the balance.

[7.1.19.11 NMAC - N, 4/25/2023]

7.1.19.12 GENERAL PROVISIONS:

Oversight, inspection, and audit: The department is responsible for the oversight of expenditures from the fund. All recipients of violence intervention funds under the act shall be subject to reasonable oversight and as needed, visitation by authorized representatives of the bureau. Records of purchases, training programs, or personnel expenditures accomplished with awards from the fund shall be open for inspection. This oversight may include an objective audit if deemed necessary. Findings from all oversight activities will be shared with the fund recipient and as appropriate a written deficiency correction report may be requested.

[7.1.12. NMAC - N, 4/25/2023]

PART 20: ACCESS TO HEALTH INFORMATION SYSTEM DATA AND REPORTS

7.1.20.1 ISSUING AGENCY:

New Mexico Health Policy Commission.

[8/30/1997; 7.1.20.1 NMAC - Rn, 7 NMAC 1.20.1, 03/31/2008]

7.1.20.2 SCOPE:

This rule applies to all persons who request data or reports based on data maintained as part of the health information system.

[8/30/1997; 7.1.20.2 NMAC - Rn, 7 NMAC 1.20.2, 03/31/2008]

7.1.20.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 24-14A-3D(5) and 24-14A-6A of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[8/30/1997; 7.1.20.3 NMAC - Rn, 7 NMAC 1.20.3, 03/31/2008]

7.1.20.4 DURATION:

Permanent.

[8/30/1997; 7.1.20.4 NMAC - Rn, 7 NMAC 1.20.4, 03/31/2008]

7.1.20.5 EFFECTIVE DATE:

August 30, 1997, unless a later date is cited at the end of a section.

[8/30/1997; 7.1.20.5 NMAC - Rn & A, 7 NMAC 1.20.5, 03/31/2008]

7.1.20.6 OBJECTIVE:

The purpose of this rule is to establish the requirements for access to data or reports based on data maintained as part of the health information system.

[8/30/1997; 7.1.20.6 NMAC - Rn, 7 NMAC 1.20.6, 03/31/2008]

7.1.20.7 DEFINITIONS:

In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following definitions apply for purposes of this rule.

A. **Access level** means a set of information or data maintained as part of the health information system which may be released to requestors pursuant to this rule, including:

(1) aggregate analysis;

(2) consumer health information report;

(3) research database;

(4) analytical database;

(5) linking database.

B. **Aggregate analysis** means information in report form that contains data combined in a manner which precludes specific identification of a single patient or health care provider.

C. **Analytical database** means a set of annual permanent data based on individual patient hospital discharge abstract data or any other database collected under the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, that excludes all identifiers of individual patients and health care professionals.

D. **Annual permanent database** means one calendar year of permanent hospital inpatient discharge data or any other database collected under the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, that is deemed complete by commission staff.

E. **Consumer health information report** means a report that provides the public with information on which to base health care purchasing decisions, published by the commission pursuant to Sections 24-14A-3D(11) and 24-14A-3.1D(2) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and 7 NMAC 1.22 [now 7.1.22 NMAC].

F. **Data provider** means a data source that has provided data to the health information system on a regular basis.

G. **Data source** has the meaning given in Section 24-14A-2 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and includes those categories of persons or entities that possess health information, including any public or private sector licensed hospital, health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, pharmacy, third-party payer and any public entity that has health information.

H. **Director** means the director of the commission.

I. **Federal agency** means any agency, department, bureau, board, commission, institution or other organization of the United States government.

J. **Governing agreement** means either a joint powers agreement or a contract signed by the director with approval of the commission.

K. **Health care** means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual’s physical or mental condition.

L. **Health care professional** means any individual licensed, certified or otherwise authorized or permitted by law to provide health care in the practice of a profession.

M. **Health care provider** means any individual, corporation, partnership, organization, facility, institution or other entity licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

N. **HEDIS® data elements** means the rate, numerator, denominator, size of the eligible population and data collection methodology for non-tabular measures that are reported as percentages and are contained in the health plan employer data and information set published by the national committee for quality assurance (NCQA). NCQA registered trademark.

O. **Health information system** or **HIS** means the health information system established by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

P. **HIS advisory committee** means the committee the commission establishes pursuant to Section 24-14A-3.1 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

Q. **Hospital inpatient discharge data (HIDD) clinical file** means the subset of reported hospital inpatient discharge data containing demographic, medical, inpatient stay and payer information.

R. **Hospital inpatient discharge data (HIDD) confidential file** means the subset of reported hospital inpatient discharge data containing identifiers of individual patients and health care professionals.

S. **Identifier** means any information that reveals the identity of, or could reasonably be used to reveal the identity of, a single patient, data provider or health care provider, but does not include a number assigned to a single patient for the purpose of conducting longitudinal or linking studies.

T. **Linked file** means the data that results from the co-joining of the linking database with another database.

U. **Linking database** means the available set of permanent hospital inpatient discharge data based upon individual patient hospital discharge abstract data or any other database collected under the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, that may contain specific patient or health care provider demographic and clinical information. The linking database also includes identifiers used solely in accordance with 7.1.20.13 NMAC for the purpose of linking to other existing health data.

V. **Patient** means a person for whom health information is contained in the health information system.

W. **Permanent hospital inpatient discharge data** means hospital inpatient discharge data contained in a data set created by the commission after the submitting data provider has either (1) reviewed and approved a commission statistical report based on the data provider's patient discharges, or (2) been provided a 30 day period to review the commission's statistical report.

X. **Proprietary information** means confidential technical information, administrative information, and/or business methods that are the property of the data provider and are perceived to confer a competitive position in the health care market by not being openly known by competitors.

Y. **Requestor** means a person who makes a request for access to health information system data or reports pursuant to this rule.

Z. **Research database** means a set of annual permanent data based on individual patient hospital discharge abstract data or any other database collected under the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, that excludes all identifiers of individual patients, health care providers, and third-party payers of health care.

AA. **Research organization** means an organization that conducts health-related research and that is recognized by the commission as a source for information that is useful for consumer health care decision making or for development of public policy related to health.

BB. **Routine report** means a report that contains information of use to the general public that is issued by the commission on its own initiative and not in response to a specific, individualized request.

CC. **State agency** means any agency, department, bureau, board, commission, institution or other organization of a state government, including state educational institutions and political subdivisions. "State agency" does not include any health care facility operated by a state agency.

[8/30/1997; 7.1.20.7 NMAC - Rn & A, 7 NMAC 1.20.7, 03/31/2008]

7.1.20.8 GENERAL PROVISIONS ON ACCESS TO HIS DATA:

A. **Access requirements:** Data and reports based on access levels in the HIS may be obtained only in accordance with the requirements of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and this rule.

B. **Evaluation of requests:** In addition to other requirements stated in this rule, all requests for HIS data and reports, other than routine reports, shall be evaluated by the commission and commission staff and shall satisfy the following criteria for approval:

(1) the specific intended use of the data shall comport with the purposes of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, as stated in Section 24-14A-3A and rules promulgated pursuant to the act, including use of data to assist in:

(a) the performance of health planning and policy making functions for the benefit of the public;

(b) informed health care decision making by consumers;

(c) administration, monitoring and evaluation of a statewide health plan; and

(2) the request shall be consistent with the responsibilities of the commission in accomplishing the priorities of the HIS.

C. **Request procedures:** All requests for data shall be made pursuant to the requirements of 7.1.20.14 NMAC.

D. **Fees:** Fees for access to data and reports shall be paid pursuant to the requirements of 7.1.20.15 NMAC.

E. **Restrictions on specificity:** Information at a level of specificity that might compromise patient confidentiality or data provider proprietary information, as determined by commission staff, shall not be released.

F. **Restrictions on access to sensitive data:** The commission shall have the authority to deny access to information in the research, clinical or linking database where use of the information, as determined by the commission, could result in violation of a patient's privacy, such as data on certain diagnosis codes or code ranges.

G. **Compliance with other laws:** The commission shall ensure that any access to data that is subject to restrictions on use pursuant to state, federal or tribal law or regulation, or any other legal agreement, complies with those restrictions.

H. **Disclaimer:** The commission shall include a disclaimer in all HIS data and reports released pursuant to this rule stating that the accuracy of the original data is the responsibility of the submitting data provider and that the commission assumes no responsibility for any use made of or conclusions drawn from the data.

I. **Agency contractors:**

(1) A state or federal agency that receives HIS data or reports under an agreement with the commission pursuant to Sections 11, 12 or 13 of 7.1.20 NMAC shall be solely responsible for fulfillment of the agreement, including responsibility for the actions of any subcontractor engaged to perform services that require access to HIS data or reports.

(2) No state or federal agency shall subcontract any portion of services to be performed under an agreement with the commission without prior written approval of the commission.

(3) A state or federal agency subcontractor that is provided access to HIS data or reports shall be subject to the full provisions of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and this rule, including Sections 18, 19 and 20 of 7.1.20 NMAC.

(4) In no event shall a data provider engaged as a subcontractor to a state or federal agency obtain access to data in the research, analytical or linking database.

J. **Public data:** The restrictions that apply to the release of data provider specific information do not apply when the data provider is a government agency and the data provided to the HIS otherwise would be considered public data in accordance with the Public Records Act, Section 14-3-1 et seq. NMSA 1978, and the Open Meetings Act, Section 10-15-1 et seq. NMSA 1978.

[12/16/1994; Rn, 7 NMAC 1.1.9.1 & 7 NMAC 1.1.9.2, 8/30/1997; A, 8/30/1997; 7.1.20.8 NMAC - Rn, 7 NMAC 1.20.8, 03/31/2008]

7.1.20.9 ACCESS TO AGGREGATE ANALYSIS:

Pursuant to the requirements of 7.1.20.8 NMAC, as determined by commission staff, any person may obtain access to aggregate analysis in the form of routine reports or non-routine reports pursuant to the procedures in 7.1.20.14 NMAC.

[8/30/1997; 7.1.20.9 NMAC - Rn, 7 NMAC 1.20.9, 03/31/2008]

7.1.20.10 ACCESS TO CONSUMER HEALTH INFORMATION REPORT DATA:

A. **Release of reports:** The commission shall release consumer health information reports to the public on a periodic schedule as determined by the commission in accordance with 7 NMAC 1.22 [now 7.1.22 NMAC].

B. **Prohibition on access to HEDIS data elements:** No person may obtain access to the HEDIS® data elements underlying a consumer health information report except for government agencies in accordance with the requirements in 7.1.20.12 NMAC NCQA registered trademark.

[8/30/1997; 7.1.20.10 NMAC - Rn, 7 NMAC 1.20.10, 03/31/2008]

7.1.20.11 ACCESS TO RESEARCH DATABASE:

A. **Research organizations and government agencies:** Pursuant to the requirements of 7.1.20.8 NMAC, a research organization, New Mexico state agencies, state agencies of other states, and federal agencies may obtain access to data in or reports based on the subset or portion of the research database that is relevant to the organization’s or agency’s stated purpose upon approval of the request by the director. The director may require an organization or agency to agree to specific confidentiality and use requirements prior to release of the data or reports. Federal agencies may obtain this information only if the agency agrees to fully protect its confidentiality as provided by federal law. No other person shall have access to data in or nonaggregate analytical reports based on the research database.

B. **Protection of identity:** Any data or report that is provided from the research database shall be configured in a manner that precludes actual or potential identification of individual patients, health care providers and third-party payers of health care.

[8/30/1997; 7.1.20.11 NMAC - Rn, 7 NMAC 1.20.11, 03/31/2008]

7.1.20.12 ACCESS TO ANALYTICAL DATABASE:

A. **Government agencies:** Pursuant to the requirements of 7.1.20.8 NMAC, New Mexico state agencies, state agencies of other states, and federal agencies may obtain access to data in or reports based on the subset or portion of the analytical database that is relevant to the agency's stated purpose upon approval of the request by the director after review by the data access advisory board pursuant to 7.1.20.16 NMAC. The director may require an agency to agree to specific confidentiality and use requirements prior to release of the data or reports. Federal agencies may obtain this information only if the agency agrees to fully protect its confidentiality as provided by federal law. No other person shall have access to data in or nonaggregate analytical reports based on the analytical database.

B. **Protection of identity:** Any data or report that the commission provides from the analytical database shall be configured in a manner that precludes actual or potential identification of individual patients and health care professionals.

[8/30/1997; 7.1.20.12 NMAC - Rn, 7 NMAC 1.20.12, 03/31/2008]

7.1.20.13 ACCESS TO LINKING DATABASE:

A. **Persons authorized to link:** New Mexico state agencies, state agencies of other states, and federal agencies may be authorized to link their databases with the subset or portion of the linking database that is relevant to the agency's stated purpose if the commission approves the request after review by the data access advisory board pursuant to 7.1.20.16 NMAC. No other person shall have access to the linking database.

B. **Ownership of data:** When the linking database is used to create a linked file, the linked file shall be jointly owned by the contributing parties for the purposes stated in the governing agreement required by Subsection C of 7.1.20.13 NMAC. Prior to permitting access to the linking database, all parties, including the commission as administrator of the HIS, must approve both the use of their contributed data and the use of data in the resulting linked file that could not have been derived without their contributed data.

C. **Governing agreements:**

(1) **General requirements:** All linking to the linking database shall be conducted pursuant to a governing agreement, the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and this rule. The commission shall enter into a governing agreement with any New Mexico state agency, agency of another state or federal agency that is permitted to link its database with the linking database. This agreement shall contain specific confidentiality and use requirements. A federal agency

may be authorized to link to the linking database only if the agency agrees to fully protect the confidentiality of the data as provided by federal law.

(2) **Medicaid information:** A governing agreement entered into pursuant to this section shall protect of the confidentiality of any medicaid recipient identifier information that is used. The human services department shall approve any governing agreement that authorizes linking to medicaid data in the linking database to ensure that the federal requirements for use of medicaid data are satisfied. The requestor shall bear the responsibility of obtaining this approval in writing from the human services department.

D. **Prohibition on dual possession:** In no event shall a requestor be in possession of both the HIDD confidential file and the HIDD clinical file at the same time.

E. **Prohibition on patient identifiers:** Linked files derived from the linking database shall not contain any patient identifiers.

F. **Return of data:** The requestor shall return the HIDD confidential file and the HIDD clinical file to the commission upon completion of the linking process and shall not retain any copies of either of these files.

[8/30/1997; 7.1.20.13 NMAC - Rn, 7 NMAC 1.20.13, 03/31/2008]

7.1.20.14 PROCEDURES FOR REQUESTS OF DATA:

A. **Requests for routine reports:** Requests for copies of routine reports produced by the commission for public use shall be made either verbally or in writing. Fees for these reports shall be paid in accordance with Subsection A of 7.1.20.15 NMAC.

B. **Requests for previously-prepared, non-routine reports:** Requests for copies of previously-prepared, non-routine reports shall be made in writing. These reports shall be made available pursuant to the requirements of this rule. Fees for these reports shall be paid in accordance with Subsection B of 7.1.20.15 NMAC.

C. **Individualized requests:** Requests for not previously-prepared, non-routine reports or for data contained in the research, analytical or linking database shall be made in writing by specifying the following information on a request form provided by the commission:

(1) date of request;

(2) name, address and organizational affiliation;

(3) specific data or analysis requested;

(4) specific intended use of the data, including proposed analytical or research methodology, together with an acknowledgment that the data will not be used in violation of Subsection B of 7.1.20.19 NMAC;

(5) desired date by which the information is needed, allowing a minimum of two weeks to process the request;

(6) for requests for data, the names and positions of individuals who will have access to the data if the request is granted;

(7) for requests for data, the requestor's specific plans for protecting the confidentiality and use of the data in accordance with the requirements of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and this rule; and

(8) any additional information the commission may request.

D. **Review of requests for data:** Commission staff shall conduct a preliminary review of requests made for HIS data or reports and may require the requestor to submit supplemental information to achieve a final project request. As required by this rule, commission staff shall make the determination on whether to grant the request or refer the request to the data access advisory board as appropriate. Requestors shall be notified of whether the request meets the criteria for approval within a reasonable period of time from the initial date of the request. The commission shall make reasonable efforts to review requests expeditiously within available resources.

E. **Fee estimate:** If a request for data or reports made pursuant to Subsection C of 7.1.20.14 NMAC is approved, commission staff shall prepare a preliminary estimate of the fee required for preparing the data or report, in accordance with 7.1.20.15 NMAC. This estimate, which shall not serve as a guarantee of final charges, shall be included with the notification of approval or disapproval provided pursuant to Subsection D of 7.1.20.14 NMAC. If the requestor agrees to pay the fee, commission staff shall proceed with preparing the data or report.

F. **Provision of data:** Commission staff shall prepare data or reports for approved requests within a reasonable period of time given the nature of the request, making reasonable efforts to prepare the information expeditiously within available resources. Linkage to the linking database shall be conducted within a reasonable period of time from the date the governing agreement is signed by all the parties.

[8/30/1997; 7.1.20.14 NMAC - Rn, 7 NMAC 1.20.14, 03/31/2008]

7.1.20.15 FEES FOR DATA AND REPORTS:

A. **Fees for routine reports:**

(1) **Generally:** The fees for copies of available routine reports produced for public use shall be as follows:

(a) single copies of any consumer health information reports or HIS annual reports shall be provided free of charge upon request; and

(b) all other reports shall be provided for $10.00 per report.

(2) **Data providers:** Data providers shall receive one free copy of the commission's routine reports upon request.

B. **Previously-prepared reports:** The fee for copies of available previously-prepared, non-routine reports provided to persons other than the original requestor for whom the report was prepared shall be $20.00 per report.

C. **Fees for data and non-routine reports:** The fee for preparing data and non-routine reports that have not been previously prepared shall be charged at the hourly rate of the analyst(s) preparing the data or report, as follows:

(1) data providers shall be charged a rate of $50.00 per analyst hour;

(2) state agencies shall be charged a rate of $75.00 per analyst hour; and

(3) all others shall be charged a rate of $100.00 per analyst hour.

D. **Electronic media reports:** Fees for reports made available on computer tape or other electronic media may include charges for the cost of the magnetic tape, diskette or other electronic media, in addition to the fees required by this section.

E. **Waiver or reduction of fees:**

(1) **Standard for waiver or reduction:** The director may reduce or waive the fee for data and non-routine reports that have not been previously prepared when the director determines that the requestor's proposed use of the information would be of value to the commission in fulfilling its statutory mandates to a degree equal to or greater than the fee reduction or waiver.

(2) **Payment upon failure to perform:** When a fee waiver or reduction has been granted and the research for which the fee was waived or reduced is not completed, or the product for which the fee was waived or reduced is not delivered to the commission, the full fee shall be assessed in accordance with Subsection C of 7.1.20.15 NMAC.

F. **Statement of fees:** The commission shall prepare a statement of the fee for requests made pursuant to Subsection C of 7.1.20.14 NMAC and provide it to the

requestor with the data or report. The fee must be paid no later than 30 days after receipt of the data or report.

[12/16/1994; Rn, 7 NMAC 1.1.12, 8/30/1997; A, 8/30/1997; 7.1.20.15 NMAC - Rn & A, 7 NMAC 1.20.15, 03/31/2008]

7.1.20.16 DATA ACCESS ADVISORY BOARD:

A. **Purpose:** A data access advisory board shall review requests for access to data in or reports based on the analytical database or linking database as required by this rule and shall make recommendations to the director or the commission on whether to grant the requests.

B. **Membership:** The commission shall appoint five members of its HIS advisory committee to the data access advisory board for two year renewable terms. To the extent feasible, the membership shall include representatives of hospitals, voluntary data providers and consumer interests, as well as individuals with experience in epidemiology, law, research and privacy, data management or other relevant fields. A commission staff member shall be the nonvoting chair of the board.

C. **Meetings:** The data access advisory board shall meet as frequently as reasonably necessary to review requests for access to HIS data as required by this rule, or when requested by the data access advisory board chair. A quorum shall consist of the majority of the appointed members of the board.

D. **Requests for access to analytical database:** In determining whether to recommend to the director approval of a request for data in or reports based on the analytical database, the data access advisory board shall evaluate whether the following criteria are satisfied:

(1) the information supplied on the request form shall adequately support the request;

(2) the qualifications of the requestor shall be sufficiently established, including that the requestor shall be reputable and have no prior violations for use of data; and

(3) the intended use of the requested information shall:

(a) satisfy the requirements of 7.1.20.8 NMAC, including that the use of the data shall be consistent with the stated purposes of the Health Information System Act, Section 24-14A-1 *et seq*. NMSA 1978;

(b) be credible and relevant to the requestor’s stated purposes; and

(c) adequately protect patient and health care provider confidentiality.

E. **Requests for access to the linking database:** In determining whether to recommend to the commission approval of a request for access to the linking database, the data access advisory board shall evaluate whether the following criteria are satisfied:

(1) all the criteria listed in Subsection D of 7.1.20.16 NMAC shall be met;

(2) the requestor's purpose shall be impractical without access to the linking database;

(3) the requestor shall demonstrate sufficient capability to perform the linking process, including financial and personnel resources; and

(4) the requestor's intended use of the information shall:

(a) contain reasonable safeguards, as determined by the board, to protect the information from redisclosure; and

(b) contain reasonable safeguards, as determined by the board, to protect against the identification of any patient in any report produced by the requestor based on the data.

F. **Review of recommendation:** The data access advisory board shall report to the director or the chair of the commission, as required by this rule, the board's recommendation on approval, denial or modification of a request for access to data in or reports based on the analytical database or linking database. Where authorized by the rule, the director or the commission shall determine whether to grant the request.

[8/30/1997; 7.1.20.16 NMAC - Rn, 7 NMAC 1.20.16, 03/31/2008]

7.1.20.17 APPEAL OF DENIAL OF REQUESTS FOR DATA:

A. **Appeal of commission staff determinations:** Requestors who are denied access to HIS data or reports by commission staff, where commission staff is authorized to make the determination, may appeal the denial to the director. The director shall review the denial and make a decision on the request. Requestors may appeal the director's denial of a request to the commission. The commission shall make a final determination on the request.

B. **Appeal of commission determinations:** The commission's decision on whether to grant a request for access to HIS data or reports is a final determination.

[8/30/1997; 7.1.20.17 NMAC - Rn, 7 NMAC 1.20.17, 03/31/2008]

7.1.20.18 OBLIGATIONS UPON RECEIPT OF DATA:

A. **Specific requirements:** Requestors and any individuals who are permitted access to HIS data or reports through approval of a request made pursuant to Subsection C of 7.1.20.14 NMAC shall:

(1) limit use of the information to the purposes stated on the request form;

(2) give full credit to the commission in any published or unpublished reports using HIS information;

(3) include a disclaimer in any published or unpublished reports using HIS information which states that the accuracy of the original data is the responsibility of the submitting data provider and that the commission assumes no responsibility for any use made of or conclusions drawn from the data; and

(4) provide the commission with a copy of any reports and linked files resulting from access to the linking database.

B. **Prior approval:** The director shall review and approve in advance of distribution any report or analysis produced using data from the analytical database or the linking database to any person beyond those specified in the request made pursuant to Subsection C of 7.1.20.14 NMAC. Reports or analysis of this nature shall not be released if disapproved by the director.

[8/30/1997; 7.1.20.18 NMAC - Rn, 7 NMAC 1.20.18, 03/31/2008]

7.1.20.19 CONFIDENTIALITY REQUIREMENTS FOR USE OF DATA:

A. **Confidentiality pledge:** Requestors and any individuals who are permitted access to data in the research database, analytical database or linking database shall sign and abide by a pledge of confidentiality in the use of the data, on a form provided by the commission.

B. **Prohibition on use:** Data or information obtained in accordance with this rule shall not under any circumstance be used for the purpose of identifying, locating or contacting individual patients or their families.

C. **Scope of confidentiality:** All data provided to the HIS under the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, shall be subject to the confidentiality requirements of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978. This includes any linked files provided to the commission pursuant to Paragraph of 4 of Subsection A of 7.1.20.18 NMAC.

[8/30/1997; 7.1.20.19 NMAC - Rn, 7 NMAC 1.20.19, 03/31/2008]

7.1.20.20 REDISCLOSURE OF DATA:

Requestors and any individuals who are permitted access to data in or non-routine reports based on the research database, analytical database or linking database shall not:

A. provide the data or portion of it to any persons other than those identified in the request form; or

B. resell any portion of the data, aggregate data, analysis, linked file or other information gained as a result of obtaining access to the data.

[8/30/1997; 7.1.20.20 NMAC - Rn, 7 NMAC 1.20.20, 03/31/2008]

7.1.20.21 REPORTS AVAILABLE THROUGH THE STATE LIBRARY DEPOSITORY SYSTEM:

Paper copies of all public use routine reports produced by the commission shall be available to the public through the state library depository system.

[12/16/1994; Rn, 7 NMAC 1.1.11, 8/30/1997; A, 8/30/1997; 7.1.20.21 NMAC - Rn, 7 NMAC 1.20.21, 03/31/2008]

7.1.20.22 PENALTIES FOR RULE VIOLATION:

A. **Commission sanctions:** A requestor who violates the requirements of this rule may be subject to any or all of the following sanctions, as determined by the commission:

(1) temporary or permanent denial of access to HIS data or reports;

(2) termination of current access; and

(3) mandated immediate return, without duplication, of HIS data or reports provided by the commission.

B. **Other penalties:** A requestor who violates the requirements of this rule or the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, may be subject to sanctions provided in applicable state, federal or tribal laws or regulations, including but not limited to injunctive relief and civil penalties of up to $1,000 per violation.

[8/30/1997; 7.1.20.22 NMAC - Rn, 7 NMAC 1.20.22, 03/31/2008]

PART 21: DATA REPORTING REQUIREMENTS FOR HEALTH PLANS

7.1.21.1 ISSUING AGENCY:

New Mexico Health Policy Commission.

[8-30-97; Recompiled 10/31/01]

7.1.21.2 SCOPE:

This rule applies to all reporting health plans in New Mexico.

[8-30-97; Recompiled 10/31/01]

7.1.21.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 24-14A-3D(5) and (6); 24-14A-5A through C; 24-14A-8A and B; and 24-14A-9 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[8-30-97; Recompiled 10/31/01]

7.1.21.4 DURATION:

Permanent.

[8-30-97; Recompiled 10/31/01]

7.1.21.5 EFFECTIVE DATE:

August 30, 1997, unless a later date is cited at the end of a section or paragraph.

[8-30-97; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.1.21.6 OBJECTIVE:

The purpose of this rule is to specify the data reporting requirements for health plans pursuant to the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[8-30-97; Recompiled 10/31/01]

7.1.21.7 DEFINITIONS:

In addition to the definitions in the health information system Act, Section 24-14A-1 et seq. NMSA 1978, the following definitions apply for purposes of this rule:

A. **Consumer health information report** means a report that provides the public with information on which to base health care purchasing decisions, published by the

commission pursuant to Sections 24-14A-3D(11) and 24-14A-3.1D(2) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and 7 NMAC 1.22 [now 7.1.22 NMAC].

B. **Director** means the director of the commission

C. **Health care** means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

D. **Health care professional** means any individual licensed, certified or otherwise authorized or permitted by law to provide health care in the practice of a profession.

E. **Health care provider** means any individual, corporation, partnership, organization, facility, institution or other entity licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

F. **Health information system** or **HIS** means the health information system established by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

G. **Health plan report** means the document or electronic submission required by this rule to be submitted annually to the commission, containing the HEDIS® reporting set and additional core performance measures required by the commission. ®NCQA registered trademark.

H. **Health plan reporting period** means the calendar year in which a reporting health plan delivers the services included in the health plan report. To illustrate, the 1996 reporting period is for services delivered in 1996.

I. **HEDIS** means the Health Plan Employer Data and Information set published by the national committee for quality assurance (NCQA).

J. **HEDIS data elements** means the rate, numerator, denominator, size of the eligible population and data collection methodology for non-tabular measures that are reported as percentages and are contained in HEDIS.

K. **HEDIS reporting set** means the full set of measures designated by the national committee for Quality Assurance as reporting measures in the current version of HEDIS.

L. **HEDIS reporting version** means the version of HEDIS published by the national committee for quality assurance applicable to the same reporting period designated by the national committee for quality assurance as the health plan reporting period defined in this rule.

M. **HEDIS specifications** means the specifications contained in the latest version or technical update of HEDIS applicable to the health plan reporting period, which may include separate reports for service populations and product types, such as health maintenance organization products, point of service products, preferred provider organization products, medicare risk products, and medicaid managed care products.

N. **HIS advisory committee** means the committee the commission establishes pursuant to Section 24-14A-3.1 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

O. **Managed health care plan** means a health benefit plan offered by a health care insurer that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in such plans through its own employed health care professionals or by contracting with selected or participating health care providers that conform to explicit selection standards, or both, and which either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, employed by, or under contract with the managed health care plan or health care insurer.

P. **Outcome measures** means changes in patient health status and satisfaction resulting from specific medical and health interventions, as distinguished from the effects of other factors that influence patient health and satisfaction.

Q. **Patient** means a person for whom health information is contained in the health information system.

R. **Performance measures** include, but are not limited to, quality indicators, outcome measures and health care service information.

S. **Proprietary information** means confidential technical information, administrative information, and/or business methods that are the property of the reporting health plan and are perceived to confer a competitive position in the health care market by not being openly known by competitors.

T. **Quality compass^{SM}** means a national database maintained and disseminated by the NCQA which includes plan-specific comparative and descriptive information on managed health care plan performance.

U. **Quality indicator** means a standardized and nationally or professionally recognized measure of a discrete element or aspect of health care useful for the purpose of monitoring quality of care.

V. **Quality of care** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes or are consistent with current professional knowledge. The provision of health services should reflect appropriate use of the most current knowledge about scientific, clinical, technical,

interpersonal, manual, cognitive, and organizational and management elements of health care.

W. **Reporting health plan** means a health care insurer that:

(1) is required to obtain a certificate of authority or licensure in New Mexico;

(2) has a total premium volume in excess of $5,000,000 in the year prior to the health plan reporting period; and

(3) offered one or more managed health care plans in New Mexico during the health plan reporting period.

X. **Total premium volume** means the annual premium volume in dollars reported by a health care insurer in its annual statement to the superintendent of insurance.

[8-30-97; Recompiled 10/31/01]

7.1.21.8 HEALTH PLAN REPORT:

A. **Components of report:** The health plan report required by this rule shall consist of the following components:

(1) the HEDIS reporting set; and

(2) an additional core set of performance measures specific to the needs of New Mexico consumers, as required by the commission.

B. **Additional core set:**

(1) **Recommendations:** The HIS advisory committee shall adopt a process for determining which performance measures, in addition to those in the HEDIS reporting set, should be included in a core set of performance measures to be regularly reported to the commission and provided to consumers as consumer health information. The HIS advisory committee shall evaluate and recommend to the commission the adoption of additional performance measures that are in accordance with the criteria in 7 NMAC 1.22.9.2 [now Subsection B of 7.1.22.9 NMAC] and relevant to the health status and needs of New Mexico health care consumers.

(2) **Adoption:** Upon recommendation of the HIS advisory committee, the commission may require reporting health plans to report a core set of performance measures in addition to those in HEDIS, provided that these measures shall be in accordance with the criteria in 7 NMAC 1.22.9.2 [now Subsection B of 7.1.22.9 NMAC] and relevant to the health status and needs of New Mexico health care consumers.

(3) **Periodic review:** The HIS advisory committee periodically shall review and recommend to the commission changes in the additional core set of performance measures, as appropriate. The HIS advisory committee and the commission shall endeavor to maintain the consistency of the additional core set over time for longitudinal comparison purposes.

C. **Notification of required data:**

(1) **HEDIS reporting set:** The HEDIS reporting version for the health plan reporting period shall serve as notice of the data that shall be provided to the commission in the HEDIS reporting set.

(2) **Additional core set:** The commission shall notify reporting health plans by August 1 of the year preceding the health plan reporting period of any additional performance measures that shall be reported in the health plan report. For performance measures that are complex or time-consuming to collect, the commission shall provide as much additional advance notice of the reporting requirement as reasonably necessary to afford reporting health plans sufficient time to comply while meeting the needs of New Mexico consumers for comparative health care data.

[8-30-97; Recompiled 10/31/01]

7.1.21.9 REPORTING REQUIREMENTS:

A. **Mandatory reporting:** Reporting health plans shall submit to the commission a health plan report as follows:

(1) For the 1996 health plan reporting period, the health plan report shall be submitted by October 1, 1997 and shall consist of the HEDIS reporting set only.

(2) For all subsequent health plan reporting periods, the health plan report shall be submitted by August 1 of the year following the health plan reporting period. To illustrate, for the 1997 health plan reporting period the health plan report shall be submitted by August 1, 1998.

B. **HEDIS data elements:** Reporting health plans shall provide to the commission in the health plan report the HEDIS data elements for each reporting measure, to be used by the commission for data quality verification or policy and planning purposes as defined in Section 24-14A-3 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978. The commission recommends that reporting health plans capture the data elements identified by NCQA in their HEDIS specifications.

C. **Required specifications:** In submitting the HEDIS reporting set component of the health plan report, reporting health plans shall use the complete HEDIS specifications, templates, electronic data submission formats and any other documents

provided by the commission or made directly available to the plans by the NCQA, all of which shall be consistent with those published by the NCQA.

D. **Submission to NCQA's quality compass:** Reporting health plans that submit a HEDIS report to the quality compass program maintained by the NCQA may submit to the commission electronically or on electronic media a copy of that report. This submission shall meet the HEDIS reporting set requirements of this rule if the HEDIS report submitted to quality compass[SM] is specific to New Mexico.

[8-30-97; Recompiled 10/31/01]

7.1.21.10 ELECTRONIC REPORTING REQUIREMENTS:

All reporting health plans shall submit the health plan report by electronic media (includes computer tape, cartridge or diskette) or by direct electronic transmission, beginning no later than the health plan report submitted in 1999 for the 1998 health plan reporting period.

[8-30-97; Recompiled 10/31/01]

7.1.21.11 MODIFICATION OR EXEMPTION FROM REPORTING COMPLIANCE:

A reporting health plan may submit to the director a written request for modification or exemption from compliance with the reporting requirements of this rule. The director may grant the request if the reporting health plan makes a reasonable showing that compliance would require unreasonable costs, would be unduly burdensome given the particular circumstances of the reporting health plan, is not feasible due to no fault of the reporting health plan, or would constitute disclosure of proprietary information. The reporting health plan may appeal the director's decision to the commission, which shall make a final determination on the request.

[8-30-97; Recompiled 10/31/01]

7.1.21.12 PUBLIC RELEASE OF HEDIS DATA ELEMENTS:

A reporting health plan that objects on proprietary grounds to the potential release of its reported HEDIS data elements pursuant to 7 NMAC 1.20.10.2 [now Subsection B of 7.1.20.10 NMAC] shall submit to the director a written request for confidentiality. This request shall explicitly and specifically identify the HEDIS® data elements considered to be proprietary and provide a justification for this position. The director may consult with the HIS advisory committee in determining the merits of the request and shall provide a written decision to the reporting health plan. A reporting health plan may appeal the director's denial of the request to the commission. The commission shall make a final determination on the request. ®NCQA registered trademark.

[8-30-97; Recompiled 10/31/01]

7.1.21.13 PENALTIES FOR RULE VIOLATION:

In addition to the penalties provided in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, for violation of the data reporting requirements of the Act and its rules, the commission may impose any or all of the following sanctions for violation of this rule:

A. a statement in a relevant consumer health information report indicating the failure of the reporting health plan to comply with the requirements of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and this rule; and

B. temporary or permanent denial of access to health information system data or reports.

[8-30-97; Recompiled 10/31/01]

PART 22: CONSUMER HEALTH INFORMATION REPORTS

7.1.22.1 ISSUING AGENCY:

New Mexico Health Policy Commission.

[8/30/97; Recompiled 10/31/01]

7.1.22.2 SCOPE:

This rule applies to consumer health information reports issued by the commission.

[8/30/97; Recompiled 10/31/01]

7.1.22.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Section 24-14A-3D(5) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[8/30/97; Recompiled 10/31/01]

7.1.22.4 DURATION:

Permanent.

[8/30/97; Recompiled 10/31/01]

7.1.22.5 EFFECTIVE DATE:

August 30, 1997, unless a later date is cited at the end of a section or paragraph.

[8/30/97; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.1.22.6 OBJECTIVE:

The purpose of this rule is to effectuate Sections 24-14A-3D(11) and 24-14A-3.1D(2) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, by specifying the process for issuance of consumer health information reports.

[8/30/97; Recompiled 10/31/01]

7.1.22.7 DEFINITIONS:

In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following definitions apply for purposes of this rule:

A. "Administrative database" means any automated data supplied by the data provider, its contracted providers and vendors or public agencies.

B. "Consumer health information report" means a report that provides the public information on which to base health care purchasing decisions, published by the commission pursuant to Sections 24-14A-3D(11) and 24-14A-3.1D(2) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

C. "Data provider" means a data source that has provided data to the Health Information System on a regular basis.

D. "Data source" has the meaning given in Section 24-14A-2 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and includes those categories of persons or entities that possess health information, including any public or private sector licensed hospital, health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, pharmacy, third-party payer and any public entity that has health information.

E. "Director" means the director of the commission.

F. "Health care" means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

G. "Health care provider" means any individual, corporation, partnership, organization, facility, institution or other entity licensed, certified or otherwise authorized

or permitted by law to provide health care in the ordinary course of business or practice of a profession.

H. "Health care survey" means a survey of health care consumers or health care providers or any other type of subjective assessment of health care.

I. "Health information system" or "HIS" means the health information system established by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

J. "HIS advisory committee" means the committee the commission establishes pursuant to Section 24-14A-3.1 of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

K. "Medical record" means the paper or electronic record of patient visits, treatments and test results assembled by the collective accumulation of notes kept by all health care providers who treat the patient.

L. "Outcome measures" means changes in patient health status and satisfaction resulting from specific medical and health interventions, as distinguished from the effects of other factors that influence patient health and satisfaction.

M. "Patient" means a person for whom health information is contained in the health information system.

N. "Patient confidential information" means the medical record and claims history of an individual patient.

O. "Performance measures" include, but are not limited to, quality indicators, outcome measures and health care service information.

P. "Proprietary information" means confidential technical information, administrative information, and/or business methods that are the property of the data provider and are perceived to confer a competitive position in the health care market by not being openly known by competitors.

Q. "Quality indicator" means a standardized and nationally or professionally recognized measure of a discrete element or aspect of health care useful for the purpose of monitoring quality of care.

R. "Quality of care" means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes or are consistent with current professional knowledge. The provision of health services should reflect appropriate use of the most current knowledge about scientific, clinical, technical, interpersonal, manual, cognitive, and organizational and management elements of health care.

S. "Reporting year" means the calendar year in which the health care services that are the subject of a consumer health information report were delivered.

T. "Risk adjustment" means a method of analyzing patient-level data that accounts for patient risk factors, such as age, sex, severity of illness and presence of multiple diseases, that could affect patient outcomes or resource use. Risk adjustment is intended to provide more accurate comparisons among health care providers than would exist without risk adjustment.

[8/30/97; Recompiled 10/31/01]

7.1.22.8 GENERAL PROVISIONS:

A. Issuance of reports: The commission annually shall issue, pursuant to the requirements of this rule, one or more consumer health information reports designed to assist health care consumers in comparatively evaluating the quality of care and performance of health care providers and organizations in New Mexico. Consumer health information reports may include information reported from any data provider where release of the information in a consumer health information report would effectuate the purposes of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, and be in compliance with this rule. Consumer health information reports shall be issued by December 31 of the year following the reporting year.

B. Contents of reports: Consumer health information reports may contain, but are not limited to, the following information:

(1) performance measures that are intended to assist consumers in evaluating health care services, health care providers, organizations and payers;

(2) subjective measures obtained from health care surveys, if surveys are conducted pursuant to 7 NMAC 1.22.10 [now 7.1.22.10 NMAC]; and

(3) educational information to assist consumers in placing the information in the context of health care and the health care system.

C. Risk adjustment: The commission shall apply nationally recognized standards for risk adjustment in analyzing the data contained in consumer health information reports, to the extent feasible given the availability of appropriate data and scientifically valid methodologies.

D. Proprietary and confidential information:

(1) Proprietary information and patient confidential information shall not be disclosed in or as part of a consumer health information report by the commission.

(2) A data provider that objects on proprietary grounds to the potential release in a consumer health information report of its reported data or information derived from its reported data shall submit to the director a written request for confidentiality. This request shall explicitly and specifically identify the data and/or derived information considered to be proprietary and provide a justification for this position. The director may consult with the HIS advisory committee in determining the merits of the request and shall provide a written decision to the data provider. A data provider may appeal the director's denial of the request to the commission. The commission shall make a final determination on the request.

[8/30/97; Recompiled 10/31/01]

7.1.22.9 EDITORIAL BOARD:

A. The commission shall establish annually a five member editorial board selected from the HIS advisory committee, including representatives of data providers and consumers. A commission staff member shall be the nonvoting chair of the editorial board. The editorial board shall plan, review and recommend to the commission the report format, performance and survey measures, and educational information to be included in consumer health information reports.

B. The editorial board's recommendations, and any subsequent adoption of a consumer information report by the commission, shall take into account the relevancy of the performance and survey measures to the health status of New Mexico health care consumers and shall be guided by the following criteria:

(1) Availability - whether the performance or survey measure is or should be available from a source readily accessible to the data provider or survey administrator, or whether provision of the information can be achieved without extraordinary effort by the data provider or survey administrator;

(2) Comparability - whether the performance or survey measure allows for comparisons among data providers or categories of data providers, or whether mechanisms are available to the commission to adjust for variations in patient risk factors if comparability across data providers is limited;

(3) Confidentiality - whether patient confidential information can be protected;

(4) Cost - whether the overall cost to compile or submit the performance or survey measure meets standards of reasonableness as required by Sections 24-14A-3D(14) and 24-14A-3.1D(3) of the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978;

(5) Meaningfulness - whether the performance or survey measure meets minimum standards of statistical reliability, validity, and accuracy and the performance or survey measure's reliability, validity and accuracy can be validated by an

independent audit or verified by analysis of the component data elements of the measure;

(6) Rationale - whether the performance or survey measure has relevance to consumer decision-making, or whether there is a consumer-based reason for including the performance or survey measure;

(7) Specifications - whether there is a standardized method to quantify the performance or survey measure;

(8) Standard - whether there is a desired level of performance that has gained acceptance nationally or professionally for the performance or survey measure.

[8/30/97; Recompiled 10/31/01]

7.1.22.10 HEALTH CARE SURVEYS:

Upon recommendation of the editorial board, the commission may contract for health care surveys to be conducted. Data providers shall participate in the survey process upon request of the commission. The surveys shall be undertaken based upon the criteria in 7 NMAC 1.22.9.2 [now Subsection B of 7.1.22.9 NMAC] and upon the following factors:

A. National standardized survey: The commission shall use a national standard health care survey instrument or instruments, verified and tested by scientific methods. Where practical, the commission shall adopt for use a standard survey instrument that is in accordance with generally accepted industry practices.

B. Independently administered: Standard surveys shall be independently administered by independent contractors, using the protocol or specifications provided with the surveys where available and as applicable to the health information needs of New Mexico health care consumers. As appropriate and practical, surveys shall be conducted by a firm certified by the generally recognized industry association or quality-certifying entity.

C. Coordination among state agencies: If feasible the commission shall coordinate its survey efforts with other state agencies that have regulatory or contractual oversight of data providers to avoid redundant reporting requirements.

D. Burden on survey populations: Where possible the commission shall limit redundant requests of the survey target populations, and when feasible coordinate survey efforts with other public and private entities, to ease any burden imposed by multiple survey efforts.

[8/30/97; Recompiled 10/31/01]

7.1.22.11 OPPORTUNITY FOR ADVANCE REVIEW:

A. Review by data providers: Data providers whose data is included in a consumer health information report and who submit the required data by the submission deadline shall be provided a draft of the report that contains the provisional statewide aggregate results for each included performance measure, the presentation style of the performance measures, the educational information, and results of any surveys conducted. For the 1996 reporting year, the commission shall make every effort to provide the draft report by October 30, 1997. For all subsequent reporting years the commission shall make every effort to provide the draft report by September 1 of the following year. Data providers shall have a 30 day review period from the postmarked date of the draft report to review the draft. Data providers may submit to the commission written corrections and comments by the last date of the review period, either by facsimile or by mail postmarked as of that date. Upon request of the data provider, the commission shall publish these written comments in the final consumer health information report, subject to editing by the commission for length, clarity and suitability, provided that the commission's edits shall attempt to fairly and accurately represent the substance of the data provider's comments. Data shall be considered final when the review period has elapsed.

B. Review by the HIS advisory committee: The HIS advisory committee, in accordance with its functions under the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, shall review consumer health information reports prior to their issuance and make recommendations to the commission on content, format and any other pertinent factors.

C. Review by the commission: The commission shall review and approve consumer health information reports prior to their issuance.

[8/30/97; Recompiled 10/31/01]

7.1.22.12 VERIFICATION OF SUBMITTED DATA:

A. Audit requirement: In order to verify the validity, reliability and comparability of data submitted by a data provider, the commission may conduct or contract for an independent audit or approve a plan-contracted audit conducted by an independent organization certified by NCQA to perform HEDIS® audits. Data providers shall participate in the audit process upon request of the commission. ®NCQA registered trademark.

B. Audit process: The commission may design and conduct an audit process solely for the purpose of verifying submitted data that may include one or more of the following activities concerning a data provider:

(1) an audit of the data provider's data collection and reporting processes, including its administrative database;

(2) one or more site visits;

(3) review and verification of the data provider's specifications, source codes, and data elements for each reporting measure;

(4) review of patient confidential information, which shall be limited to cases selected for verification purposes; and

(5) any other reasonable activities necessary to satisfy the purposes of the audit requirement.

C. Confidentiality requirements: All audits of data provider reports shall be conducted in a manner that protects the privacy of individual patients and patient confidential information to the extent consistent with the purposes of the audit. No information obtained during an audit shall be used for any purpose other than to satisfy the audit requirements.

[8/30/97; Recompiled 10/31/01]

PART 23: DATA REPORTING REQUIREMENTS FOR THE GEOGRAPHIC ACCESS DATA SYSTEM

7.1.23.1 ISSUING AGENCY:

New Mexico Health Policy Commission.

[1/1/99; Recompiled 10/31/01]

7.1.23.2 SCOPE:

This rule applies to all non-federal licensed health care facilities located in New Mexico and licensing agencies that have information pertaining to the geographic supply and distribution of health professionals and health services, including state entities licensing, certifying or registering health professionals or health services, and state entities administering programs to improve the distribution of health professionals.

[1/1/99; Recompiled 10/31/01]

7.1.23.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 24-14A-3D(5) and (6); 24-14A-5; 24-14A-8A and B and 24-14A-9 of the Health Information System Act, Section 24-14A-1, NMSA 1978.

[1/1/99; Recompiled 10/31/01]

7.1.23.4 DURATION:

Permanent.

[1/1/99; Recompiled 10/31/01]

7.1.23.5 EFFECTIVE DATE:

January 1, 1999, unless a later date is cited at the end of a section or paragraph.

[1/1/99; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.1.23.6 OBJECTIVE:

The purpose of this rule is to collect data for the geographic access data system by specifying the data reporting requirements for state health professional and facility licensing authorities, non-federal licensed health care facilities located in New Mexico and state entities administering publicly funded programs in order to improve the distribution of health professionals in rural and under-served, [sic] pursuant to the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[1/1/99; Recompiled 10/31/01]

7.1.23.7 DEFINITIONS:

In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following terms have the following meaning for purposes of this rule:

A. Amount of payment of award means the total dollar amount paid during the reporting period to or on behalf of a participant in a program designated by this rule.

B. Behavioral health or psychiatric beds (as specified by the facility) means the licensed bed capacity, as specified by the state health facility licensing authority, for hospital beds reserved for acute, residential or long-term care to emotionally disturbed patients, including patients admitted for diagnosis and those admitted on the basis of an authorized health professional's orders and approved nursing care plans. Long-term care may include intensive supervision to persons with chronic mental illnesses, mental disorders, or other chronic or severe mental disabilities.

C. Current license expiration date means the date on which the current license issued by the state health facility licensing authority expires.

D. Current license issuance date means the date on which the current license was issued by the state health facility licensing authority.

E. Current license number means the number assigned and listed on the licensed document of each health facility licensed by the state health facility licensing authority.

F. Date first licensed in New Mexico means the date that the health care professional was initially licensed to practice in the stated profession at their current professional level in New Mexico.

G. Date of birth means the date of birth of a licensed health care professional or a participant in a state administered program to improve the distribution of health professionals.

H. Date of graduation means the month and the year that the health care professional graduated from the health professional educational institution.

I. Dental care means preventive, restorative and/or emergency services provided by a dental health care professional.

J. Director means the director of the New Mexico health policy commission.

K. Dually certified beds means beds certified by the federal health care finance administration (HCFA) for reimbursement under both medicaid and medicare programs.

L. Emergency care means provision of emergency services, either on site or through stabilization and transport on a regular basis, to meet life, limb or function-threatening conditions.

M. Facility ID means the identification number assigned for internal control to a health facility licensed by the state health facility licensing authority.

N. Facility type means the type of a facility licensed by the state health facility licensing authority or a federal agency, including inpatient, community health or public health, laboratory, etc., as designated by the state health facility licensing authority.

O. Family planning services means provision of contraceptive/birth control and/or infertility treatment, including counseling and education by health professionals.

P. Full time equivalent means the average portion of the amount of time considered normal for working during a week. In general, this means the average number of hours worked weekly by an individual divided by forty; however, the value should not exceed one, regardless of average hours worked.

Q. Gender means the sex of the licensed health care professional.

R. Geographic access data system (GADS) means the data system developed pursuant to the Health Information Systems Act, Section 24-14A-1 et seq. NMSA 1978, to provide data and information to assist the commission, the legislature and other agencies and organizations in planning, formulating policy, administering programs and allocating resources to improve geographic access to health services.

S. Geographic access data system (GADS) data sources means state health professional and facility licensing agencies and boards; licensed outpatient medical facilities; and state entities administering programs to improve the distribution of health professionals.

T. Gynecological services means the provision of diagnostic and treatment services relating to the female reproductive system, including annual pelvic exams and pap smears, follow-up and outpatient treatment of abnormal findings, and diagnosis and treatment of sexually transmitted diseases, but not including family planning services.

U. Health care means any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

V. Health care professional means any individual licensed, certified or otherwise authorized or permitted by law to provide health care in the practice of a profession.

W. License employment classification means the employment status of a person licensed by the New Mexico state board of nursing, classified as either:

(1) employed full-time;

(2) employed part-time;

(3) unemployed.

X. License number means the number assigned to a health care professional by a state health care professional licensing board or authority.

Y. License status means the type of health care professional license issued classified as:

(1) active;

(2) inactive

Z. Mailing address means the mailing address, including the street address or post office box number, city, state and zip code of a health facility licensed by the state health facility licensing authority.

AA. **Medicaid Title XIX number** means the number assigned by medicaid to the health care facility.

BB. **Medicare provider certification number** means the number assigned by medicare to the health care facility.

CC. **Mental health services** means a range of services provided by a licensed mental health care professional for the diagnosis and/or treatment of patients with behavioral, emotional or psycho-social disorders.

DD. **Name of administering entity** means the full name, including the applicable department, board or commission and any applicable divisional or sub-divisional descriptors, of a state agency charged with the day-to-day administration of a program designated by this rule.

EE. **Name of administrator** means the first name, last name and middle initial of the current administrator of a health facility licensed by the state health facility licensing authority.

FF. **Name of health care professional** means the first and last names and the middle initial of the health care professional.

GG. **Name of hospital or facility** means the name listed on the license document of each health facility licensed by the state health facility licensing authority.

HH. **Name of program** means the full name established by statute or customarily used in budget documents, audits and/or required reports to identify a program designated by this rule.

II. **Non-public data** means data submitted to the commission by a GADS data source pursuant to this rule that:

(1) has not otherwise been determined by the data source to be public data, or is not considered to be public data in accordance with the Public Records Act, Section 14-3-1 et seq. NMSA 1978 and the Open Meetings Act, Section 10-15-1 et seq. NMSA 1978; and

(2) has been determined by the commission, in consultation with the GADS data source, to be of a confidential or restricted nature.

JJ. **Number of dental hygienists** means the number of licensed full-time equivalent (FTE) dental hygienists practicing at the facility.

KK. **Number of dentists** means the number of licensed full-time equivalent (FTE) dentists practicing at the facility.

LL.Number of nurse practitioners means the number of licensed full-time equivalent (FTE) nurse practitioners practicing at the facility.

MM. Number of other advanced practice nurses means the number of full-time equivalent (FTE) nurses with advanced or specialized training, including clinical nurse specialists (CNS) and certified nurse mid-wives (CNM), practicing at the facility.

NN. Number of other nursing staff means the number of other licensed full-time equivalent (FTE) nursing staff, not otherwise reported, including licensed practical nurses (LPN) and certified nursing assistants (CNA) practicing at the facility.

OO. Number of other professional health personnel means the total number of other full-time equivalent (FTE) certified or licensed health professionals, not otherwise reported, providing health care at the facility, including pharmacists, dental assistants, occupational and physical therapists, podiatrists and optometrists. Not included are administrative support personnel, such as receptionists or medical record technicians.

PP. Number of physicians means the number of licensed full time equivalent (FTE) physicians, both allopathic and osteopathic, practicing at the facility.

QQ. Number of physicians' assistants means the number of licensed full-time equivalent (FTE) physicians' assistants practicing at the facility.

RR. Number of registered nurses means the number of licensed full-time equivalent (FTE) registered nurses practicing at the facility.

SS. Nursing facility capacity means the licensed bed capacity, as specified by the state health facility licensing authority, to provide care to patients with a variety of physical conditions or functional disabilities that do not require the care provided by a hospital or a skilled nursing facility, but do need supervision and support services.

TT.Obstetrical care means the provision of the full continuum of services related to pregnancy, delivery and postpartum care, including prenatal care, antepartum fetal assessment, labor and delivery professional care and postpartum care.

UU. Owner(s) of facility means the name of the owner(s) listed on the current license of a health facility licensed by the state health facility licensing.

VV. Pharmaceuticals means on-site dispensing of prescription medication and other pharmaceutical products.

WW. Physical location means the street address, city, county and zip code of the physical location of a health care facility licensed by the state licensing authority.

XX. Physical location of recipient means the primary business location designated by street address, city, county and zip code of an individual or an entity that has received a payment, an award, or service during the reporting period from a program designated by this rule. For licensed health professionals this is the physical location of their primary practice site. For other individuals, such as students, this is the official address recognized by the program designated by this rule.

YY. Practice/business address(es) means the full address, city, county, state and zip code of the principal current practice location of each licensed health professional and any additional practice sites listed; or the official address, city, county, state and zip code as recognized by the health professional licensing board or authority.

ZZ.Prenatal care means a range of services including diagnosis, counseling, treatment and follow-up provided to pregnant women up to the onset of labor.

AAA. Primary care services means services that address the first level of basic or general health care for an individual's health needs.

BBB. Professional degree(s) means the health professional degree awarded as a consequence of completion or graduation from a health professional educational institution.

CCC. Professional educational institution means the name and the city, state and county of the health professional educational institution from which the health care professional graduated.

DDD. Public data means data submitted to the commission by a GADS data source pursuant to this rule that:

(1) has otherwise been determined by the data source to be public data, or is considered to be public data in accordance with the Public Records Act, Section 14-3-1 et seq. NMSA 1978 and the Open Meetings Act, Section 10-15-1 et seq. NMSA 1978; or

(2) has been determined by the commission, in consultation with the GADS data source, to be exempt from the access provisions of 7 NMAC 1.20 [now 7.1.20 NMAC].

EEE. Skilled nursing capacity means the licensed bed capacity, as specified by the state health facility licensing authority, to provide non-acute medical and nursing services, therapy and social services under the supervision of a licensed registered nurse on a 24-hour basis.

FFF. Specialties means certain branches or sub-divisions of a health professional discipline relating to specific services, as certified in accordance with

standards specified by a board, association or agency recognized as competent within each health professional group in which a health professional is specially trained.

GGG. **State general fund funding** means the total dollar amount appropriated from the state general fund for the reporting period for activities of a program designated by this rule.

HHH. **Status of recipient** means the status during the reporting period of any person who has a current service obligation incurred in the course of participation in a program designated by this rule, classified as either:

(1) in service;

(2) cash repayment;

(3) default;

(4) deferred - education/training;

(5) deferred - other;

(6) obligation completed;

(7) obligation resolved in other manner

III. **Substance abuse services** means a range of services to patients with alcoholism, drug dependency, or other substance abuse disorders. May include screening and diagnosis, detoxification, individual and group counseling, self-help support groups, alcohol and drug education, rehabilitation, remedial education and vocational training services and aftercare.

JJJ. **Swing bed capacity** means the licensed bed capacity, as specified by the state health facility licensing authority, for hospital or other facility beds which may be used for either skilled nursing care or general medical surgical care according to the presenting needs of the patient population.

KKK. **Telephone number of facility** means the phone number, including the area code, of a health facility licensed by the state health facility licensing authority.

LLL. **Total expenditures by eligible health professional discipline** means the total dollar amount directly expended during the reporting period by a program designated by this rule, subtotaled by each health profession approved for participation according to the terms and conditions of the program or administering entity.

MMM. **Total licensed bed capacity** means the total licensed bed capacity for the facility, as specified by the state health facility licensing authority, for hospital or other facility beds.

NNN. **Total number of individuals by eligible health professional discipline** means the total number of individuals who participated during the reporting period in a program designated by this rule, subtotaled by each health profession approved for participation according to the terms and conditions of the program or administering entity.

OOO. **Total program funding** means the total dollar amount during the reporting period available for or allocated to activities, including administration, of a program designated by this rule.

PPP. **Twenty four-hour coverage** means the provision of health care services on a 24-hour basis , 7 days a week, 365 days a year.

QQQ. **Unit of service(s) by health profession** means a specific quantifiable measure of impact in terms of outcomes and output mutually agreed upon by the commission and a program designated by this rule, subtotaled by each health profession approved for participation according to the terms and conditions of the program or administering entity.

RRR. **Urgent care** means provision of health care of an urgent or immediate nature on a routine or regular basis.

SSS. **Use of payment** means the specific purpose for which a payment or award has been made by a program designated by this rule to a local entity, including community based health facilities or political subdivisions, during the reporting period. Payment purposes are classified as either:

(1) continuing health professional education;

(2) housing;

(3) malpractice insurance;

(4) moving expenses;

(5) practice development and/or maintenance;

(6) professional development education;

(7) retention bonus;

(8) salary and benefits;

(9) other incentives to recruit and/or retain a health professional.

TTT. X-ray diagnostic services means technical services provided on-site through the means of radiological equipment and testing procedures for the purpose of identifying presenting or potential diseases or health risk factors. (Does not include services of a physician to order and/or to analyze/interpret results from these procedures.)

[1/1/99; Recompiled 10/31/01]

7.1.23.8 DATA REPORTING SCHEDULE FOR GEOGRAPHIC ACCESS DATA SYSTEM DATA SOURCES:

A. Data reporting by state health professional and facility licensing agencies or boards.

(1) All state health professional and facility licensing agencies and boards shall submit quarterly the specified data elements in a record layout agreed upon with the commission, according to the following schedule:

Reporting Period	Report Due to Commission
January 1 - March 31	April 30
April 1 - June 30	July 31
July 1 - Sept. 30	October 31
October 1 - Dec. 31	January 31 of the following year

(2) Data from state health professional and facility licensing agencies and boards shall be collected in phases consisting of specified health professions and types of health facilities.

(3) The first phase of data collection shall be carried out as follows:

(a) The first phase of data collection from state health professional licensing boards and agencies shall consist of entities responsible for the licensing or certification of allopathic physicians, allopathic physician assistants, dentists, dental hygienists and all levels of nursing.

(b) The first phase of data collection from state health facility licensing agencies shall consist of general and special hospitals.

(c) Data from the groups designated for the first phase shall be due beginning April 30, 1999.

(4) In subsequent phases of data collection, the commission may require state health professional and facility licensing agencies to begin submitting, in accordance with section 8.1.1 [now Paragraph (4) of Subsection A of 7.1.23.8 NMAC] of this rule data pertaining to other health professions and types of health facilities. The commission shall provide 90 days notice prior to the due date for data submission for data collected during the ordinary course of business and 180 days notice for all other required data.

B. Data reporting by licensed outpatient medical facilities: All facilities licensed by the state facility licensing authority as 1) "diagnostic treatment centers," 2) "limited diagnostic and treatment centers"and receiving funds under the Rural Primary Health Care Act or classified as a federally qualified health center or equivalent and 3) "rural health clinics" shall annually submit by April 30, beginning in 1999, the specified data elements for the preceding calendar year in a record layout agreed upon with the commission.

C. Data reporting by state entities administering programs to improve the distribution of health professionals: All state entities administering programs to improve the distribution of health professionals shall annually submit by October 1, beginning in 1999, the specified data elements for the preceding state fiscal year in a record layout agreed upon with the commission.

[1/1/99; Recompiled 10/31/01]

7.1.23.9 DATA REPORTING BY STATE HEALTH PROFESSIONAL LICENSING AGENCIES AND BOARDS:

A. All state health professional licensing agencies or boards, as required by the commission pursuant to 7 NMAC 1.23.8.1 [now Subsection A of 7.1.23.8 NMAC] and established pursuant to Chapter 61 NMSA 1978, excluding 61-13-1 to 61-13-17 (nursing home administrators) and 61-14-1 to 61-14-20 (veterinary medicine) shall submit the following data elements in a record layout agreed upon with the commission for each of the designated health care professionals licensed by the agency or board:

(1) name of health care professional;

(2) license number;

(3) date of birth;

(4) gender;

(5) professional educational institution;

(6) date of graduation;

(7) professional degree(s);

(8) specialties;

(9) date first licensed in New Mexico;

(10) license employment classification;

(11) license status;

(12) practice business address(es);

(13) any additional data, consistent with the purpose of this rule, that is customarily collected by the agency or board in its ordinary course of operation, and as specified by the commission with at least 90 days notice prior to submission date.

B. The commission may require any other agency or board licensing or certifying health professionals to submit specified health data pursuant to the Health Information System Act 24-14A-4.3, consistent with the purpose of this rule, that is customarily collected by the agency or board in its ordinary course of operation. The commission shall provide at least 90 days notice prior to the submission date.

[1/1/99; Recompiled 10/31/01]

7.1.23.10 DATA REPORTING BY THE STATE HEALTH FACILITY LICENSING AUTHORITY FOR ALL LICENSED HEALTH CARE FACILITIES IN NEW MEXICO:

The state health facility licensing authority shall submit to the commission the following data elements, in a record layout agreed upon with the commission, for each of the designated health facilities licensed by the authority.

A. facility ID;

B. current license number;

C. medicare provider certification number;

D. medicaid Title 19 number;

E. name of administrator;

F. name of facility;

G. telephone number of facility;

H. business address of facility;

I. mailing address;

J. facility type;

K. owner(s) of facility;

L. current license issuance date;

M. current license expiration date;

N. nursing facility capacity;

O. skilled nursing capacity;

P. dually certified beds;

Q. behavioral health or psychiatric beds;

R. swing bed capacity;

S. total licensed bed capacity; [and]

T. any additional data, consistent with the purpose of this rule, that is customarily collected by the authority in its ordinary course of operation, as specified by the commission with at least 90 days notice prior to the submission date.

[1/1/99; Recompiled 10/31/01]

7.1.23.11 DATA REPORTING BY EACH FACILITY LICENSED BY THE STATE HEALTH FACILITY LICENSING AUTHORITY AS A "DIAGNOSTIC TREATMENT CENTER," "LIMITED DIAGNOSTIC AND TREATMENT CENTER," OR "RURAL HEALTH CLINIC":

Each facility licensed by the state facility licensing authority as a 1) "diagnostic treatment center," 2) "limited diagnostic and treatment center" and receiving funds under the Rural Primary Health Care Act or classified as a federally qualified health center or equivalent or 3) "rural health clinic" shall submit the following data elements in a record layout agreed upon with the commission.

A. facility ID;

B. current license number;

C. name of administrator;

D. name of facility;

E. telephone number of facility;

F. business address of facility;

G. mailing address;

H. facility type;

I. owner(s) of facility;

J. types of services available:

(1) primary care services;

(2) laboratory diagnostic services;

(3) x-ray diagnostic services;

(4) emergency care;

(5) urgent care;

(6) 24-hour coverage

(7) family planning services;

(8) gynecological service;

(9) obstetrical care;

(10) prenatal care;

(11) dental care;

(12) mental health services;

(13) substance abuse services;

(14) pharmaceutical services.

K. Average number of hours per week that services are available:

(1) primary care services;

(2) laboratory diagnostic services;

(3) x-ray diagnostic services;

(4) emergency care;

(5) urgent care;

(6) family planning services;

(7) gynecological services;

(8) obstetrical care;

(9) prenatal care;

(10) dental care;

(11) mental health services;

(12) substance abuse services;

(13) pharmaceuticals;

L. number of physicians;

M. number of dentists;

N. number of dental hygienists;

O. number of physicians' assistants;

P. number of nurse practitioners;

Q. number of other advanced practice nurses;

R. number of registered nurses;

S. number of other nursing staff;

T. number of other professional health personnel;

U. Any additional data, consistent with the purpose of this rule, that is customarily collected by the facility in its ordinary course of operation, as specified by the commission with at least 90 days notice prior to the submission date.

[1/1/99; recompiled 10/31/01]

7.1.23.12 DATA REPORTING BY STATE ENTITIES ADMINISTERING PROGRAMS TO IMPROVE DISTRIBUTION OF HEALTH PROFESSIONALS:

All state entities administering health professional recruitment and retention programs specifically intended to improve the distribution of health professionals in the state shall submit the following data in a record layout agreed upon with the commission, except as expressly prohibited by federal law:

A. Data requirements for individual financial incentive programs: All state entities administering programs providing financial payments in exchange for service in a designated area shall report the following:

(1) name of administering entity;

(2) name of program;

(3) total program funding;

(4) state general fund funding;

(5) name of recipient;

(6) date of birth of recipient;

(7) health profession of recipient;

(8) license number;

(9) amount of payment of award;

(10) physical location of recipient;

(11) status of recipient;

(12) total number of individuals by eligible health professional discipline;

(13) total expenditures by eligible health professional discipline;

B. Data requirements for programs providing community based financial payments: All state entities administering programs providing financial payments to local entities, including community based health facilities and political subdivisions, shall report the following:

(1) name of administering entity;

(2) name of program;

(3) total program funding;

(4) state general fund funding;

(5) name of recipient;

(6) physical location of recipient;

(7) amount of payment of award;

(8) use of payment;

C. Data requirements for programs providing services to community based entities or professionals: All state entities administering programs providing services to community based health facilities or directly to support or assist health professionals to improve the distribution of health professionals in New Mexico, shall report the following:

(1) name of administering entity;

(2) name of program;

(3) total program funding;

(4) state general fund funding;

(5) total expenditures for direct service(s);

(6) name(s) of sites receiving services;

(7) physical location of recipient;

(8) units of service(s) by health profession;

[1/1/99; Recompiled 10/31/01]

7.1.23.13 HEALTH CARE SURVEYS:

The commission may utilize surveys of licensed health care professionals and/or the administrators of licensed health care facilities to gather data, consistent with the purpose of this rule. GADS data sources shall participate in the survey process upon request of the commission. The surveys shall be undertaken in consideration of the following factors:

A. Coordination among state agencies: If feasible, the commission shall coordinate its survey efforts with other state agencies that have regulatory authority over health professionals and facilities to avoid redundant reporting requirements.

B. Burden on survey populations: Where feasible, the commission shall limit redundant requests of the survey target populations by coordinating survey efforts with other public and private entities, to ease any burden imposed by multiple survey efforts.

[1/1/99; Recompiled 10/31/01]

7.1.23.14 STATUS OF DATA:

All data and health information collected pursuant to this rule shall become the property of the commission upon receipt.

[1/1/99; Recompiled 10/31/01]

7.1.23.15 ACCESS TO GEOGRAPHIC ACCESS DATA SYSTEM DATA:

Access to GADS data shall be as follows:

A. Access to public data:

(1) Internet access: All public data submitted to the commission pursuant to this rule may be made accessible, as determined to be appropriate by the commission, to any person through the health data system internet site.

(2) Requests made directly to the commission: Requests made directly to the commission for public data shall be subject to the provisions of 7 NMAC 1.20.14 [now 7.1.20.14 NMAC]. The commission may assess fees for preparing the requested data and reports, as specified in 7 NMAC 1.20.15 [now 7.1.20.15 NMAC].

B. Access to non-public data: Access to all non-public data submitted to the commission pursuant to this rule shall be in accordance with 7 NMAC 1.20 [now 7.1.20 NMAC] unless other provisions for release are made upon the expressed written authority of the designated administrator of the data source.

[1/1/99; Recompiled 10/31/01]

7.1.23.16 ELECTRONIC REPORTING REQUIREMENTS:

As of January 1, 2000, all GADS data sources shall submit the required quarterly or annual data by electronic media (such as computer tape, cartridge or diskette) or by direct electronic transmission, per the record layout and instruction provided by the commission.

[1/1/99; Recompiled 10/31/01]

7.1.23.17 MODIFICATION OR EXEMPTION FROM REPORTING COMPLIANCE:

A. Upon written application to the director, the director may grant a GADS data source a 1) modification in reporting requirements or 2) temporary exemption, not to exceed two reporting quarters or one year, whichever is less, from the schedule required by 7 NMAC 1.23.8 [now 7.1.23.8 NMAC]. Temporary exemption from reporting does not excuse the GADS data source from reporting the data from the exempted period. Upon resumption of the regular reporting schedule the GADS data source shall promptly report data for the exempted period. A modification or exemption shall be granted only when the data source makes reasonable showing that compliance would require unreasonable costs, would be unduly burdensome given the particular circumstances of the data source, or is not feasible due to no fault of the data source. In requesting a modification, the data source must also make a reasonable showing that it will effectuate the purposes of this rule through alternatives means. The GADS data source may appeal the director's decision to the commission, which shall make a final determination on the request.

B. Modifications to the specificity of any required data field may be directed by the health policy commission to accommodate updates in technology, public policy needs or as otherwise deemed necessary by the commission to fulfill the intent of this rule.

[1/1/99; Recompiled 10/31/01]

7.1.23.18 PENALTIES FOR RULE VIOLATION:

Failure to comply with any of the reporting requirements in this rule may result in injunctive relief and a civil penalty not to exceed $1,000 per violation, as provided by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[1/1/99; Recompiled 10/31/01]

PART 24: CHARITY CARE DATA REPORTING REQUIREMENTS

7.1.24.1 ISSUING AGENCY:

New Mexico Health Policy Commission.

[7.1.24.1 NMAC - Rp, 7 NMAC 1.24.1, 12/31/2000]

7.1.24.2 SCOPE:

This rule applies to all non-federal health care facilities licensed by the state health facility licensing authority and located in New Mexico.

[7.1.24.2 NMAC - Rp, 7 NMAC 1.24.2, 12/31/2000]

7.1.24.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 24-14A-3(D) and 24-14A-5 of the Health Information Systems Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.24.3 NMAC - Rp, 7 NMAC 1.24.3, 12/31/2000]

7.1.24.4 DURATION:

Permanent.

[7.1.24.4 NMAC - Rp, 7 NMAC 1.24.4, 12/31/2000]

7.1.24.5 EFFECTIVE DATE:

December 31, 2000, unless a later date is cited in the history note at the end of a section.

[7.1.24.5 NMAC - Rp, 7 NMAC 1.24.5, 12/31/2000]

7.1.24.6 OBJECTIVE:

The purpose of this rule is to specify the reporting requirements related to charity care for non-federal, licensed health care facilities located in New Mexico, pursuant to the Health Information Systems Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.24.6 NMAC - Rp, 7 NMAC 1.24.6, 12/31/2000]

7.1.24.7 DEFINITIONS:

In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following terms have the following meaning for the purpose of this rule:

A. Audited FQHC rate means the 100% total allowable cost per service as determined by the FQHC cost report after audit and finalization by the New Mexico entity legally responsible for administering the Medicaid program (Title XIX of the federal Social Security Act), to be submitted if the facility is certified as a FQHC or FQHC equivalent or receives cost-based reimbursement pursuant to federal law.

B. Bad debt means an account receivable based on services furnished to a patient which is: (1) regarded as uncollectible, following reasonable collection efforts, pursuant to the facility's credit and collection policies and procedures; (2) charged as a credit loss

pursuant to the facility's credit and collection policies and procedures; and (3) not otherwise classified as charity care.

C. Charity care means the provision of medically necessary health care without any expectation of cash inflow and without classification as revenue or receivables in a financial statement, as determined by the criteria established in a formal policy by the facility providing the care.

D. Charity care charges means the charges for the provision of health care that is classified as charity care according to the facility's charity care policy. Charity care charges do not include the difference between full charges and allowable amount paid by a third party, including Medicaid, Medicare or the county indigent fund, regardless of a patient's income level.

E. Charity care encounters means the total number of patient visits at which charity care was provided in whole or in part.

F. Charity care policy means a facility's formal policy that establishes criteria for classifying the provision of medically necessary health care as charity care and includes as a criterion the level of qualifying income as a percentage of the applicable federal poverty level.

G. Cost to charge ratio means the relationship that a facility's total operating expenses bear to the facility's reported charges for the same period as determined using total costs and total charges from the federal Health Care Financing Administration Medicare Cost Report.

H. County indigent fund revenue means the gross amount received by the facility from a county pursuant to the Indigent Hospital and County Health Care Act, Section 27-5-1 et seq. NMSA 1978, regardless of the purpose, including sole community provider revenue.

I. Director means the director of the commission.

J. Discharges means the number of patients with at least one patient day who are formally released from the facility after receiving health care, including patients who die in the facility and excluding newborns and individuals who are dead on arrival.

K. Emergency room charity care inpatient revenue means the total charity care charges for the following services provided to inpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and

treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

L. Emergency room charity care outpatient revenue means the total charity care charges for the following services provided to outpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

M. Emergency room encounters means the total number of patient visits for: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

N. Emergency room inpatient revenue means the total charges for the following services provided to inpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

O. Emergency room outpatient revenue means the total charges for the following services provided to outpatients: (1) medically necessary care for the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent lay

person to result in placing the patient's health in jeopardy, impairment to bodily functions or dysfunction of a bodily organ or part; (2) examination or treatment for emergency medical condition or active labor in women or any other service rendered to the extent required by 42 USC 1395(dd); or (3) screening and treatment of patients presenting themselves for unscheduled treatment, in those cases which are ultimately determined not to qualify as an emergency, to the extent that such screening is required by law or is in accordance with accepted standards of medical care.

P. Facility control means the classification for the type of organization that exercises primary control over facility policy and has primary financial responsibility for the operation of the facility. Facility control is reported as of the last day of the reporting period. Facility control is considered vested in the actual operator (i.e. lessee) of the hospital if that entity is different from the owner. Facility control types are: (1) government, including state and local political subdivisions; (2) nongovernment, not-for-profit; and (3) investor owned, for-profit.

Q. Facility ID means the identification number assigned for internal control to a health care facility licensed by a state health facility licensing authority.

R. Facility license number means the unique number assigned and listed on the facility's license document issued by the state health facility licensing authority.

S. Federal funds means all revenues under contracts or grants that the facility received directly from the federal government for the support and provision of medically necessary care to individuals which were not paid on an individual claims basis, including but not limited to those funds appropriated under the Public Health Services Consolidated 330 Act formerly Section 330 Community Health Center, Section 329 Migrant Health Center and Section 340 Homeless.

T. Fiscal year ending means the last day of the 12-month accounting cycle for which a facility plans the use of its funds.

U. Fund balance or equity means the residual interest in the assets of an entity that remains after liabilities, also called net assets.

V. FQHC means federally qualified health center.

W. FQHC rate means the total allowable cost per service as determined by the Medicaid FQHC cost report, to be submitted if the facility is certified as a FQHC or FQHC equivalent or receives cost-based reimbursement pursuant to federal law.

X. Governmental appropriations means revenue realized by the facility from state and local taxing authorities, including county indigent fund revenue and sole community provider revenue.

Y. Inpatient means a patient who is admitted to and lodged in a facility while receiving services.

Z. Medicaid charges means the total charges attributable to inpatient and outpatient services provided by the facility for participants of the Medicaid or Medicaid presumptive eligibility program billed to Medicaid or a Medicaid contractor and reasonably assumed to be reimbursable under the Medicaid program, excluding Salud and payments from other states.

AA. Medicaid discharges means the number of patients with at least one patient day who are formally released from the facility after receiving health care and who are participants of the Medicaid or Medicaid presumptive eligibility program, excluding Salud and patients from other states. This number includes patients who die in the facility and excludes newborns and individuals who are dead on arrival.

BB. Medicaid encounters means the total number of patient visits for medically necessary care attributable to participants of the Medicaid or Medicaid presumptive eligibility program and reasonably assumed to be reimbursable under the Medicaid program, excluding Salud and patients from other states.

CC. Medicaid patient days means the total number of patient days for patients discharged from the facility attributable to participants of the Medicaid or Medicaid presumptive eligibility program, excluding HMO, organ acquisition, observation bed days, Salud and patients from other states.

DD. Medically necessary care means a service that is deemed by accepted medical standards of care to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the recipient that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; including physical, oral and behavioral health services. Medically necessary care does not include: (1) nonmedical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; or (4) any service for which the facility could not reasonably expect to receive payment from a third party payer.

EE. Medicare charges means the total charges attributable to inpatient, outpatient and ancillary services provided by the facility for participants of the Medicare program billed to Medicare or a Medicare contractor and reasonably assumed to be reimbursable under the Medicare program.

FF.Medicare discharges means the number of patients with at least one patient day who are formally released from the facility after receiving health care and who are participants of the Medicare program. This number includes patients who die in the facility and excludes newborns and individuals who are dead on arrival.

GG. **Medicare encounters** means the total number of patient visits for medically necessary care attributable to participants of the Medicare program and reasonably expected to be reimbursable by Medicare.

HH. **Medicare patient days** means the total number of patient days for patients discharged from the facility attributable to participants of the Medicare program, excluding HMO, organ acquisition or observation bed days.

II. **Net Medicaid revenue** means Medicaid charges less provisions for contractual adjustments, excluding Salud and payments from other states.

JJ. **Net Medicare revenue** means Medicare charges less provisions for contractual adjustments, including estimated retroactive adjustments.

KK. **Net patient revenue** means gross revenue from health care services less provisions for contractual adjustments with third-party payers.

LL.Notice Program Reimbursement means the letter of notice from the Medicare audit agents containing final adjustments.

MM. **Outpatient** means a patient who is not admitted to or lodged in a facility while receiving services.

NN. **Patient day** means the unit of measure denoting lodging provided and services rendered to a patient between the census taking hours (usually at midnight) of two successive days. A patient formally admitted who is discharged or dies on the same day is counted as one patient day, regardless of the number of hours the patient occupies a facility bed.

OO. **Rural Primary Health Care funds** means all revenues received pursuant to the New Mexico Rural Primary Health Care Act, Section 24-1A-1 et seq. NMSA 1978.

PP. **Supplemental Medicaid revenue** means the amount received by a FQHC or FQHC equivalent that represents the difference between the negotiated managed care revenue and FQHC allowable rate.

QQ. **Total contractual allowances** means deductions from revenue for the differences between charges at full established rates and negotiated amounts received or to be received from third party payers under contractual agreements.

RR. **Total expenses** means the total expenses incurred by the facility during the reporting period.

SS. **Total other income** means revenue, gains or losses derived from services other than the provision of health care to patients.

TT.Total patient costs means all costs incurred in providing patient services and operating the facility.

UU. Total patient encounters means the total number of visits for medically necessary care.

VV. Total patient revenue means the total patient charges for medical services provided to patients at the facility before provisions for contractual and other adjustments and revenue forgone for charity care and bad debt.

WW. Total revenue means the total amount of revenue realized by the facility from all sources, operating and non-operating.

[7.1.24.7 NMAC - Rp, 7 NMAC 1.24.7, 12/31/2000]

7.1.24.8 REQUIRED SUBMISSIONS:

A. All non-federal health care facilities shall submit the data required by 7.1.24.12 NMAC or 7.1.24.13 NMAC, as applicable, to the commission in accordance with the schedule set forth in 7.1.24.11 NMAC.

B. All non-federal health care facilities shall submit their federal Health Care Financing Administration Medicare Cost Report for the same fiscal year as the data required by 7.1.24.12 NMAC or 7.1.24.13 NMAC, as applicable, to the commission in accordance with the schedule set forth in 7.1.24.11 NMAC.

C. All non-federal health care facilities shall submit the facility's formal charity care policy or policies to the commission in accordance with the schedule set forth in 7.1.24.11 NMAC. The charity care policy or policies shall include as a criterion the level of qualifying income as a percentage of the applicable federal poverty level.

D. All non-federal health care facilities shall submit any Notice Program Reimbursement indicating adjustments that are five percent or greater than costs to the commission within 30 days of the facility's receipt of the Notice Program Reimbursement.

[7.1.24.8 NMAC - N, 12/31/2000]

7.1.24.9 DATA SOURCE REQUIREMENTS:

A. All data required to be reported by this rule shall be obtained from the facility's most recently filed federal Health Care Financing Administration Medicare Cost Report, to the extent the data is available on that report. If the Medicare Cost Report is the source of the data, the definitions governing the Medicare Cost Report shall supersede any inconsistent definitions in this rule.

B. Data required to be reported by this rule that is not available from the facility's most recently filed federal Health Care Financing Administration Medicare Cost Report shall be obtained from the source specified on the reporting form provided by the commission. If the data is not obtained from the specified source, the facility shall report both the required data and its source.

[7.1.24.9 NMAC - N, 12/31/2000]

7.1.24.10 REPORTING FORMAT:

A. Required data shall be submitted in accordance with the reporting form and instructions provided by the commission. The commission may require facilities to submit the data required to be reported by this rule and other commission rules on one reporting form.

B. The commission may specify software or other requirements to promote uniform reporting and efficient analysis. The commission may require that all data be submitted by electronic media (such as computer tape, cartridge or diskette) or by direct electronic transmission.

[7.1.24.10 NMAC - Rp, 7 NMAC 1.24.10, 12/31/2000]

7.1.24.11 SCHEDULE FOR REPORTING:

A. For fiscal years ending prior to the effective date of this rule: All facilities shall submit the required data according to either the requirements of the initial rule 7 NMAC 1.24, "Charity Care Data Reporting Requirements", sections 8 and 9, effective January 1, 1999 or the requirements of this replacement rule 7.1.24 NMAC, "Charity Care Data Reporting Requirements", effective December 31, 2000.

B. For fiscal years ending after the effective date of this rule: All facilities shall submit the required data per this replacement rule 7.1.24.NMAC, effective December 31, 2000, for the facility's prior fiscal year to the commission no later than six months after the end of the prior fiscal year.

[7.1.24.11 NMAC - Rp, 7 NMAC 1.24.8.1, 7 NMAC 1.24.9.1, 12/31/2000]

7.1.24.12 DATA REPORTING BY LICENSED NONFEDERAL GENERAL AND SPECIALTY INPATIENT HEALTH CARE FACILITIES:

All licensed non-federal general and specialty inpatient health care facilities in New Mexico shall report to the commission the following data for their prior fiscal year:

A. Bad debt

B. Charity care charges

C. Cost to charge ratio (facilities with special circumstances, such as teaching and transplant costs and charges, shall provide a reconciliation of the cost to charge ratio with a modified ratio reflecting those circumstances)

D. County indigent fund revenue (facilities with significant pass-through funds to physicians and others shall report the net amount and provide a reconciliation of the gross and net amounts)

E. Emergency room charity care inpatient revenue (required for fiscal years ending on or after 10/31/2001)

F. Emergency room charity care outpatient revenue (required for fiscal years ending on or after 10/31/2001)

G. Emergency room encounters (required for fiscal years ending on or after (10/31/2001)

H. Emergency room inpatient revenue (required for fiscal years ending on or after 10/31/2001)

I. Emergency room outpatient revenue (required for fiscal years ending on or after (10/31/2001)

J. Facility control

K. Facility ID

L. Facility license number

M. Fiscal year ending

N. Fund balance or equity

O. Governmental appropriations

P. Medicaid charges

Q. Medicaid discharges

R. Medicaid patient days

S. Medicare charges

T. Medicare discharges

U. Medicare patient days

V. Net Medicaid revenue

W. Net Medicare revenue

X. Net patient revenue

Y. Total contractual allowances

Z. Total discharges

AA. Total expenses

BB. Total other income

CC. Total patient costs

DD. Total patient revenue

EE. Total revenue

[7.1.24.12 NMAC - Rp, 7 NMAC 1.24.8.2, 12/31/2000]

7.1.24.13 DATA REPORTING BY EACH FACILITY LICENSED BY A STATE HEALTH FACILITY LICENSING AUTHORITY AS A "DIAGNOSTIC AND TREATMENT CENTER," "LIMITED DIAGNOSTIC AND TREATMENT CENTER," OR "RURAL HEALTH CLINIC":

All licensed diagnostic and treatment centers, limited diagnostic and treatment centers and rural health clinics or the equivalent shall report to the commission the following data for their prior fiscal year:

A. Audited FQHC rate(s)

B. Bad debt

C. Charity care charges

D. Charity care encounters

E. County indigent fund revenue (facilities with significant pass-through funds to physicians and others shall report the net amount and provide a reconciliation of the gross and net amounts)

F. Facility control

G. Facility ID

H. Facility license number

I. Federal funds

J. FQHC rate

K. Fund balance or equity

L. Governmental appropriations

M. Medicaid encounters

N. Medicare encounters

O. Net Medicaid revenue

P. Net Medicare revenue

Q. Net patient revenue

R. Rural Primary Health Care funds

S. Supplemental Medicaid revenue

T. Total contractual allowances

U. Total expenses

V. Total other income

W. Total patient costs

X. Total patient encounters

Y. Total patient revenue

[7.1.24.13 NMAC - Rp, 7 NMAC 1.24.9.2, 12/31/2000]

7.1.24.14 STATUS AND USE OF DATA:

A. All data and information reported under this rule shall become the property of the commission upon receipt.

B. The commission may use the data submitted according to this rule to assist it in carrying out the provisions of the Health Information Systems Act, Section 24-14A-1 et

seq. NMSA 1978, which may include performing analysis and calculations to determine additional information.

[7.1.24.14 NMAC - Rp, 7 NMAC 1.24.11, 12/31/2000]

7.1.24.15 MODIFICATION OR EXEMPTION FROM REPORTING COMPLIANCE:

A. Upon written application to the director, the director may grant a health care facility subject to this rule a temporary modification in reporting requirements or a temporary exemption for up to one year. A modification or exemption shall be granted only when the facility makes a reasonable showing that compliance would require unreasonable costs, would be unduly burdensome given the facility's particular circumstances, or is not feasible due to no fault of the facility. A facility requesting a modification must also make a reasonable showing that it will effectuate the purposes of this rule through alternative means.

B. A facility granted a temporary modification in reporting requirements shall report data according to the modification. Upon resumption of the regular reporting requirements the facility shall report data according to the requirements of this rule.

C. A facility granted a temporary exemption from reporting is not excused from reporting data for the exempted period. Upon resumption of the regular reporting schedule the facility shall promptly report data for the exempted period.

D. The facility may appeal the director's decision to the commission, which shall make a final determination on the application.

[7.1.24.15 NMAC - Rp, 7 NMAC 1.24.12, 12/31/2000]

7.1.24.16 ACCESS TO DATA:

Data collected pursuant to this rule shall be considered an analytical database in accordance with Access to Health Information System Data and Reports, 7.1.20 NMAC (8/30/1997) and access to such data shall be subject to the provisions of 7.1.20 NMAC or made available upon the expressed written authority of the designated administrator of the facility that submitted the data.

[7.1.24.16 NMAC - Rp, 7 NMAC 1.24.13, 12/31/2000]

7.1.24.17 PENALTIES FOR RULE VIOLATION:

Failure to comply with any of the reporting requirements in this rule may result in injunctive relief and a civil penalty not to exceed $1,000 per violation, as provided by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.24.17 NMAC - Rp, 7 NMAC 1.24.14, 12/31/2000]

PART 25: CAPITAL ASSETS DATA REPORTING REQUIREMENTS

7.1.25.1 ISSUING AGENCY:

New Mexico Health Policy Commission.

[7.1.25.1 NMAC - Rp, 7 NMAC 1.25.1, 12/31/2000]

7.1.25.2 SCOPE:

This rule applies to all non-federal health care facilities licensed by a state health facility licensing authority and located in New Mexico.

[7.1.25.2 NMAC - Rp, 7 NMAC 1.25.2, 12/31/2000]

7.1.25.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 24-14A-3(D) and 24-14A-5 of the Health information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.25.3 NMAC - Rp, 7 NMAC 1.25.3, 12/31/2000]

7.1.25.4 DURATION:

Permanent.

[7.1.25.4 NMAC - Rp, 7 NMAC 1.25.4, 12/31/2000]

7.1.25.5 EFFECTIVE DATE:

December 31, 2000, unless a later date is cited in the history note at the end of a section.

[7.1.25.5 NMAC - Rp, 7 NMAC 1.25.5, 12/31/2000]

7.1.25.6 OBJECTIVE:

The purpose of this rule is to specify the reporting requirements related to capital assets for all nonfederal health care facilities licensed by a state health facility licensing authority and located in New Mexico, pursuant to the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.25.6 NMAC - Rp, 7 NMAC 1.25.6, 12/31/2000]

7.1.25.7 DEFINITIONS:

In addition to the definitions in the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978, the following terms have the following meaning for purposes of this rule:

A. Capital asset disposals and retirements means the disposal or retirement of long-term assets which a facility used in its operation.

B. Depreciation means the systematic and rational allocation of the cost of a long-term asset over its estimated useful life.

C. Director means the director of the commission.

D. Facility license number means the unique number assigned and listed on the facility's license document issued by the state health facility licensing authority.

E. Fiscal year ending means the last day of the 12-month accounting cycle for which a facility plans the use of its funds.

F. Long-term asset means a fixed, tangible asset, such as land, land improvements, buildings and improvements, leasehold improvements, equipment (fixed and moveable), leased property and equipment, and construction in progress.

G. Net income (loss) means the difference between total revenue and total expenses.

H. Owner(s) of facility means the name of the owner(s) listed on the current license of a facility licensed by the state health facility licensing authority.

I. Return on capital assets means a facility's net income divided by average capital assets.

J. Total capital asset ending balance means the total amount of all long-term assets used in the facility's operations.

K. Total new capital asset purchases means the total amount of new long-term assets purchased for use in the facility's operations.

[7.1.25.7 NMAC - Rp, 7 NMAC 1.25.7, 12/31/2000]

7.1.25.8 REQUIRED SUBMISSIONS:

A. All non-federal health care facilities shall submit the data required by 7.1.25.12 NMAC to the commission in accordance with the schedule set forth in 7.1.25.11 NMAC.

B. The commission may require a facility to submit detailed lists of new capital asset purchases and capital asset disposals and retirements if the facility's average capital

assets indicates a significant deviation from the facility's average capital assets in prior years, or if the facility's return on capital assets indicates a significant deviation from: (1) the facility's return on capital assets in prior years; (2) the average return on capital assets for licensed non-federal health care facilities in New Mexico; or (3) the average return on capital assets for health care facilities based on national data.

[7.1.25.8 NMAC - N, 12/31/2000]

7.1.25.9 DATA SOURCE REQUIREMENTS:

A. All data required to be reported by this rule shall be obtained from the facility's most recently filed federal Health Care Financing Administration Medicare Cost Report, to the extent the data is available on that report. If the Medicare Cost Report is the source of the data, the definitions governing the Medicare Cost Report shall supercede any inconsistent definitions in this rule.

B. Data required to be reported by this rule that is not available from the facility's most recently filed federal Health Care Financing Administration Medicare Cost Report shall be obtained from the source specified on the reporting form provided by the commission. If the data is not obtained from the specified source, the facility shall report both the required data and its source.

[7.1.25.9 NMAC - N, 12/31/2000]

7.1.25.10 REPORTING FORMAT:

A. Required data shall be submitted in accordance with the reporting form and instructions provided by the commission. The commission may require facilities to submit the data required to be reported by this rule and other commission rules on one reporting form.

B. The commission may specify software or other requirements to promote uniform reporting and efficient analysis. The commission may require that all data be submitted by electronic media (such as computer tape, cartridge or diskette) or by direct electronic transmission.

[7.1.25.10 NMAC - Rp, 7 NMAC 1.25.9, 12/31/2000]

7.1.25.11 SCHEDULE FOR REPORTING:

A. For fiscal years ending prior to the effective date of this rule: All facilities shall submit the required data according to either the requirements of the initial rule 7 NMAC 1.25, "Capital Assests Data Reporting Requirements", section 8, effective December 31, 1998 or the requirements of this replacement rule, 7.1.25 NMAC, "Capital Assets Data Reporting Requirements", effective December 31, 2000.

B. For fiscal years ending after the effective date of this rule: All facilities shall submit the required data per this replacement rule 7.1.25 NMAC, effective December 31, 2000, for the facility's prior fiscal year to the commission no later than six months after the end of the prior fiscal year.

[7.1.25.11 NMAC - Rp, 7 NMAC 1.25.8.1, 12/31/2000]

7.1.25.12 DATA REPORTING BY ALL NON-FEDERAL LICENSED HEALTH CARE FACILITIES LOCATED IN NEW MEXICO:

All non-federal licensed health care facilities in New Mexico shall report to the commission the following data for their prior fiscal year:

A. Capital asset disposals and retirements

B. Depreciation

C. Facility license number

D. Facility name

E. Fiscal year ending

F. Net income (loss)

G. Owner(s) of facility

H. Total capital asset ending balance

I. Total new capital asset purchases

[7.1.25.12 NMAC - Rp, 7 NMAC 1.25.8.2, 12/31/2000]

7.1.25.13 STATUS AND USE OF DATA:

A. All data and information collected pursuant to this rule shall become the property of the commission upon receipt.

B. The commission may use the data submitted according to this rule to assist it in carrying out the provisions of the Health Information Systems Act, Section 24-14A-1 et seq. NMSA 1978, which may include performing analysis and calculations to determine additional information.

[7.1.25.13 NMAC - Rp, 7 NMAC 1.25.10, 12/31/2000]

7.1.25.14 MODIFICATION OR EXEMPTION FROM REPORTING REQUIREMENTS:

A. Upon written application to the director, the director may grant a health care facility subject to this rule a temporary modification in reporting requirements or a temporary exemption for up to one year. A modification or exemption shall be granted only when the facility makes a reasonable showing that compliance would require unreasonable costs, would be unduly burdensome given the facility's particular circumstances, or is not feasible due to no fault of the facility. A facility requesting a modification must also make a reasonable showing that it will effectuate the purposes of this rule through alternative means.

B. A facility granted a temporary modification in reporting requirements shall report data according to the modification. Upon resumption of the regular reporting requirements the facility shall report data according to the requirements of this rule.

C. A facility granted a temporary exemption from reporting is not excused from reporting data for the exempted period. Upon resumption of the regular reporting schedule the facility shall promptly report data for the exempted period.

D. The facility may appeal the director's decision to the commission, which shall make a final determination on the application.

[7.1.25.14 NMAC - Rp, 7 NMAC 1.25.11, 12/31/2000]

7.1.25.15 ACCESS TO DATA:

Data collected pursuant to this rule shall be considered an analytical database in accordance with Access to Health Information System Data and Reports, 7.1.20 NMAC (8/30/1997) and access to such data shall be subject to the provisions of 7.1.20 NMAC or made available upon the expressed written authority of the designated administrator of the facility that submitted the data.

[7.1.25.15 NMAC - Rp, 7 NMAC 1.25.12, 12/31/2000]

7.1.25.16 PENALTIES FOR RULE VIOLATION:

Failure to comply with any of the reporting requirements in this rule may result in injunctive relief and a civil penalty not to exceed $1,000 per violation, as provided by the Health Information System Act, Section 24-14A-1 et seq. NMSA 1978.

[7.1.25.16 NMAC - Rp, 7 NMAC 1.25.13, 12/31/2000]

PART 26: VOLUNTEER HEALTH CARE PROVIDER TORT COVERAGE PROGRAM

7.1.26.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.1.26.1 NMAC - N, 2/15/2008]

7.1.26.2 SCOPE:

This rule applies to all health care providers with no liability insurance licensed within New Mexico who render voluntary health care services without compensation under the auspices of a registered health care agency or organization.

[7.1.26.2 NMAC - N, 2/15/2008]

7.1.26.3 STATUTORY AUTHORITY:

NMSA 1978 Section 41-4-3 F (16).

[7.1.26.3 NMAC - N, 2/15/2008]

7.1.26.4 DURATION:

Permanent.

[7.1.26.4 NMAC - N, 2/15/2008]

7.1.26.5 EFFECTIVE DATE:

02/15/2008, unless a later date is cited in the history note at the end of a section.

[7.1.26.5 NMAC - N, 2/15/2008]

7.1.26.6 OBJECTIVE:

The purpose of this rule is to provide guidance for the registration and administration of eligible licensed New Mexico health care providers with no liability insurance who will serve without compensation, and the eligible agencies who seek their health care services.

[7.1.26.6 NMAC - N, 2/15/2008]

7.1.26.7 DEFINITIONS:

A. "Licensed health care provider" defined as a health care provider licensed to practice in the state of New Mexico or a health care provider in federal service with a license issued in another state, including the following professional disciplines:

(1) optometrists;

(2) chiropractic physicians;

(3) dentists;

(4) physicians;

(5) podiatrists;

(6) osteopathic physicians;

(7) physician assistants;

(8) certified nurse practitioners;

(9) physical therapists;

(10) occupational therapists;

(11) speech-language pathologists;

(12) doctors of oriental medicine;

(13) nutritionists;

(14) psychologists;

(15) certified nurse-midwives;

(16) clinical nurse specialists;

(17) registered nurses;

(18) dental hygienists;

(19) pharmacists;

(20) athletic trainers;

(21) anesthesiologist assistants.

B. "Voluntary health care services" defined as health care services delivered by a health care provider without compensation to that provider. Reimbursement of reasonable travel, meal, or lodging expenses is not considered compensation.

C. "Secretary" defined as secretary of health.

[7.1.26.7 NMAC - N, 2/15/2008]

7.1.26.8 REGISTRATION OF ELIGIBLE HEALTH CARE AGENCIES AND ORGANIZATIONS:

A. Registration requirements - all health care agencies and organizations seeking to participate in the program must apply to the New Mexico department of health, epidemiology and response division and be approved and registered in the program.

B. Term of approval - successful applicants will be approved for participation in the program for a term to be established by the New Mexico department of health. Successful applicants will be notified of the approval of their participation in the program and be provided an indication of the term of that approval.

C. Termination of approval - the New Mexico department of health shall at its discretion terminate a registered agency or organization's participation in the program. The registered agency or organization will be notified of any termination decision.

D. Registered health care providers participating in the program may provide voluntary health care services at locations operated or sponsored by registered agencies and organizations including:

(1) public health offices operated by the New Mexico department of health;

(2) public health contractors of the New Mexico department of health including:

(a) family planning contractors;

(b) oral health service providers;

(c) human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) service providers;

(3) community-based primary care centers licensed by the New Mexico department of health;

(4) school-based health centers;

(5) emergency medical services licensed by the state of New Mexico;

(6) Indian health services and tribal health services;

(7) other health programs operated by the New Mexico department of health;

(8) other locations and volunteer opportunities as recognized by the New Mexico department of health;

(9) mobile and portable outreach and extension efforts sponsored by registered agency, organization, or program including:

(a) health fairs;

(b) head start - school outreach.

[7.1.26.8 NMAC - N, 2/15/2008]

7.1.26.9 REGISTRATION OF ELIGIBLE HEALTH CARE PROVIDERS:

A. Eligible health care providers - all licensed health care providers with no liability insurance who seek to render voluntary health care services without compensation under the auspices of a registered health care agency or organization are eligible to apply for participation in the program.

B. Registration requirements - all health care providers seeking to participate in the program must apply to the New Mexico department of health, epidemiology and response division and be approved and registered in the program.

C. Term of approval - successful applicants will be approved for participation in the program for a term to be established by the New Mexico department of health. Successful applicants will be notified of the approval of their participation in the program and be provided an indication of the term of that approval.

D. Termination of approval - the New Mexico department of health shall at its discretion terminate a registered health care provider's participation in the program. The registered health care provider will be notified of any termination decision.

E. Scope of practice - all state registered health care providers participating in the volunteer health care provider program (program) are limited to the practice permitted under each provider's licensure in the state of New Mexico.

[7.1.26.9 NMAC - N, 02/15/2008]

7.1.26.10 RECONSIDERATION:

Reconsideration - the secretary may, at his discretion, reconsider the application of any eligible health care provider or of any eligible health care agency or organization that is denied approval for participation in the program.

[7.1.26.10 NMAC - N, 2/15/2008]

7.1.26.11 MEASURES TO ENSURE QUALITY OF CARE:

A. Credentialing - before an eligible health care provider is approved and registered in the program, a review of the applicant's licensing and credentialing will be conducted. Only applicants who have successfully passed this review will be approved for participation in the program.

B. Supervision - where a volunteer health care provider's professional license requires specific supervision or professional consultation, the eligible health care organization or agency must demonstrate that adequate arrangements for supervision or professional consultation are in place at the location of volunteer service.

C. Service protocols - an eligible health care organization or agency must demonstrate that there are service protocols in place for any service that is to be provided by volunteers participating in the program. All participating volunteers must comply with this guidance.

D. Facility license - when volunteer health care providers participating in the program are providing health care in a licensed health facility, the services provided must be in accordance with the limits imposed by the facility's license.

E. Extension and outreach events and non-licensed locations - when eligible voluntary health care services are provided at an outreach, extension, or other non-licensed location, these services must be provided in a manner permissible under New Mexico law.

[7.1.26.11 NMAC - N, 2/15/2008]

PART 27: HEALTH INFORMATION SYSTEM REPORTING REQUIREMENTS FOR HEALTHCARE FACILITIES AND ACCESS TO DATA AND REPORTS

7.1.27.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.1.27.1 NMAC - N, 12/31/2012]

7.1.27.2 SCOPE:

This rule applies to all licensed inpatient and outpatient general and specialty health care facilities located within New Mexico.

[7.1.27.2 NMAC - N, 12/31/2012]

7.1.27.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Subsections 24-14A-3D (5) and (6); 24-14A-5(A) through C; 24-14A-8(A) and B; and 24-14A-9 of the Health Information System (HIS) Act, Sections 24-14A-1 to -10, NMSA 1978.

[7.1.27.3 NMAC - N, 12/31/2012]

7.1.27.4 DURATION:

Permanent.

[7.1.27.4 NMAC - N, 12/31/2012]

7.1.27.5 EFFECTIVE DATE:

December 31, 2012, unless another date is cited at the end of a section.

[7.1.27.5 NMAC - N, 12/31/2012]

7.1.27.6 OBJECTIVE:

The purpose of this rule is to specify the data reporting requirements for licensed inpatient and outpatient general and specialty health care facilities pursuant to the HIS Act, Sections 24-14A-1 to -10, NMSA 1978.

[7.1.27.6 NMAC - N, 12/31/2012]

7.1.27.7 DEFINITIONS:

In addition to the definitions in the HIS Act, Sections 24-14A-1 to -10, NMSA 1978, the following terms have the following meaning for purposes of this rule.

A. All definitions that begin with the letter A.

(1) **Accident state** means the two-digit state abbreviation where the accident occurred when services are related to an auto accident.

(2) **Admission hour** means the hour and minute the patient was admitted as an inpatient, coded in military time (e.g., 2:45 p.m. is represented as 1445).

(3) **Aggregate analysis** means information in report form that contains data combined in a manner which precludes specific identification of a single patient or health care provider.

(4) **Annual permanent database** means one calendar year of permanent hospital inpatient discharge data or any other database collected under the HIS Act that is deemed complete by division staff.

(5) **Attending physician NPI** means the national provider identifier (NPI), a unique, government-issued, standard identification 10-digit number for individual health care providers and provider organizations like clinics, hospitals, schools and group practices.

B. All definitions that begin with the letter B. **Birth weight** means weight of newborns coded in grams.

C. All definitions that begin with the letter C.

(1) **Centers for medicare and medicaid services or CMS** means the United States federal agency which administers medicare, medicaid, and the state children's health insurance programs.

(2) **1st condition code, 2nd condition code, 3rd condition code, 4th condition code, 5th condition code, 6th condition code, 7th condition code, 8th condition code, 9th condition code, 10th condition code, 11th condition code** means the codes used to identify conditions or events relating to the billing claim that may affect processing as defined in the form locators 18-28 of the UB-04 manual. (**Usage note: The state requires public health data reporting to indicate that a patient was admitted directly from the facility's emergency room/department. Provider will use the code "P7" to indicate the patient was admitted from the provider facility's emergency room/department**).

D. All definitions that begin with the letter D.

(1) **Data provider** means a data source that has provided data to the health information system on a regular basis.

(2) **Data source** has the meaning given in Section 24-14A-2 of the HIS Act, and includes those categories of persons or entities that possess health information, including any public or private sector licensed hospital, health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, pharmacy, third-party payer, and any public entity that has health information.

(3) **Database** means a set of data based on individual patient hospital discharge abstract data or any other database collected under the HIS Act.

(4) **Department** means the New Mexico department of health.

(5) **Division** means the epidemiology and response division of the department, P.O. Box 26110, Santa Fe, NM 87502-6110.

(6) **Discharge hour** means the hour and minute the patient was discharged as an inpatient, coded in military time (e.g., 2:45 p.m. is represented as 1445).

(7) **Durable medical equipment or DME** means medical equipment used in the home to aid in a better quality of living.

E. All definitions that begin with the letter E.

(1) **1st e-code** means the first code for external causes of injury, poisoning, or adverse effect. (Usage note: If a patient has an injury diagnosis in a range of ICD-9-CM 800-999, an e-code is required. This is the primary (first-listed) external cause of injury).

(2) **2nd e-code** means the second code for external causes of injury, poisoning, or adverse effect.

(3) **3rd e-code** means the third code for external causes of injury, poisoning, or adverse effect.

F. All definitions that begin with the letter F. **Federal agency** means any agency, department, bureau, board, division, institution, or other organization of the United States government.

G. All definitions that begin with the letter G.

H. All definitions that begin with the letter H.

(1) **Health care** means any care, treatment, service, or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

(2) **Health care professional** means any individual licensed, certified, or otherwise authorized or permitted by law to provide health care in the practice of a profession.

(3) **Health care provider** means any individual, corporation, partnership, organization, facility, institution, or other entity licensed, certified, or otherwise authorized or permitted by law to provide health care in the ordinary course of business or practice of a profession.

(4) **Health information system or HIS** means the health information system established by the Health Information System Act, Sections 24-14A-1 to 24-14A-10, NMSA 1978.

(5) **HIS advisory committee** means individuals from the division pursuant to Subsection 24-14A-3.1 of the HIS Act.

(6) **Health Information System Act (HIS Act)** means the Health Information System Act, Sections 24-14A-1 to 24-14A-10, NMSA 1978.

(7) **Health insurance prospective payment system (HIPPS) rate code** means the three-digit codes that represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers and reported in form locator 71 of the UB-04 manual.

I. All definitions that begin with the letter I.

(1) **ICD-9-CM** is the international classification of disease, ninth revision, clinical modification for clinical diagnosis and procedure coding (October 2011) American medical association.

(2) **ICD-10-CM** is the international classification of disease, 10th revision, clinical modification for clinical diagnosis coding.

(3) **ICD-10-PCS** is the international classification of disease, 10th revision, clinical modification for procedure coding.

(4) **Identifier** means any information that reveals the identity of, or could reasonably be used to reveal the identity of, a single patient, or health care professional, but does not include a number assigned to a single patient for the purpose of conducting longitudinal or linking studies.

(5) **Inpatient health care facility** means a hospital or other health facility which admits patients for overnight or longer (and therefore is responsible for patients' room and board) for the purpose of providing diagnostic treatment or other health services.

(6) **Inpatient rehabilitation facility or IRF** is an inpatient rehabilitation hospital or part of a rehabilitation hospital, which provides an intensive rehabilitation program for inpatients.

(7) **ISO 3166** is the codes for representation of names of countries issued by the American national standards institute (ANSI) (latest release).

J. All definitions that begin with the letter J.

K. All definitions that begin with the letter K.

L. All definitions that begin with the letter L. **Long-term care hospital or LTCH** means an acute care hospital certified by the centers for medicare and medicaid services (CMS) that provide rehabilitative, restorative, or on-going skilled nursing care to patients or residents in need of assistance with activities of daily living. Long-term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, and long-term chronic care hospitals.

M. All definitions that begin with the letter M. **Medicare provider number** means the six digit number assigned by medicare to the data source providing the reported service(s).

N. All definitions that begin with the letter N.

(1) **National provider identifier (NPI)** means the 10-digit NPI from the national plan and provider enumeration system (NPPES).

(2) **New Mexico state license number** means the four to eight digit license number issued by the New Mexico health department for the data source providing the reported service(s).

(3) **National uniform billing committee or NUBC** is an entity formed by the American hospital association (AHA) in 1975, which includes participation by all major national provider and payer organizations and develops single billing forms and standard data sets that are used nationwide by institutional providers and payers for handling health care claims.

O. All definitions that begin with the letter O.

(1) **Operating physician NPI** means the national provider identifier (NPI), a unique, government-issued, standard identification 10-digit number for individual health care providers and provider organizations like clinics, hospitals, schools and group practices.

(2) **Outpatient health care facility** means a hospital or other health facility that provides ambulatory care to a patient without admitting the patient to the facility or providing lodging services.

P. All definitions that begin with the letter P.

(1) **Patient** means a person who has received or is receiving health care.

(2) **Patient admission date** means the date the patient was admitted by the provider for inpatient care. Format as, "mmddyyyy". For example, if the admission date was July 1, 1983, "07011983" would be coded.

(3) **Patient admitting diagnosis code, patient principle diagnosis code, patient 2nd diagnosis code, patient 3rd diagnosis code, patient 4th diagnosis code, patient 5th diagnosis code, patient 6th diagnosis code, patient 7th diagnosis code, patient 8th diagnosis code, patient 9th diagnosis code, patient 10th diagnosis code, patient 11th diagnosis code, patient 12th diagnosis code, patient 13th diagnosis code, patient 14th diagnosis code, patient 15th diagnosis code, patient 16th diagnosis code, patient 17th diagnosis code, and patient 18th diagnosis code** means the ICD-9-CM (or ICD-10-CM or subsequent versions of ICD coding) diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

(4) **Patient city** means the city of the patient's residence at the time of discharge.

(5) **Patient control number** means the patient's unique alpha-numeric number assigned by the provider.

(6) **Patient country code** means the two-digit alpha-two codes of the patient's residence at the time of discharge, from Part I of the ISO 3166 as required in form locator 9e of the UB-04 manual. (Usage note: Reported only if other than a United States residence).

(7) **Patient county** means the county of the patient's residence at the time of discharge.

(8) **Patient date of birth** means the date of birth of the patient. Required format is "mmddyyyy". Note that all four digits of year are required (e.g., "08191898" is for August 19, 1898).

(9) **Patient diagnosis related group (DRG) code** means the diagnostic related group code used for the HIPPS code in form locator 71 of the UB-04 manual.

(10) **Patient diagnostic code qualifier** means the revision number of the international classifications of disease diagnosis codes used to record the diagnoses represented by Paragraph (20) of Subsection P of 7.1.27.7 NMAC.

(a) 9-ICD-9-CM, ninth revision required on claims through September 30, 2013.

(b) 0-ICD-10-CM, 10th revision when implemented.

(c) 1-ICD-11-CM, 11th revision reservation for future reporting requirements.

(11) **Patient’s discharge date** means the date the patient was discharged by the provider from the inpatient health care facility. Formatted as "mmddyyyy" (i.e., an admission date of July 1, 1983, would be coded "07011983").

(12) **Patient’s emergency medical services (EMS) ambulance run number** means the emergency medical services ambulance run number.

(13) **Patient’s ethnicity** means the gross classification of a patient's stated ethnicity, coded as follows:

(a) E1-Hispanic or Latino;

(b) E2-not Hispanic or Latino;

(c) E6-declined;

(d) E7-unknown or unable to obtain.

(14) **Patient’s first name** means the first name of the patient.

(15) **Patient’s medicaid number** means the patient’s unique identification number assigned by medicaid.

(16) **Patient’s medical record number** means the medical record number used by the provider to identify the patient.

(17) **Patient’s middle initial** means the middle initial of the patient.

(18) **Patient’s last name** means the last name of patient. Last name should not have a space between a prefix and a name as in "MacBeth", but hyphenated names retain the hyphen as in "Smith-Jones". Titles should not be recorded. If the last name has a suffix, put the last name, a space, and then the suffix as in "Snyder III". Last name does not include abbreviations of academic achievement or profession, such as "M.D.", "Ph.D." etc.

(19) **Patient’s phone number** means the 10 digit phone number provided by the patient, without section separating characters like dashes, hyphens or slashes (i.e., "5051234567").

(20) **Patient’s principle diagnosis code, present on admission; patient 2nd diagnosis code; present on admission; patient 3rd diagnosis code, present on admission; patient 4th diagnosis code, present on admission; patient 5th diagnosis code, present on admission; patient 6th diagnosis code, present on admission; patient 7th diagnosis code, present on admission; patient 8th diagnosis code, present on admission; patient 9th diagnosis code, present on admission; patient 10th diagnosis code, present on admission; patient 11th**

diagnosis code, present on admission; patient 12th diagnosis code, present on admission; patient 13th diagnosis code, present on admission; patient 14th diagnosis code, present on admission; patient 15th diagnosis code, present on admission; patient 16th diagnosis code, present on admission; patient 17th diagnosis code, present on admission; patient 18th diagnosis code, present on admission means diagnosis was present at the time the order for inpatient admission occurs-conditions that develop during an outpatient encounter, including emergency room, observation, or outpatient surgery are considered as present on admission.

(a) Y-yes.

(b) N-no.

(c) U-no information on the record.

(d) W-clinically undetermined.

(e) 1-exempt.

(21) **Patient principal procedure code, patient 2nd procedure code, patient 3rd procedure code, patient 4th procedure code, patient 5th procedure code, patient 6th procedure code** means the codes identifying the significant procedures, performed during the patient's stay.

(22) **Patient race** means 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 American Indian and other the race field would be R1R9.

(a) R1-American Indian or Alaska Native.

(b) R2-Asian (including Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese).

(c) R3-Black or African American.

(d) R4-Native Hawaiian or Pacific Islander (including Chamorro and Samoan).

(e) R5-White.

(f) R6-declined.

(g) R7-unknown or unable to obtain.

(h) R9-other race.

(23) **Patient's social security number** means the nine digit social security number provided by the patient, without section separating characters like dashes, hyphens or slashes (i.e., "123456789").

(24) **Patient's state** means the two-digit state code of the patient's residence at the time of discharge.

(25) **Patient's status** means the code indicating patient's disposition at time of discharge. The codes are:

(a) 01-discharged to home or self care (routine discharge); (usage note: includes discharge to home; home on oxygen if DME only; any other DME only; group home; foster care; independent living and other residential care arrangements; outpatient programs, such as partial hospitalization of outpatient chemical dependency programs);

(b) 02-discharged/transferred to a short-term general hospital for inpatient care;

(c) 03-discharged/transferred to skilled nursing facility (SNF) with medicare certification in anticipation of skilled care; (usage note: medicare-indicates that the patient is discharged/transferred to a medicare certified nursing facility; for hospitals with an approved swing bed arrangement, use code 61-swing bed; for reporting other discharges/transfers to nursing facilities see definitions for codes 04 and 64 in accordance with 7.1.27.7 NMAC);

(d) 04-discharged/transferred to a facility that provides custodial or supportive care; (usage note: includes intermediate care facilities (ICF) if specifically designated at the state level; also used to designate patients that are discharged/transferred to a nursing facility with neither medicare nor medicaid certification and for discharges/transfers to assisted living facilities);

(e) 05-discharged/transferred to a designated cancer center of children's hospital;

(f) 06-discharged/transferred to home under care of an organized home health service organization in anticipation of covered skilled care; (usage note: report this code when a patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services; not used for home health services provided by a DME supplier or from a home IV provider for home IV services);

(g) 07-left against medical advice or discontinued care;

(h) 08-reserved for national assignment by the NUBC;

(i) 09-admitted as an inpatient to this hospital; (usage note: this is for use only on medicare outpatient claims; applies only to those medicare outpatient services that begin greater than three days prior to admission and therefore should not be reported for inpatient discharges);

(j) 10-19 reserved for national assignment by the NUBC;

(k) 20-expired;

(l) 21-discharged/transferred to court/law enforcement (covers patients sent to jail, prison or other detention facilities);

(m) 22-29-reserved for national assignment by the NUBC;

(n) 30-still patient or expected to return for outpatient services; (usage note: used when patient is still within the same facility; typically used when billing for leave of absence days or interim bills);

(o) 31-39-reserved for national assignment by the NUBC;

(p) 40-expired at home (hospice claims only);

(q) 41-expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice (hospice claims only);

(r) 42-expired-place unknown (hospice claims only);

(s) 43-discharged/transferred to a federal health care facility; (usage note: discharges and transfers to a government operated health care facility such as a department of defense hospital, a veteran's administration (VA) hospital or a VA nursing facility; to be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not);

(t) 44-49-reserved for national assignment by the NUBC;

(u) 50-discharged/transferred to hospice-home;

(v) 51-discharged/transferred to hospice-medical facility (certified) providing hospice level of care;

(w) 52-60-reserved for national assignment by the NUBC;

(x) 61-discharged/transferred within this institution to a hospital based medicare approved swing bed; (usage note: medicare-used for reporting patients discharged/transferred to SNF level of care within the hospital's approved swing bed arrangement);

(y) 62-discharged/transferred to an IRF including rehabilitation distinct part units of a hospital;

(z) 63-discharged/transferred to a LTCH; (usage note: for hospitals that meet the medicare criteria for LTCH certification);

(aa) 64-discharged/transferred to a nursing facility certified under medicaid but not certified under medicare;

(bb) 65-discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital;

(cc) 66-discharged/transferred to a critical access hospital (CAH);

(dd) 67-69 reserved for national assignment by the NUBC;

(ee) 70-discharge/transfer to another type of health care institution not defined elsewhere in the code list;

(ff) 71-99-reserved for national assignment by the NUBC.

(26) **Patient's street address** means the mailing address of the patient at the time of discharge including street name and number or post office box number or rural route number.

(27) **Patient's tribal affiliation** means the classification(s) of patient's stated New Mexico tribal affiliation, if stated race indicates American Indian. Up to five reported affiliations can be reported, coded as shown below. When reporting multiple affiliations do not use spaces or delimiters. For example, if a patient states that he or she has affiliations with both Acoma pueblo and the Navajo nation the tribal affiliation field would be T1T10:

(a) T1-Acoma pueblo;

(b) T2-Cochiti pueblo;

(c) T3-Isleta pueblo;

(d) T4-Jemez pueblo;

(e) T5-Jicarilla Apache nation;

(f) T6-Kewa/Santo Domingo pueblo;

(g) T7-Laguna pueblo;

(h) T8-Mescalero Apache nation;

(i) T9-Nambe pueblo;

(j) T10-Navajo nation;

(k) T11-Ohkay Owingeh pueblo;

(l) T12-Picuris pueblo;

(m) T13-Pojoaque pueblo;

(n) T14-San Felipe pueblo;

(o) T15-San Ildefonso pueblo;

(p) T16-Sandia pueblo;

(q) T17-Santa Ana pueblo;

(r) T18-Santa Clara pueblo;

(s) T19-Taos pueblo;

(t) T20-Tesuque pueblo;

(u) T21-Zia pueblo;

(v) T22-Zuni pueblo;

(w) T100-other tribal affiliation;

(x) T200-declined;

(y) T300-unknown.

(28) **Patient's zip code** means the zip code of the patient's residence at the time of discharge. Use either five or nine digits (e.g., 87501 or 875010968).

(29) **Permanent hospital inpatient discharge data** means hospital inpatient discharge data contained in a data set created by the division after submitting data the provider has either (1) reviewed and approved a division statistical report based on the data provider's patient discharges; or (2) been provided a 30-day period to review the division's statistical report.

(30) **Point of origin for admission or visit** means the source of referral for this admission.

(a) **Adults and pediatrics:** Source of admission codes for adults and pediatrics are:

(i) 1-non-health care facility point of origin-the patient was admitted to this facility upon the recommendation of his or her personal physician if other than a clinic physician or a health maintenance organization (HMO) physician (this includes patients coming from home, a physician's office, or workplace;

(ii) 2-clinic referral-the patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic;

(iii) 4-transfer from a hospital-the patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient or outpatient (excludes transfers from hospital inpatient in the same facility);

(iv) 5-transfer from SNF or ICF-the patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident;

(v) 6-transfer from another health care facility-the patient was admitted to this facility as a transfer from a health care facility not defined elsewhere in this code list (i.e., other than an acute care facility or skilled nursing facility);

(vi) 8-court/law enforcement-the patient was admitted to this facility upon the direction of a court of law, or upon a request of a law enforcement agency representative (includes transfers from incarceration facilities);

(vii) 9-information not available-the means by which the patient was referred to this facility is not known;

(viii) A-reserved for national assignment;

(ix) D-transfer from hospital inpatient in the same facility resulting in a separate claim to the payer-the patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer;

(x) E-transfer from ambulatory surgery center-the patient was admitted to this facility from an ambulatory or same-day surgery center (does not include patients admitted from the same facilities' outpatient surgery department);

(xi) F-transfer from hospice and is under a hospice plan of care or enrolled in a hospice program-the patient was admitted to this facility as acute inpatient status and was receiving hospice care;

(xii) G-Z-reserved for national assignment.

(b) **Newborns:** Newborn codes must be used when the **type of admission** is code 4. The codes are:

(i) 5-born inside this facility-a baby born inside this facility;

(ii) 6-born outside of this facility-a baby born outside of this facility.

(31) **Primary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the primary payer identification name field:

(a) 1-**medicare** is the primary payer from which the provider might expect some payment;

(b) 2-**medicaid** is the primary payer from which the provider might expect some payment;

(c) 3-**other government (federal/state/local**) is the primary payer from which the provider might expect some payment (excluding department of corrections);

(d) 4-**department of corrections** is the primary payer from which the provider might expect some payment;

(e) 5-**private health insurance** is the primary payer from which the provider might expect some payment;

(f) 6-**blue cross/blue shield** is the primary payer from which the provider might expect some payment;

(g) 7-**managed care, unspecified** is the primary payer from which the provider might expect some payment (to be used only if one cannot distinguish public from private);

(h) 8-**no payment** from an organization, agency, program or private payer is listed as the primary payer;

(i) 9-**miscellaneous/other** primary payer source from which the provider might expect some payment.

(32) **Primary payer identification name** means the name identifying the primary payer from which the provider might expect some payment for the reported service(s).

(33) **Primary payer type** means the type of primary payer as defined below from which the provider might expect some payment for the reported services(s):

(a) 1-**HMO**-health maintenance organization;

(b) 2-**other managed care**-includes provider service networks;

(c) 3-**indemnity plan**;

(d) 88-**unknown**.

(34) **Procedure code qualifier** means the revision number of the international classifications of disease diagnosis codes used to record the procedure represented by Paragraph (21) of Subsection P of 7.1.27.7 NMAC.

(a) 9-ICD-9-PCS, ninth revision required on claims through September 30, 2013.

(b) 0-ICD-10-PCS, 10th revision to take effect October 1, 2013 or such later date as required by the CMS.

(c) 1-ICD-11-PCS, 11th revision reservation for future reporting requirements.

(35) **Procedure date for patient's principal procedure code; procedure date for 2nd procedure code; procedure date for 3rd procedure code; procedure date for 4th procedure code; procedure date for 5th procedure code; procedure date for 6th procedure code** means the date of the procedure that is reported as it coincides with the procedure code that was performed (mmddyyyy).

(36) **Proprietary information** means confidential technical information, administrative information, or business methods that are the property of the data provider and are perceived to confer a competitive position in the health care market by not being openly known by competitors.

(37) **Provider zip code** means the zip code whose boundaries physically contain the facility where the reported service(s) were provided. Use either five or nine digits (i.e., 12345 or 123456789).

Q. All definitions that begin with the letter Q.

R. All definitions that begin with the letter R.

(1) **Requestor** means a person who makes a request for access to health information system data or reports pursuant to this rule.

(2) **Routine report** means a report that contains information of use to the general public that is issued by the division on its own initiative and not in response to a specific, individualized request.

(3) **1st revenue code, 2nd revenue code, 3rd revenue code, 4th revenue code, 5th revenue code, 6th revenue code, 7th revenue code, 8th revenue code, 9th revenue code, 10th revenue code, 11th revenue code, 12th revenue code, 13th revenue code, 14th revenue code, 15th revenue code, 16th revenue code, 17th revenue code, 18th revenue code, 19th revenue code, 20th revenue code, 21st revenue code, and 22nd revenue code** means the four-digt revenue codes that identify the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(4) **1st revenue description, 2nd revenue description, 3rd revenue description, 4th revenue description, 5th revenue description, 6th revenue description, 7th revenue description, 8th revenue description, 9th revenue description, 10th revenue description, 11th revenue description, 12th revenue description, 13th revenue description, 14th revenue description, 15th revenue description, 16th revenue description, 17th revenue description, 18th revenue description, 19th revenue description, 20th revenue description, 21st revenue description, and 22nd revenue description** means the revenue standard abbreviated descriptions that identify the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(5) **1st revenue line item charges, 2nd revenue line item charges, 3rd revenue line item charges, 4th revenue line item charges, 5th revenue line item charges, 6th revenue line item charges, 7th revenue line item charges, 8th revenue line item charges, 9th revenue line item charges, 10th revenue line item charges, 11th revenue line item charges, 12th revenue line item charges, 13th revenue line item charges, 14th revenue line item charges, 15th revenue line item charges, 16th revenue line item charges, 17th revenue line item charges, 18th revenue line item charges, 19th revenue line item charges, 20th revenue line item charges, 21st revenue line item charges, and 22nd revenue line item charges** means the revenue line item charges, rounded to the whole dollar, for the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(6) 1st revenue non-covered charges, 2nd revenue non-covered charges, 3rd revenue non-covered charges, 4th revenue non-covered charges, 5th revenue non-covered charges, 6th revenue non-covered charges, 7th revenue non-covered charges, 8th revenue non-covered charges, 9th revenue non-covered charges, 10th revenue non-covered charges, 11th revenue non-covered charges, 12th revenue non-covered charges, 13th revenue non-covered charges, 14th revenue non-covered charges, 15th revenue non-covered charges, 16th revenue non-covered charges, 17th revenue non-covered charges, 18th revenue non-covered charges, 19th revenue non-covered charges, 20th revenue non-covered charges, 21st revenue non-covered charges, and

22nd revenue non-covered charges means the revenue non-covered charges, rounded to the whole dollar, for the specific accommodation, ancillary service or unique billing calculations, or arrangements made during the patient's stay.

(7) **1st revenue service date, 2nd revenue service date, 3rd revenue service date, 4th revenue service date, 5th revenue service date, 6th revenue service date, 7th revenue service date, 8th revenue service date, 9th revenue service date, 10th revenue service date, 11th revenue service date, 12th revenue service date, 13th revenue service date, 14th revenue service date, 15th revenue service date, 16th revenue service date, 17th revenue service date, 18th revenue service date, 19th revenue service date, 20th revenue service date, 21st revenue service date, and 22nd revenue service date** means the revenue service dates that the specific accommodation, ancillary service or unique billing calculations, or arrangements occurred on.

(8) **1st revenue service units, 2nd revenue service units, 3rd revenue service units, 4th revenue service units, 5th revenue service units, 6th revenue service units, 7th revenue service units, 8th revenue service units, 9th revenue service units, 10th revenue service units, 11th revenue service units, 12th revenue service units, 13th revenue service units, 14th revenue service units, 15th revenue service units, 16th revenue service units, 17th revenue service units, 18th revenue service units, 19th revenue service units, 20th revenue service units, 21st revenue service units, and 22nd revenue service units** means the quantitative measure of services rendered by the revenue category to or for the patient to include items such as number of accommodation dates, miles, pints of blood, renal dialysis treatments, etc.

S. All definitions that begin with the letter S.

(1) **Secondary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the secondary payer identification name field:

(a) 1-**medicare** is the secondary payer from which the provider might expect some payment;

(b) 2-**medicaid** is the secondary payer from which the provider might expect some payment;

(c) 3-**other government (federal/state/local**) is the secondary payer from which the provider might expect some payment (excluding department of corrections);

(d) 4-**department of corrections** is the secondary payer from which the provider might expect some payment;

(e) 5-**private health insurance** is the secondary payer from which the provider might expect some payment;

(f) 6-**blue cross/blue shield** is the secondary payer from which the provider might expect some payment;

(g) 7-**managed care, unspecified** is the secondary payer from which the provider might expect some payment (to be used only if one cannot distinguish public from private);

(h) 8-**no payment** from an organization, agency, program, or private payer is listed as the secondary payer;

(i) 9-**miscellaneous/other** secondary payer source from which the provider might expect some payment.

(2) **Secondary payer identification name** means the name identifying a secondary payer from which the provider might expect some payment for the reported service(s).

(3) **Secondary payer type** means the type of secondary payer as defined below from which the provider might expect some payment for the reported service(s):

(a) 1-**HMO**-health maintenance organization;

(b) 2-**other managed care**-includes provider service networks;

(c) 3-**indemnity plan**;

(d) 88-**unknown**.

(4) **Secretary** means the cabinet secretary of the department of health.

(5) **Sex of patient** means the sex of the patient as recorded at discharge. Enter the sex of the patient, coded as follows:

(a) F-female;

(b) M-male;

(c) U-unknown.

(6) **Skilled nursing facility or SNF** means a type of nursing home recognized by the medicare and medicaid systems as meeting long-term health care needs for individuals who the potential to function independently after a limited period of care.

(7) **State agency** means any agency, department, division, bureau, board, commission, institution, or other organization of a state government, including state educational institutions and political subdivisions. "State agency" does not include any health care facility operated by a state agency.

T. All definitions that begin with the letter T.

(1) **Tertiary payer category** means one of the following broad categories assigned by the data provider to the payment source identified in the tertiary payer identification name field:

(a) 1-**medicare** is the tertiary payer from which the provider might expect some payment;

(b) 2-**medicaid** is the tertiary payer from which the provider might expect some payment;

(c) 3-**other government (federal/state/local**) is the tertiary payer from which the provider might expect some payment (excluding the department of corrections);

(d) 4-**department of corrections** is the tertiary payer from which the provider might expect some payment;

(e) 5-**private health insurance** is the tertiary payer from which the provider might expect some payment;

(f) 6-**blue cross/blue shield** is the tertiary payer from which the provider might expect some payment;

(g) 7-**managed care, unspecified** is the tertiary payer from which the provider might expect some payment (to be used only if one cannot distinguish public from private);

(h) 8-**no payment** from an organization, agency, program, or private payer is listed as the tertiary payer;

(i) 9-**miscellaneous/other** tertiary payer source from which the provider might expect some payment.

(3) **Tertiary payer identification name** means the name identifying a tertiary payer from which the provider might expect some payment for the reported service(s).

(4) **Tertiary payer type** means the type of tertiary payer as defined below from which the provider might expect some payment for the reported service(s):

(a) 1-**HMO**-health maintenance organization;

(b) 2-**other managed care**-includes provider service networks;

(c) 3-**indemnity plan**;

(d) 88-**unknown**.

(5) **Total charges** means an 11 digit number rounded to the whole dollar for the total charges for all inpatient services reported. This is the sum of all revenue service line charges.

(6) **Traffic crash report number** means the six digit number of the traffic crash/accident report form.

(7) **Type of admission** means an inpatient code indicating the priority of the admission. Type of admission codes are:

(a) 1-emergency-the patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions; generally, the patient is admitted through the emergency room;

(b) 2-urgent-the patient requires immediate medical attention for the care and treatment of a physical or mental disorder; generally, the patient is admitted to the first available and suitable accommodation;

(c) 3-elective-the patient's condition permits adequate time to schedule the availability of a suitable accommodation;

(d) 4-newborn-a baby born within this facility; use of this code necessitates the use of special source of admission codes-see source of admission;

(e) 9-information not available.

(8) **Type of bill** means the specific type of bill code indicating the type of billing for inpatient services.

U. All definitions that begin with the letter U.

(1) **UB-04 manual** is the official NUBC data specifications manual for (© AHA) issued by the NUBC.

V. All definitions that begin with the letter V.

W. All definitions that begin with the letter W.

X. All definitions that begin with the letter X.

Y. All definitions that begin with the letter Y.

Z. All definitions that begin with the letter Z.

[7.1.27.7 NMAC - N, 12/31/2012]

7.1.27.8 STATUS OF DATA:

All data and health information collected from data sources shall become the property of the department upon receipt.

[7.1.27.8 NMAC - N, 12/31/2012]

7.1.27.9 DATA REPORTING BY LICENSED NON-FEDERAL GENERAL AND SPECIALTY INPATIENT HEALTH CARE FACILITIES:

A. **Schedule for reporting:** Beginning with the first quarter of 2013 (January 1-March 31), all licensed non-federal general and specialty inpatient health care facilities in New Mexico shall submit the reporting period discharges to the division on a quarterly basis the data required by this rule, in accordance with the following schedule:

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

B. **Pursuant to the electronic reporting requirements in 7.1.27.10 NMAC, submit the data as a fixed-width ASCII text (flat) file. Follow the record layout specifications, provided by the division, for field placement and lengths (field lengths are maximum values and shall contain blank spaces as fillers for values less than the maximum length).**

C. **Data required to be reported:** All licensed non-federal general and specialty inpatient health care facilities in New Mexico shall report to the division the following data elements, in the record layout provided by the division. Required data items:

(1) New Mexico state license number, left justified;

(2) medicare provider number, left justified;

(3) provider zip code (five or nine digits), left justified;

(4) admission hour (military time);

(5) patient's admission date (mmddyyyy);

(6) point of origin (1 to 9, a, d, e, and f);

(7) type of admission (1 to 4, 9);

(8) patient's ems ambulance run number, left justified;

(9) traffic crash report number, left justified;

(10) accident state (two-digit code), left justified;

(11) patient's medical record number, left justified;

(12) patient's medicaid id number;

(13) patient's control number, left justified;

(14) birth weight (grams);

(15) attending physician NPI (assigned by medicare);

(16) operating physician NPI (assigned by medicare);

(17) discharge hour (military time);

(18) patient's discharge date (mmddyyyy);

(19) patient's status (01 to 99);

(20) primary payer category (1 to 10, 88), right justified;

(21) primary payer identification name, left justified;

(22) primary payer type (1 to 3, 88), right justified;

(23) secondary payer category (1 to 10, 88), right justified;

(24) secondary payer identification name, left justified;

(25) secondary payer type (1 to 3, 88), right justified;

(26) tertiary payer category (1 to 10, 88), right justified;

(27) tertiary payer identification name, left justified;

(28) tertiary payer type (1 to 3, 88), right justified;

(29) 1st condition code, left justified;

(30) 2nd condition code, left justified;

(31) 3rd condition code, left justified;

(32) 4th condition code, left justified;

(33) 5th condition code, left justified;

(34) 6th condition code, left justified;

(35) 7th condition code, left justified;

(36) 8th condition code, left justified;

(37) 9th condition code, left justified;

(38) 10th condition code, left justified;

(39) 11th condition code, left justified;

(40) 1st revenue code, left justified;

(41) 1st revenue code description, left justified;

(42) 1st revenue code service date (mmddyyyy), left justified;

(43) 1st revenue code service units, right justified;

(44) 1st revenue code line item charges, right justified;

(45) 1st revenue code non-covered charges, right justified;

(46) 2nd revenue code, left justified;

(47) 2nd revenue code description, left justified;

(48) 2nd revenue code service date (mmddyyyy), left justified;

(49) 2nd revenue code service units, right justified;

(50) 2nd revenue code line item charges, right justified;

(51) 2nd revenue code non-covered charges, right justified;

(52) 3rd revenue code description, left justified;

(53) 3rd revenue code service date (mmddyyyy), left justified;

(54) 3rd revenue code service units, right justified;

(55) 3rd revenue code line item charges, right justified;

(56) 3rd revenue code non-covered charges, right justified;

(57) 4th revenue code, left justified;

(58) 4th revenue code description, left justified;

(59) 4th revenue code service date (mmddyyyy), left justified;

(60) 4th revenue code service units, right justified;

(61) 4th revenue code line item charges, right justified;

(62) 4th revenue code non-covered charges, right justified;

(63) 5th revenue code, left justified;

(64) 5th revenue code description, left justified;

(65) 5th revenue code service date (mmddyyyy), left justified;

(66) 5th revenue code service units, right justified;

(67) 5th revenue code line item charges, right justified;

(68) 5th revenue code non-covered charges, right justified;

(69) 6th revenue code, left justified;

(70) 6th revenue code description, left justified;

(71) 6th revenue code service date (mmddyyyy), left justified;

(72) 6th revenue code service units, right justified;

(73) 6th revenue code line item charges, right justified;

(74) 6th revenue code non-covered charges, right justified;

(75) 7th revenue code, left justified;

(76) 7th revenue code description, left justified;

(77) 7th revenue code service date (mmddyyyy), left justified;

(78) 7th revenue code service units, right justified;

(79) 7th revenue code line item charges, right justified;

(80) 7th revenue code non-covered charges, right justified;

(81) 8th revenue code, left justified;

(82) 8th revenue code description, left justified;

(83) 8th revenue code service date (mmddyyyy), left justified;

(84) 8th revenue code service units, right justified;

(85) 8th revenue code line item charges, right justified;

(86) 8th revenue code non-covered charges, right justified;

(87) 9th revenue code, left justified;

(88) 9th revenue code description, left justified;

(89) 9th revenue code service date (mmddyyyy), left justified;

(90) 9th revenue code service units, right justified;

(91) 9th revenue code line item charges, right justified;

(92) 9th revenue code non-covered charges, right justified;

(93) 10th revenue code, left justified;

(94) 10th revenue code description, left justified;

(95) 10th revenue code service date (mmddyyyy), left justified;

(96) 10th revenue code service units, right justified;

(97) 10th revenue code line item charges, right justified;

(98) 10th revenue code non-covered charges, right justified;

(99) 11th revenue code, left justified;

(100) 11th revenue code description, left justified;

(101) 11th revenue code service date (mmddyyyy), left justified;

(102) 11th revenue code service units, right justified;

(103) 11th revenue code line item charges, right justified;

(104) 11th revenue code non-covered charges, right justified;

(105) 12th revenue code, left justified;

(106) 12th revenue code description, left justified;

(107) 12th revenue code service date (mmddyyyy), left justified;

(108) 12th revenue code service units, right justified;

(109) 12th revenue code line item charges, right justified;

(110) 12th revenue code non-covered charges, right justified;

(111) 13th revenue code, left justified;

(112) 13th revenue code description, left justified;

(113) 13th revenue code service date (mmddyyyy), left justified;

(114) 13th revenue code service units, right justified;

(115) 13th revenue code line item charges, right justified;

(116) 13th revenue code non-covered charges, right justified;

(117) 14th revenue code, left justified;

(118) 14th revenue code description, left justified;

(119) 14th revenue code service date (mmddyyyy), left justified;

(120) 14th revenue code service units, right justified;

(121) 14th revenue code line item charges, right justified;

(122) 14th revenue code non-covered charges, right justified;

(123) 15th revenue code, left justified;

(124) 15th revenue code description, left justified;

(125) 15th revenue code service date (mmddyyyy), left justified;

(126) 15th revenue code service units, right justified;

(127) 15th revenue code line item charges, right justified;

(128) 15th revenue code non-covered charges, right justified;

(129) 16th revenue code, left justified;

(130) 16th revenue code description, left justified;

(131) 16th revenue code service date (mmddyyyy), left justified;

(132) 16th revenue code service units, right justified;

(133) 16th revenue code line item charges, right justified;

(134) 16th revenue code non-covered charges, right justified;

(135) 17th revenue code, left justified;

(136) 17th revenue code description, left justified;

(137) 17th revenue code service date (mmddyyyy), left justified;

(138) 17th revenue code service units, right justified;

(139) 17th revenue code line item charges, right justified;

(140) 17th revenue code non-covered charges, right justified;

(141) 18th revenue code, left justified;

(142) 18th revenue code description, left justified;

(143) 18th revenue code service date (mmddyyyy), left justified;

(144) 18th revenue code service units, right justified;

(145) 18th revenue code line item charges, right justified;

(146) 18th revenue code non-covered charges, right justified;

(147) 19th revenue code, left justified;

(148) 19th revenue code description, left justified;

(149) 19th revenue code service date (mmddyyyy), left justified;

(150) 19th revenue code service units, right justified;

(151) 19th revenue code line item charges, right justified;

(152) 19th revenue code non-covered charges, right justified;

(153) 20th revenue code, left justified;

(154) 20th revenue code description, left justified;

(155) 20th revenue code service date (mmddyyyy), left justified;

(156) 20th revenue code service units, right justified;

(157) 20th revenue code line item charges, right justified;

(158) 20th revenue code non-covered charges, right justified;

(159) 21st revenue code, left justified;

(160) 21st revenue code description, left justified;

(161) 21st revenue code service date (mmddyyyy), left justified;

(162) 21st revenue code service units, right justified;

(163) 21st revenue code line item charges, right justified;

(164) 21st revenue code non-covered charges, right justified;

(165) 22nd revenue code, left justified;

(166) 22nd revenue code description, left justified;

(167) 22nd revenue code service date (mmddyyyy), left justified;

(168) 22nd revenue code service units, right justified;

(169) 22nd revenue code line item charges, right justified;

(170) 22nd revenue code non-covered charges, right justified;

(171) patient's last name, left justified;

(172) patient's middle initial;

(173) patient's social security number;

(174) patient's street address, left justified;

(175) patient's city, left justified;

(176) patient's county, left justified;

(177) patient's state, left justified;

(178) patient's zip code (five or nine digits), left justified;

(179) patient's date of birth (mmddyyyy);

(180) patient's race-multiple (r1 to r7. r9);

(181) patient's ethnicity (e1, e2, e6, e7);

(182) patient's tribal affiliation-up to five (t1 to t22, t100, t200, t300);

(183) sex of patient (m, f, u);

(184) patient's phone number, left justified;

(185) patient’s admitting diagnosis code, left justified;

(186) patient’s principal diagnosis code, left justified;

(187) patient’s 2nd diagnosis code, left justified;

(188) patient’s 3rd diagnosis code, left justified;

(189) patient’s 4th diagnosis code, left justified;

(190) patient’s 5th diagnosis code, left justified;

(191) patient’s 6th diagnosis code, left justified;

(192) patient’s 7th diagnosis code, left justified;

(193) patient’s 8th diagnosis code, left justified;

(194) patient’s 9th diagnosis code, left justified;

(195) patient’s 10th diagnosis code, left justified;

(196) patient’s 11th diagnosis code, left justified;

(197) patient’s 12th diagnosis code, left justified;

(198) patient’s 13th diagnosis code, left justified;

(199) patient’s 14th diagnosis code, left justified;

(200) patient’s 15th diagnosis code, left justified;

(201) patient’s 16th diagnosis code, left justified;

(202) patient’s 17th diagnosis code, left justified;

(203) patient’s 18th diagnosis code, left justified;

(204) patient’s admitting diagnosis code qualifier (9, 0, 1), left justified;

(205) patient’s principal diagnosis code qualifier (9, 0, 1), left justified;

(206) patient’s 2nd diagnosis code qualifier (9, 0, 1), left justified;

(207) patient’s 3rd diagnosis code qualifier (9, 0, 1), left justified;

(208) patient’s 4th diagnosis code qualifier (9, 0, 1), left justified;

(209) patient’s 5th diagnosis code qualifier (9, 0, 1), left justified;

(210) patient’s 6th diagnosis code qualifier (9, 0, 1), left justified;

(211) patient’s 7th diagnosis code qualifier (9, 0, 1), left justified;

(212) patient’s 8th diagnosis code qualifier (9, 0, 1), left justified;

(213) patient’s 9th diagnosis code qualifier (9, 0, 1), left justified;

(214) patient’s 10th diagnosis code qualifier (9, 0, 1), left justified;

(215) patient’s 11th diagnosis code qualifier (9, 0, 1), left justified;

(216) patient’s 12th diagnosis code qualifier (9, 0, 1), left justified;

(217) patient’s 13th diagnosis code qualifier (9, 0, 1), left justified;

(218) patient’s 14th diagnosis code qualifier (9, 0, 1), left justified;

(219) patient’s 15th diagnosis code qualifier (9, 0, 1), left justified;

(220) patient’s 16th diagnosis code qualifier (9, 0, 1), left justified;

(221) patient’s 17th diagnosis code qualifier (9, 0, 1), left justified;

(222) patient’s 18th diagnosis code qualifier (9, 0, 1), left justified;

(223) 1st e-code, left justified, (required);

(224) 2nd e-code, left justified;

(225) 3rd e-code, left justified;

(226) patient’s admitting diagnosis, present on admission, left justified;

(227) patient’s principal diagnosis, present on admission, left justified;

(228) patient’s 2nd diagnosis, present on admission, left justified ;

(229) patient’s 3rd diagnosis, present on admission, left justified ;

(230) patient’s 4th diagnosis, present on admission, left justified ;

(231) patient’s 5th diagnosis, present on admission, left justified ;

(232) patient’s 6th diagnosis, present on admission, left justified ;

(233) patient’s 7th diagnosis, present on admission, left justified ;

(234) patient’s 8th diagnosis, present on admission, left justified ;

(235) patient’s 9th diagnosis, present on admission, left justified ;

(236) patient’s 10th diagnosis, present on admission, left justified ;

(237) patient’s 11th diagnosis, present on admission, left justified ;

(238) patient’s 12th diagnosis, present on admission, left justified ;

(239) patient’s 13th diagnosis, present on admission, left justified ;

(240) patient’s 14th diagnosis, present on admission, left justified ;

(241) patient’s 15th diagnosis, present on admission, left justified ;

(242) patient’s 16th diagnosis, present on admission, left justified ;

(243) patient’s 17th diagnosis, present on admission, left justified ;

(244) patient’s 18th diagnosis, present on admission, left justified ;

(245) patient’s diagnosis related group (DRG) code ;

(246) patient’s principal procedure code, left justified;

(247) patient’s 2nd procedure code, left justified;

(248) patient’s 3rd procedure code, left justified;

(249) patient’s 4th procedure code, left justified;

(250) patient’s 5th procedure code, left justified;

(251) patient’s 6th procedure code, left justified;

(252) patient’s 2nd procedure code, left justified;

(253) patient’s 3rd procedure code, left justified;

(254) patient’s 4th procedure code, left justified;

(255) patient’s 5th procedure code, left justified;

(256) patient’s 6th procedure code, left justified;

(257) patient’s principal procedure code qualifier (9, 0, 1), left justified;

(258) patient’s 2nd procedure code qualifier (9, 0, 1), left justified;

(259) patient’s 3rd procedure code qualifier (9, 0, 1), left justified;

(260) patient’s 4th procedure code qualifier (9, 0, 1), left justified;

(261) patient’s 5th procedure code qualifier (9, 0, 1), left justified;

(262) patient’s 6th procedure code qualifier (9, 0, 1), left justified;

(263) patient’s 2nd procedure code qualifier (9, 0, 1), left justified;

(264) patient’s 3rd procedure code qualifier (9, 0, 1), left justified;

(265) patient’s 4th procedure code qualifier (9, 0, 1), left justified;

(266) patient’s 5th procedure code qualifier (9, 0, 1), left justified;

(267) patient’s 6th procedure code qualifier (9, 0, 1), left justified;

D. **Data reporting requirements for New Mexico human services department's medicaid system:** The New Mexico human service department’s medicaid system shall provide all data listed by cooperative agreement between the division and the human services department, pursuant to the reporting schedule contained in Subsection A of 7.1.27.10 NMAC.

E. **Data reporting requirements for the medicare (part A) fiscal intermediary:** The medicare (part A) fiscal intermediary shall provide all data mutually agreed upon in accordance with law between the division and the fiscal intermediary, pursuant to the reporting schedule contained in Subsection A of 7.1.27.9 NMAC.

F. **Annual financial statements:** All licensed non-federal general and specialty inpatient health care facilities shall submit annual audited financial statements to the division. If the owners of such facilities obtain one audit covering more than one facility, combined annual audited financial statements may be submitted in compliance with this section. Facilities reporting in combined annual audited financial statements must also submit annual unaudited, individual facility financial statements to the division. These

reports shall be submitted no later than the end of the calendar year following the statement year.

[7.1.27.9 NMAC - N, 12/31/2012]

7.1.27.10 ELECTRONIC REPORTING REQUIREMENTS:

Starting with 2012 data, all data providers shall submit the required quarterly discharge data pursuant to the reporting schedule contained in Subsection A of 7.1.27.9 NMAC and all final corrected reports, for the full year's worth of data, are due no later than March 31of the following year. Data providers shall submit data by electronic media, which includes CD, DVD, or direct electronic transmission by encrypted e-mail or secure file transmission protocol (SFTP), in an ASCII file format, per the most current record layout and instruction provided by the division. Data providers shall label all media and data files with the following information: type of data, hospital name and license number, year, file name, point of contact and telephone number, and mail data to "New Mexico department of health epidemiology and response division, attn: division, 1190 St. Francis Drive, Santa Fe, NM 87502." Any data transmitted by mail or overnight delivery is the responsibility of the data provider until it is acknowledged as received by the division. Therefore, all data transmitted by third party mail provider will be sent using a tracking mechanism (e.g., fedex tracking website) or be certified for acknowledgement (e.g., certified postal mail requiring a signature for delivery).

[7.1.27.10 NMAC - N, 12/31/2012]

7.1.27.11 REPORTING EXEMPTIONS:

Upon written application to the division, the division may grant a health care facility a temporary exemption, not to exceed two reporting quarters, from the schedule required by Subsection A of 7.1.27.9 NMAC. Temporary exemption from reporting does not excuse the health care facility from reporting the requested data items for activity that occurred during the exempted period. Upon resumption of the regular reporting schedule the health care facility shall promptly report data for the exempted period.

[7.1.27.11 NMAC - N, 12/31/2012]

7.1.27.12 PENALTIES FOR REPORTING VIOLATION:

Failure to comply with any of the reporting requirements in this rule may result in injunctive relief and a civil penalty not to exceed $1,000 per violation, as provided by the HIS Act.

[7.1.27.12 NMAC - N, 12/31/2012]

7.1.27.13 GENERAL PROVISIONS ON ACCESS TO THE HEALTH INFORMATION SYSTEM DATA:

A. **Reporting:** In accordance with Subsections 24-14A-3 (D) (6), 24-14A-4.3 & 24-14A-6 (D) of the HIS Act, data may be reported routinely to authorized federal, state, and local public agencies. Record-level data shall be reported to the agency for healthcare research and quality (AHRQ) for incorporation into the healthcare cost and utilization project (HCUP) databases as part of the federal-state-industry partnership.

B. **Access requirements:** Data and reports based on the HIS may be obtained only in accordance with the requirements of the HIS Act and this rule. Any request for information that would not be contained in routine reports will require completion of a data request form available on the division's website or by contacting the division.

C. **Evaluation of requests:** In addition to other requirements stated in this rule, all requests for HIS data and reports, other than routine reports, shall be evaluated by the division and shall satisfy the following criteria for approval.

(1) The specific intended use of the data shall comport with the purposes of the HIS Act, as stated in 24-14A-3A and rules promulgated pursuant to the act, including use of data to assist in:

(a) the performance of health planning, policy making functions, and research conducted for the benefit of the public;

(b) informed health care decision making by consumers;

(c) surveillance for the control of disease and conditions of public health significance as required by Public Health Act, Subsection 24-1-3(C) NMSA 1978;

(d) administration, monitoring, and evaluation of a statewide health plan.

(2) The request shall be consistent with the responsibilities of the division in accomplishing the priorities of the HIS.

(3) The request is for data that are either:

(a) in a routine report previously published by the division, or

(b) aggregate data in or reports based on a subset or portion of the HIS database that is relevant to the individual's stated purpose upon approval of the request by the division , or

(c) record-level data, such that an individual patient or healthcare professional cannot be identified, pursuant to the HIS Act, to federal, state, and local public agencies, and upon approval of the request by the division.

D. **Request procedures:** All requests for data shall be made pursuant to the requirements of 7.1.27.14 NMAC.

E. **Fees:** Fees for access to data and reports shall be paid pursuant to the requirements of 7.1.27.18 NMAC.

F. **Restrictions on access to sensitive data:** The division shall have the authority to deny access to information from the HIS database where use of the information, as determined by the division, could result in violation of a patient's privacy.

G. **Compliance with other laws:** The division shall ensure that any access to data that is subject to restrictions on use pursuant to state, federal, or tribal law or regulation, or any other legal agreement, complies with those restrictions.

H. **Disclaimer:** The division shall include a disclaimer in all HIS data and reports released pursuant to this rule stating that the accuracy of the original data is the responsibility of the submitting data provider and that the division assumes no responsibility for any use made of or conclusions drawn from the data.

I. **Agency contractors:**

(1) A state or federal agency that receives HIS data or reports under an agreement with the division pursuant to 7.1.27.15 NMAC, 7.1.27.16 NMAC, and 7.1.27.17 NMAC shall be solely responsible for fulfillment of the agreement, including responsibility for the actions of any subcontractor engaged to perform services that require access to HIS data or reports.

(2) No state or federal agency shall subcontract any portion of services to be performed under an agreement with the division without prior written approval of the division.

(3) A state or federal agency subcontractor that is provided access to HIS data or reports shall be subject to the full provisions of the HIS Act, and this rule, including 7.1.27.15 NMAC, 7.1.27.16 NMAC, and 7.1.27.17.

J. **Public data:** The restrictions that apply to the release of data do not apply when the data provider is a government agency and the data provided to the HIS otherwise would be considered public data in accordance with the Public Records Act, Sections 14-3-1 to 14-3-23, NMSA 1978, and the Open Meetings Act, Sections 10-15-1 to 10-15-4, NMSA 1978.

K. **Proprietary and confidential information:**

(1) Proprietary information and patient confidential information shall not be routinely disclosed in or as part of a public health information report by the division.

(2) A data provider that objects on proprietary grounds to the potential release in a public health information report, or a record level data disclosure, of its reported data or information derived from its reported data shall submit to the division a written

request to exempt its data from such disclosures. By the end of each fiscal year (June 30th) data providers must notify, in writing, the division regarding data items that they deem proprietary. Application for an exemption must be addressed by a representative of the data provider to the division.

L. Final determination:

(1) The division shall prepare a recommended written decision in the format required by Subsection 39-3-1.1 NMSA 1978. The recommended written decision shall be approved or disapproved by the department division director or designee within 10 days or as expeditiously as possible after the issuance of the division's written recommendation.

(2) The decision by the department division director or designee is subject to review by the secretary at the secretary's discretion and is the final determination for purpose of judicial review.

(3) The department shall issue a final decision that includes an order granting or denying relief. The final decision may incorporate the division's recommended decision or the department may render any other final decision supported by law. The final decision shall include a statement of the factual and legal basis for the decision.

[7.1.27.13 NMAC - N, 12/31/2012]

7.1.27.14 PROCEDURES FOR REQUESTS OF THE HIS DATA:

A. **Requests for public and previously-prepared routine reports:** Requests for copies of public and routine reports produced by the division for public use shall be made either in writing or by e-mail to the division. Fees for these reports shall be paid in accordance with 7.1.27.18 NMAC.

B. **Requests for previously-prepared, non-routine reports:** Requests for copies of previously-prepared, non-routine reports shall be made in writing or by e-mail to the division. These reports shall be made available pursuant to the requirements of this rule. Fees for these reports shall be paid in accordance with 7.1.27.18 NMAC.

C. **Individualized requests:** Requests for not previously prepared, non-routine reports, or for data contained in the HIS database shall be made in writing to the division by specifying the following information on a request form provided by the division.

(1) Date of request.

(2) Name, address, and organizational affiliation.

(3) Specific data or analysis requested.

(4) Specific intended use of the data, including proposed analytical or research methodology, and expected outcomes of analysis, together with an acknowledgment that the data will not be used in violation of 7.1.27.19 NMAC and 7.1.27.20 NMAC.

(5) Desired date by which the information is needed, allowing a minimum of two weeks to process the request.

(6) For requests for data, the names and positions of individuals who will have access to the data if the request is granted.

(7) For requests for data, the requestor's specific plans for protecting these data and use of the data in accordance with the requirements of the HIS Act, and this rule.

(8) Any additional information the division may request.

D. **Review of requests for data:** The division shall conduct a preliminary review of requests made for HIS data or reports and may require the requestor to submit supplemental information to achieve a final project request. As required by this rule, the division will make the determination on whether to grant the request. Requestors shall be notified of whether the request meets the criteria for approval within a reasonable period of time from the initial date of the request. The division shall make reasonable efforts to review requests expeditiously within available resources.

E. **Provision of data:** The division shall prepare data or reports for approved requests within a reasonable period of time given the nature of the request, making reasonable efforts to prepare the information expeditiously within available resources.

F. **Fee estimate:** If a request for data or reports made pursuant to 7.1.27.14 NMAC is approved, the division shall prepare a preliminary estimate of the fee required for preparing the data or report, in accordance with 7.1.27.18 NMAC. This estimate, which shall not serve as a guarantee of final charges, shall be included with the notification of approval or disapproval provided pursuant to Subsection D of 7.1.27.14 NMAC. If the requestor agrees to pay the fee, the division shall proceed with preparing the data or report.

[7.1.27.14 NMAC - N, 12/31/2012]

7.1.27.15 ACCESS TO ROUTINE AND PUBLISHED REPORTS:

The division shall release reports to the public on a periodic schedule as determined by the division and in accordance with the HIS Act.

[7.1.27.15 NMAC - N, 12/31/2012]

7.1.27.16 ACCESS TO AGGREGATE DATA AND REPORTS: Individuals:

Pursuant to the requirements of 7.1.27.13 NMAC, any person may obtain access to aggregate data in or reports based on the subset or portion of the HIS database that is relevant to the individual's stated purpose upon approval of the request by the division.

[7.1.27.16 NMAC - N, 12/31/2012]

7.1.27.17 ACCESS TO DE-IDENTIFIED RECORD-LEVEL DATA:

A. **Disclosure authorization:** Pursuant to the requirements of the HIS Act and 45 CFR 164.512, New Mexico state agencies or political subdivisions, and federal agencies authorized to collect, analyze. or disseminate health information, may obtain access to record level data in or records based upon the subset or portion of the record level data that is relevant to the organization's or agency's stated purpose, upon approval of the request by the director. The director may require such agency or organization to agree to specific confidentiality and data use requirements prior to the release of the data or reports. Federal agencies may obtain the information only if the agency agrees to fully protect its confidentiality as provided by state and federal law. No other persons or entities shall have access to data in, or non-aggregate analytical reports based on the record level data.

B. **Protection of identity:** Any data or report that is provided from the HIS database shall be configured in a manner that precludes actual or potential identification of individual patients, as defined in 45 CFR Subsection 164.514(e), or health care providers unless the division determines that disclosure of identifiable hospital information is necessary for a state, tribal, or federal agency's or local political subdivision's authorized use, and that the disclosure complies with state and federal privacy and confidentiality laws, rules, and regulations.

C. Deletion of data: The requestor shall delete the HIS data file upon completion of the approved research and shall not retain any copies of HIS data files. The requestor must inform the division annually of the status of the work being done, the expected date of HIS dataset deletion, description of how HIS data files are stored, and a cumulative listing of how the HIS dataset has been used as well as any publications or presentations that were informed or created using the HIS data file (unless otherwise agreed to in writing).

[7.1.27.17 NMAC - N, 12/31/2012]

7.1.27.18 FEES FOR DATA AND REPORTS:

A. **Fees for routine reports:**

(1) **Generally:** The fees for copies of available routine reports produced for public use shall be as follows:

(a) single copies of any consumer health information reports or HIS annual reports shall be provided free of charge upon request; and

(b) all other reports shall be provided for $10.00 per report.

(2) **Data providers:** Data providers may receive one free copy of the division's routine reports upon request.

B. **Previously-prepared reports:** The fee for copies of available previously-prepared, non-routine reports provided to persons other than the original requestor for whom the report was prepared shall be $20.00 per report.

C. **Fees for data and non-routine reports:** The fee for preparing data and non-routine reports that have not been previously prepared shall be charged at the hourly rate of the analyst(s) preparing the data or report, as follows:

(1) data providers shall be charged a rate of $50.00 per analyst hour;

(2) state agencies shall be charged a rate of $75.00 per analyst hour; and

(3) all others shall be charged a rate of $100.00 per analyst hour.

D. **Electronic media reports:** Fees for reports made available on electronic media may include charges for the cost of the magnetic tape, diskette, CD-ROM, or other electronic media, in addition to the fees required by this section.

E. **Waiver or reduction of fees:**

(1) **Standard for waiver or reduction:** The division may reduce or waive the fee for routine reports, data, and non-routine reports that have not been previously prepared when the division determines that the requestor's proposed use of the information would be of value to the division in fulfilling its statutory mandates to a degree equal to or greater than the fee reduction or waiver.

(2) **Payment upon failure to perform:** When a fee waiver or reduction has been granted and the research for which the fee was waived or reduced is not completed, or the product for which the fee was waived or reduced is not delivered to the division, the full fee shall be assessed in accordance with Subsection C of 7.1.27.18 NMAC.

F. **Statement of fees:** The division shall prepare a statement of the fee for requests made pursuant to Subsection C of 7.1.27.14 NMAC and provide it to the requestor with the data or report. The fee must be paid no later than 30 days after receipt of the data or report.

[7.1.27.18 NMAC - N, 12/31/2012]

7.1.27.19 OBLIGATIONS UPON RECEIPT OF DATA:

A. **Specific requirements:** Requestors and any individuals who are permitted access to HIS data or reports through approval of a request made pursuant to Subsection C of 7.1.27.14 NMAC shall.

(1) Limit use of the information to the purposes stated on the request form.

(2) Give full credit to the division in any published or unpublished reports using HIS information unless otherwise agreed to in writing.

(3) Include a disclaimer in any published or unpublished reports using HIS information which states that the accuracy of the original data is the responsibility of the submitting data provider and that the division assumes no responsibility for any use made of or conclusions drawn from the data unless otherwise agreed to in writing.

(4) Provide the division with a copy of any reports, papers, posters or other publication (electronic or otherwise) resulting from access to the HIS database unless otherwise agreed to in writing.

B. **Prior approval:** The division shall review and approve in advance of distribution any report or analysis produced using data from the HIS database to any person beyond those specified in the request made pursuant to Subsection C of 7.1.27.14 NMAC unless otherwise agreed to in writing. Reports or analysis of this nature shall not be released if disapproved by the division.

[7.1.27.19 NMAC - N, 12/31/2012]

7.1.27.20 REDISCLOSURE OF DATA:

Requestors who are permitted access to aggregate data from non-routine reports, as well as record-level data, (as described in 7.1.27.16 NMAC and 7.1.27.17 NMAC of this rule) shall not (unless otherwise agreed to in writing):

A. provide the data or portion of it to any persons other than those identified in the request form; or

B. share, release, or otherwise give any or all of the information contained in the HIS dataset to any person or institution not listed on the data request form; or

C. resell any portion of the data or other information gained as a result of obtaining access to the data.

[7.1.27.20 NMAC - N, 12/31/2012]

7.1.27.21 REPORTS AVAILABLE THROUGH THE STATE LIBRARY DEPOSITORY SYSTEM:

Paper copies of all public use routine reports produced by the division shall be available to the public through the state library depository system.

[7.1.27.21 NMAC - N, 12/31/2012]

7.1.27.22 PENALTIES FOR RULE VIOLATION:

A. **Division sanctions:** A requestor who violates the requirements of this rule may be subject to any or all of the following sanctions, as determined by the division.

(1) Temporary or permanent denial of access to HIS data or reports.

(2) Termination of current access.

(3) Mandated immediate return, without duplication, of HIS data or reports provided by the division.

B. **Other penalties:** A requestor who violates the requirements of this rule or the HIS Act, may be subject to sanctions provided in applicable state, federal, or tribal laws or regulations, including but not limited to injunctive relief and civil penalties of up to $1,000 per violation.

[7.1.27.22 NMAC - N, 12/31/2012]

PART 28: HEALTH INFORMATION SYSTEM ADVISORY COMMITTEE RESPONSIBILITIES AND DUTIES

7.1.28.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.1.28.1 NMAC - N, 02/12/2016]

7.1.28.2 SCOPE:

This rule establishes the membership, duties, and responsibilities of the health information system advisory committee.

[7.1.28.2 NMAC - N, 02/12/2016]

7.1.28.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the department of health pursuant to the authority granted under Subsection E of Section 9-7-6 NMSA 1978, and the Health Information System Act, 24-14A-1 et seq. NMSA 1978.

[7.1.28.3 NMAC - N, 02/12/2016]

7.1.28.4 DURATION:

Permanent.

[7.1.28.4 NMAC - N, 02/12/2016]

7.1.28.5 EFFECTIVE DATE:

February 12, 2016, unless a later date is cited at the end of a section.

[7.1.28.5 NMAC - N, 02/12/2016]

7.1.28.6 OBJECTIVE:

The objective of this rule is to establish membership, duties, and responsibilities that govern the health information system advisory committee.

[7.1.28.6 NMAC - N, 02/12/2016]

7.1.28.7 DEFINITIONS:

A. "Advisory committee" means the health information system advisory committee.

B. "Data source" or **"data provider"** means a person that possesses health information, including any public or private sector licensed health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, hospital, pharmacy, third-party payer and any public entity that has health information.

C. "Department" means the department of health.

D. "Health information" or **"health data"** means any data relating to health care; health status, including environmental, social and economic factors; the health system; or health costs and financing.

E. "Hospital" means any general or special hospital licensed by the department, whether publicly or privately owned.

F. "Long-term care facility" means any skilled nursing facility or nursing facility licensed by the department, whether publicly or privately owned.

G. "Secretary" means the secretary of the New Mexico department of health.

H. "Third-party payer" means any public or private payer of health care services and includes health maintenance organizations and health insurers.

[7.1.28.7 NMAC - N, 02/12/2016]

7.1.28.8 ADVISORY COMMITTEE MEMBERSHIP REQUIREMENTS AND RESPONSIBILITIES:

A. Advisory committee membership: The advisory committee shall be comprised of a minimum of seven individuals, and a maximum of 13, who shall be appointed by the secretary, and shall include:

(1) the secretary or the secretary's designee, who shall serve as chair of the committee;

(2) data sources or data providers;

(3) health care consumers or representatives from health care consumer groups; and

(4) health data experts.

B. Duties and responsibilities: The advisory committee shall convene on at least a quarterly basis to:

(1) review and recommend to the department methods for the effective dissemination of health information reports, to include the availability of reports that would be of interest to the public;

(2) review health information reports and recommend amendments for the purpose of rendering reports most useful and understandable to a lay audience;

(3) recommend reports that will address public concerns regarding health information and access to health care; and

(4) advise the department in carrying out the provisions of the Health Information System Act.

C. Final determinations: The committee shall provide the secretary with written recommendation in accordance with the duties and responsibilities listed above,

including any supporting documentation or public commentary. The secretary shall make a final determination on all committee recommendations.

D. Quorum: A quorum of the committee membership shall consist of a simple majority.

E. Advisory board membership term:

(1) Members of the committee other than the secretary or secretary's designee shall serve for staggered terms of two years from the date of appointment by the secretary.

(2) A member may be reappointed to consecutive terms.

(3) No member may be removed prior to the expiration of his or her term without a showing of good cause by the secretary.

(4) Members who have not attended at least half of the meetings in a calendar year may be removed from the committee by the secretary.

(5) Should a member chose to discontinue service on the committee prior to the expiration of his or her term, the member shall submit a request in writing to the secretary.

F. Advisory meeting structure: Each member should attend committee meetings in person, but if it is otherwise difficult or impossible to attend in person, then members will have the option to participate in the meeting by conference telephone or similar communications equipment approved by the chair.

G. Per diem and mileage: All committee members may receive as their sole remuneration those amounts authorized under the Per Diem and Mileage Act, Sections 10-8-1 *et seq*., NMSA 1978.

[7.1.28.8 NMAC - N, 02/12/2016]

7.1.28.9 ADVISORY BOARD PUBLIC HEARING PROCEDURES:

A. Public hearing requirement: The committee shall convene by public hearing on at least a quarterly basis.

B. Location of the public hearing: Hearings shall take place at a location sufficient to accommodate the anticipated audience.

C. Public hearing notice: The committee chair or designee shall prepare a notice of public hearing setting forth the date, time and location of the hearing no later than 30 days prior to the hearing date.

D. Public hearing agenda: The department shall make available no later than 72 hours prior to the hearing an agenda containing a list of specific items to be discussed or information on how the public may obtain a copy of such agenda. The agenda shall also be posted on the department's website.

E. Minutes: The committee shall keep written minutes of all its meetings.

[7.1.28.9 NMAC - N, 02/12/2016]

PART 29: HEALTH INFORMATION SYSTEM PUBLIC ACCESS WEBSITE

7.1.29.1 ISSUING AGENCY:

Department of Health, Epidemiology and Response Division, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, New Mexico 87502-6110.

[7.1.29.1 NMAC - N, 7.1.29.1 NMAC, 12/26/2017]

7.1.29.2 SCOPE:

This rule establishes the provisions of a public access website.

[7.1.29.2 NMAC - N, 7.1.29.2 NMAC, 12/26/2017]

7.1.29.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the department of health pursuant to the authority granted under Subsection E of Section 9-7-6 NMSA 1978 and the Health Information System Act, 24-14A-1 et seq. NMSA 1978.

[7.1.29.3 NMAC - N, 7.1.29.3 NMAC, 12/26/2017]

7.1.29.4 DURATION:

Permanent.

[7.1.29.4 NMAC - N, 7.1.29.4 NMAC, 12/26/2017]

7.1.29.5 EFFECTIVE DATE:

December 26, 2017, unless a later date is cited at the end of a section.

[7.1.29.5 NMAC - N, 7.1.29.5 NMAC, 12/26/2017]

7.1.29.6 OBJECTIVE:

The objective of this rule is to establish provisions that govern a Health Information System Act public access website for health information or health data.

[7.1.29.6 NMAC - N, 7.1.29.6 NMAC, 12/26/2017]

7.1.29.7 DEFINITIONS:

A. "Department" means the department of health.

B. "Health information" or **"health data"** means any data relating to health care; health status, including environmental, social and economic factors; the health system; or health costs and financing.

C. "Website" means the New Mexico Health Information System Act public access website for health information or health data created under this section.

[7.1.29.7 NMAC - N, 7.1.29.7 NMAC, 12/26/2017]

7.1.29.8 PUBLIC WEBSITE REQUIREMENTS:

A. The New Mexico Health Information System Act public website shall:

(1) be accessible to the public through the sunshine portal;

(2) allow the public to search for healthcare cost, quality and such other information the department publishes pursuant to the Health Information System Act, Sections 24-14A-1 to 24-14A-11 NMSA 1978;

(3) have a unique and simplified website address;

(4) be directly accessible via the main page of the official department website.

B. The department shall regularly update the Health Information System Act public access website.

[7.1.29.8 NMAC - N, 7.1.29.8 NMAC, 12/26/2017]

PART 30: ADMINISTRATIVE HEARINGS FOR CIVIL MONETARY PENALTIES ISSUED PURSUANT TO PHERA

7.1.30.1 ISSUING AGENCY:

New Mexico department of health.

[7.1.30.1 NMAC - N, 9/15/2020]

7.1.30.2 SCOPE:

This rule applies to all persons who receive a notice of contemplated action for imposition of a civil monetary penalty pursuant to the Public Health Emergency Response Act ("Act"), Section 12-10A-19 NMSA 1978.

[7.1.30.2 NMAC - N, 9/15/2020]

7.1.30.3 STATUTORY AUTHORITY:

Public Health Emergency Response Act ("Act"), Section 12-10A-1 *et seq*, NMSA 1978; and Subsection E of Section 9-7-6, NMSA 1978.

[7.1.30.3 NMAC - N, 9/15/2020]

7.1.30.4 DURATION:

Permanent.

[7.1.30.4 NMAC - N, 9/15/2020]

7.1.30.5 EFFECTIVE DATE:

September 15, 2020, unless a later date is cited at the end of a section.

[7.1.30.5 NMAC - N, 9/15/2020]

7.1.30.6 OBJECTIVE:

The objective of this rule is to provide administrative procedural rules to govern the appeal of a civil monetary penalty that is assessed by the department under the Act.

[7.1.30.6 NMAC - N, 9/15/2020]

7.1.30.7 DEFINITIONS:

A. "Appellant" means a person who is served a notice of contemplated action for imposition of a civil monetary penalty pursuant to the Act at Section 12-10A-19 NMSA 1978, who timely submits a request for hearing, in accordance with this rule, to contest the proposed penalty.

B. "Department" means the New Mexico department of health.

C. "Notice of contemplated action" means a notice that is issued by the department to a person pursuant to the Section 12-10A-19, NMSA 1978.

D. "Person" means a living person or a legal entity.

E. "Recipient" means a recipient of a notice of contemplated action.

F. "Secretary" means the cabinet secretary of the New Mexico department of health.

[7.1.30.7 NMAC - N, 9/15/2020]

7.1.30.8 HEARINGS PURSUANT TO THE PUBLIC HEALTH EMERGENCY RESPONSE ACT:

A. Right to hearing: A person may request an administrative hearing before a hearing officer appointed by the secretary or his or her designee, to appeal the proposed imposition of a civil monetary penalty pursuant to the Act at Section 12-10A-19 NMSA 1978. An appellant may request the hearing by mailing a certified letter, return receipt requested, to the New Mexico department of health at the mailing address that is specified on the notice of contemplated action within five days after service of the notice of the contemplated action. If the recipient fails to request a hearing in the time and manner required by this section, the recipient shall forfeit the right to a hearing, and the proposed action shall become final.

B. Scheduling the hearing:

(1) Appointment of hearing officer: Upon the department's receipt of a timely request for a hearing, the department shall appoint an impartial hearing officer and schedule a hearing.

(2) Hearing date: The hearing shall be held not more than 60 days and not less than 12 days from the date of service of the notice of the hearing.

(3) Notice of hearing: The department shall notify the appellant of the date, time, and place of the hearing and the identity of the hearing officer, within twenty days of the department's timely receipt of the request for hearing.

(4) Hearing venue: The hearing shall be held in Santa Fe, NM; provided that the hearing officer may, with the agreement of the parties, hold the hearing in another location within the state of New Mexico. Hearings may be held in whole or in part via telephone or live video, upon the request of either party, at the hearing officer's discretion.

C. Method of service: Any notice or decision required to be served under this section may be served
either personally or by certified mail, return receipt requested, directed to the appellant at the appellant's last known mailing address; provided that, if the appellant is a company registered with the New Mexico secretary of state, the notice shall be served

upon the company's duly registered agent. If the notice or decision is served personally, service shall be made in the same manner allowed by the rules of civil procedure for the state district courts of New Mexico. Where the notice or decision is served by certified mail, it shall be deemed to have been served on the date borne by the return receipt showing delivery, or the date of the last attempted delivery of the notice or decision, or the date of the addressee's refusal to accept delivery.

D. Hearing officer duties: The hearing officer shall conduct the hearing, rule on any motions or
other matters that arise prior to the hearing, and issue a written report and recommendation(s) to the secretary following the close of the hearing.

E. Official file: Upon appointment, the hearing officer shall establish an official file which shall
contain all notices, hearing requests, pleadings, motions, written stipulations, evidence, briefs, and correspondence received in the case. The official file shall also contain proffered items not admitted into evidence, which shall be so identified and shall be separately maintained. Upon conclusion of the proceeding and following issuance of the final decision, the hearing officer shall tender the complete official file to the department for its retention as an official record of the proceedings.

F. Powers of hearing officer: The hearing officer shall have all the powers necessary to conduct a hearing and to take all necessary action to avoid delay, maintain order, and assure development of a clear and complete record, including but not limited to the power to: administer oaths or affirmations; schedule continuances; direct discovery; examine witnesses and direct witnesses to testify; subpoena witnesses and relevant books, papers, documents, and other evidence; limit repetitious and cumulative testimony; set reasonable limits on the amount of time a witness may testify; decide objections to the admissibility of evidence or receive the evidence subject to later ruling; receive offers of proof for the record; take notice of judicially cognizable facts; direct parties to appear and confer for the settlement or simplification of issues, and otherwise conduct pre-hearing conferences; impose appropriate evidentiary sanctions against a party who fails to provide discovery or who fails to comply with a subpoena; dispose of procedural requests or similar matters; require the parties to submit proposed findings of fact and conclusions of law, as well as written closing arguments; and enter the hearing officer's own proposed findings of fact and conclusions of law, orders, reports and recommendations for the consideration of the secretary. The hearing officer may utilize his or her experience, technical competence, or specialized knowledge in the evaluation of evidence presented.

G. Minimum discovery; inspection and copying of documents: Upon written request to another party, any party shall have access to documents in the possession of the other party that are relevant to the subject matter of the appeal, except confidential or privileged documents.

H. Minimum discovery; witnesses: The parties shall each disclose to each other and to the hearing officer, either orally or in writing, the names of witnesses to be called, together with a brief summary of the testimony of each witness, by a deadline established by the hearing officer. In situations where written statements will be offered into evidence in lieu of a witness's oral testimony, the names of the persons making the statements and a brief summary of the statements shall be disclosed.

I. Pre-hearing disposition: The subject matter of any hearing may be disposed of by stipulation, settlement or consent order, unless otherwise precluded by law. Any stipulation, settlement, or consent order reached between the parties shall be written and shall be signed by the hearing officer and the parties or their attorneys.

J. Postponement or continuance: The hearing officer, at his or her discretion, may postpone or continue a hearing upon his or her own motion, or upon the motion of a party, for good cause shown. Notice of any postponement or continuance shall be given in person, by telephone, or by mail to all parties within a reasonable time in advance of the previously scheduled hearing date.

K. Conduct of hearing: Pursuant to the Open Meetings Act, Section 10-15-1, *et seq*., NMSA 1978, hearings shall be open to the public; provided, however, that hearings may be closed in part to prevent the disclosure of confidential information, including but not limited to health information protected by state and federal laws.

L. Telephonic testimony: Upon timely notice to the opposing party and the hearing officer, and with the approval of the hearing officer, the parties may present witnesses by telephone or live video (if available).

M. Legal representation: An appellant may be represented by an attorney licensed to practice in New Mexico, by a non-attorney representative, or by both. The department may be represented by an attorney licensed to practice in New Mexico, a department employee, or by both.

N. Recording: The hearing officer or a designee shall record the hearing by means of a mechanical sound recording device provided by the department for a record of the hearing. Such recording need not be transcribed, unless requested by a party who shall arrange and pay for the transcription.

O. Burden of proof: Except as otherwise provided in this rule, the department has the burden of proving by a preponderance of the evidence the basis for the proposed action.

P. Order of presentation; general rule: Except as provided in this rule, the order of presentation for hearings in all cases shall be:

(1) appearances: opening of proceeding and taking of appearances by the hearing officer;

(2) pending matters: disposition by the hearing officer of preliminary and pending matters;

(3) opening statements: the opening statement of the department, if any; and then the opening statement of the appellant, if any;

(4) cases: the department's case-in-chief, and then the case-in-chief of the appellant;

(5) rebuttal: the department's case-in-rebuttal, if any;

(6) closing argument: the department's closing statement, if any, which may include legal argument; and then the closing statement of the party opposing the department's action or proposed action, if any, which may include legal argument; and

(7) close: close of proceedings by the hearing officer.

Q. Admissible evidence; rules of evidence not applicable: The hearing officer may admit evidence and may give probative effect to evidence that is of a kind commonly relied on by reasonably prudent persons in the conduct of serious affairs. Rules of evidence, such as the New Mexico rules of evidence for the district courts, shall not apply but may be considered in determining the weight to be given any item of evidence. The hearing officer may at his or her discretion, upon his or her motion or the motion of a party or a party's representative, exclude incompetent, irrelevant, immaterial, or unduly repetitious evidence, including testimony, and may exclude confidential or privileged evidence.

R. Objections: A party may timely object to evidentiary offers by stating the objection together with a succinct statement of the grounds for the objection. The hearing officer may rule on the admissibility of evidence at the time an objection is made or may receive the evidence subject to later ruling.

S. Official notice: The hearing officer may take notice of any facts of which judicial notice may be taken. When the hearing officer takes notice of a fact, the parties shall be notified either before or during the hearing of the fact so noticed and its source, and the parties shall be afforded an opportunity to contest the fact so noticed.

T. Record content: The record of a hearing shall include all documents contained in the official file maintained by the hearing officer, including all evidence received during the course of the hearing, proposed findings of fact and conclusions of law, the recommendations of the hearing officer, and the final decision of the secretary.

U Written evidence from witnesses: The hearing officer may admit evidence in the form of a written statement made by a witness, when doing so will serve to expedite the hearing and will not substantially prejudice the interests of the parties.

V. Failure to appear: If a party who has requested a hearing or a party's representative fails to
appear on the date, time, or location announced for a hearing, and if no continuance was previously granted, the party shall be deemed to be in default; the hearing officer shall issue his or her report, noting the default; and the secretary may subsequently render a final decision adopting the proposed action. Where a person fails to appear at a hearing because of accident, sickness, or other cause, the person may within a reasonable time apply to the hearing officer to reopen the proceeding, and the hearing officer may, upon finding sufficient cause, fix a time and place for a hearing and give notice to the parties.

W. Hearing officer written report and recommendation(s): The hearing officer shall submit a written report and recommendation(s) to the secretary that contains a statement of the issues raised at the hearing, proposed findings of fact and conclusions of law, and a recommended determination. Proposed findings of fact shall be based upon the evidence presented at the hearing or known to all parties, including matters officially noticed by the hearing officer. The hearing officer's recommended decision is a recommendation to the secretary of the New Mexico department of health and is not a final order.

X. Submission for final decision: The hearing officer's report and recommendation(s) shall be submitted together with the complete official file to the secretary of the New Mexico department of health for a final decision no later than 30 days after the hearing.

Y. Secretary's final decision: The secretary shall render a final decision within 45 calendar days of the submission of the hearing officer's written report. A copy of the final decision shall be mailed to the appealing party by certified mail, return receipt requested, within 15 days after the final decision is rendered and signed.

[7.1.30.8 NMAC - N, 9/15/2020]

PART 31: STATEWIDE HEALTH CARE CLAIMS DATABASE

7.1.31.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.1.31.1 NMAC - N, 04/20/2021]

7.1.31.2 SCOPE:

These regulations govern the creation and maintenance of a repository of healthcare claims data to be used to increase the quality and effectiveness of health care delivered in New Mexico.

[7.1.31.12 NMAC - N, 04/20/2021]

7.1.31.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the department of health pursuant to the authority granted under Subsection E of Section 9-7-6, NMSA 1978, and the Health Information System Act, 24-14A-1 et seq. NMSA 1978.

[7.1.31.3 NMAC - N, 04/20/2021]

7.1.31.4 DURATION:

Permanent.

[7.1.31.4 NMAC - N, 04/20/2021]

7.1.31.5 EFFECTIVE DATE:

April 20, 2021, unless a later date is cited at the end of a section.

[7.1.31.5 NMAC - N, 04/20/2021]

7.1.31.6 OBJECTIVE:

The objective of this rule is to establish provisions that govern the creation, maintenance, and usage of a repository of healthcare claims data for the purpose of improving health care cost and quality.

[7.1.31.6 NMAC - N, 04/20/2021]

7.1.31.7 DEFINITIONS:

A. "Allowed amount" means the negotiated amount eligible for payment for a health care service or item rendered by a provider.

B. "Billed amount" means the amount billed by a provider requesting payment for health care services or items rendered.

C. "Claim" means a financial accounting of or a request for payment for health care items or services rendered by a provider.

D. "Data" means the data required by this rule to be submitted to this database, including data on the following health factors: mortality and natality, including accidental causes of death; morbidity; health behavior; disability; health system costs, availability, utilization and revenues; environmental factors; health personnel; demographic factors; social, cultural and economic conditions affecting health, including language preference;

family status; medical and practice outcomes as measured by nationally accepted standards and quality of care; and participation in clinical research trials.

E. "Data provider" means a person that possesses health information, including any public or private sector licensed health care practitioner, primary care clinic, ambulatory surgery center, ambulatory urgent care center, ambulatory dialysis unit, home health agency, long-term care facility, hospital, pharmacy, third-party payer and any public entity that has health information.

F. "Database" means the statewide all-payer health care claims database established in this rule.

G. "Department" means the department of health.

H. "Direct patient identifier" means a data variable that identifies an individual, including: names; telephone numbers; fax numbers; social security number; medical record numbers; health plan beneficiary numbers; account numbers; certificate or license numbers; vehicle identifiers and serial numbers, including license plate numbers; device identifiers and serial numbers; web universal resource locators; internet protocol address numbers; biometric identifiers, including finger and voice prints; elements of dates more granular than a year; un-aggregated ages over 89; geographic subdivisions smaller than the state, except the first three digits of ZIP, full face photographic images and any comparable images; and any other unique identifying number, characteristic, or code, except as permitted by 45 C.F.R 164.514 (c).

I. "ERISA plan" means an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents under the Employee Retirement Income Security Act of 1974 directly or through insurance, reimbursement or other means.

J. "Health information" or **"health data"** means any data relating to health care; health status, including environmental, social and economic factors; a health system or provider; health costs, financing, and including data that would customarily be collected in the ordinary course of business for the data provider; annual audited financial statements customarily prepared by a data provider; information on major capital expenditures; data established by regulation to be collected to carry out the requirements of the Health Information System Act; data required to be collected by other state or federal laws; and annual surveys or collection of data may be used as an alternative to collection of health data from some health service providers to the extent it can be shown that the information collected will meet validity and quality standards.

K. "Health information system" or **"HIS"** means the health information system established by the Health Information System Act, Sections 24-14A-1 to 24-14A-10, NMSA 1978.

L. **"Health insurance carrier"** means any entity that offers the following:

(1) group health and dental coverage governed by the provisions of the Health Care Purchasing Act;

(2) individual health and dental insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978;

(3) health and dental multiple-employer welfare arrangements governed by the provisions of Section 59A-15-20 NMSA 1978;

(4) group and blanket health and dental insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;

(5) individual and group health and dental health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law Chapter 59A, Article 46 NMSA 1978; and

(6) individual and group health and dental nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law Chapter 59A, Article 47 NMSA 1978.

M. "Indirect patient identifier" means a data variable that may identify an individual when combined with other information.

N. "Proprietary financial information" means information that derives independent economic value, actual or potential, from not being generally known to and not being readily ascertainable by proper means by other persons who can obtain economic value from its disclosure or use; and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

O. "Secretary" means the secretary of the New Mexico department of health.

P. "Unique identifier" means an obfuscated identifier assigned to an individual represented in the database to establish a basis for following the individual longitudinally throughout different payers and encounters in the data without revealing the individual’s identity.

[7.1.31.7 NMAC - N, 04/20/2021]

7.1.31.8 STATEWIDE ALL-PAYER CLAIMS DATABASE–DUTIES-CONTRACT WITH DATA VENDOR:

A. Duties of the department:

(1) The department shall establish a statewide all-payer claims database to support transparent public reporting of health care information. The database must improve transparency to: assist patients, providers, and hospitals to make informed choices about care; enable providers, hospitals, and communities to improve by benchmarking their performance against that of others by focusing on best practices, enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and promote competition based on quality and cost. The database must systematically collect all medical claims for covered medical services, pharmacy claims, dental claims, member eligibility and enrollment data, and provider data with necessary identifiers from private and public payers, with data from all settings of care that permit the systematic analysis of health care delivery.

(**2)** The department shall convene subcommittees to the HIS advisory committee with the approval of the secretary, including:

(a) a subcommittee on data policy development;

(b) a subcommittee to establish a data release process consistent with the requirements of this rule and to provide advice regarding formal data release requests. The advisory subcommittees must include in-state representation from key providers, hospitals, public health and health maintenance organizations, large and small private purchasers, consumer organizations, and the two largest carriers supplying claims data to the database; and

(c) other subcommittees as needed.

B. Duties of the department in contract with data vendor:

(1) The department will conduct, or may engage a data vendor to perform, data collection, processing, aggregation, extracts, and analytics. The department or data vendor must:

(a) establish a secure data submission process with data providers;

(**b)** review data submitters' files per standards established by the department;

(c) assess each record's alignment with established format, frequency, and consistency criteria;

(**d)** maintain responsibility for quality assurance, including, but not limited to:

(i) the completeness, accuracy and validity of data provider's data;

(ii) accuracy of dates of service spans;

(iii) maintaining consistency of record layout and counts; and

(iv) identifying duplicate records;

(**e)** assign unique identifiers, as defined in this rule, to individuals represented in the database;

(**f)** ensure that direct patient identifiers, indirect patient identifiers, and proprietary information are released only in compliance with federal and state privacy laws and the terms of applicable confidentiality requirements;

(**g)** demonstrate internal controls and affiliations with separate organizations as appropriate to ensure safe data collection, security of the data with state of the art encryption methods, actuarial support, and data review for quality assurance;

(**h)** store data in a manner compliant with the federal Health Insurance Portability and Accountability Act and regulations, with access to the data strictly controlled and limited to staff with appropriate training, clearance, and background checks; and

(**i)** maintain state of the art security standards for transferring data to approved data requestors.

(2) The data vendor must submit detailed descriptions to the department's chief information security officer to ensure robust security methods are in place.

(3) The department is responsible for internal governance, management, funding, and operations of the database. The department shall work with the data vendor to:

(**a)** collect claims data from data providers as provided in this rule;

(**b)** design data collection mechanisms with consideration for the time and cost incurred by data providers and others in submission and collection and the benefits that measurement would achieve, ensuring the data submitted meet quality standards and are reviewed for quality assurance;

(**c)** ensure protection of collected data and store and use of data in a manner that protects patient privacy and complies with this section. All patient-specific information must be secured with required standard encryption algorithms;

(**d)** consistent with requirements of this rule, make information from the database available as a resource for public and private entities, including carriers, employers, providers, hospitals, and purchasers of health care;

(**e)** report performance on cost and quality pursuant to this rule.

(**f)** develop protocols and policies, including prerelease review by any entity identified by the department, to ensure the quality of data releases and reports;

(**g)** the department may not charge providers or data providers fees other than fees directly related to requested reports.

[7.1.31.8 NMAC - N, 04/20/2021]

7.1.31.9 SUBMISSION OF CLAIMS DATA TO DATABASE:

A. All-payer claims database data providers:

(1) Data providers must submit all available data and health information with necessary identifiers to the database as described in the APCD-Common Data Layout (APCD-CDL™, Version 2.1 with errata, Copyright 2021 by APCD Council, National Association of Health Data Organizations, the University of New Hampshire) within the time frames in this rule and in accordance with procedures established herein.

(2) Any data provider used by an entity that participates in the database such as a third-party administrator or pharmacy benefit manager must provide claims data to the department or the data vendor upon request of the entity.

(3) The following plans or entities may voluntarily provide claims data to the database within the time frames and in accordance with procedures established by the department:

(a) Employer sponsored plans subject to the Employee Retirement Income Security Act of 1974; and

(b) any governmental or tribal program or facility that provides health care services to American Indians and Alaska Natives.

(4) Health insurance carriers that only offer the following excepted benefit coverages are not required to report:

(a) specific disease;

(b) accident or injury;

(c) hospital indemnity and other fixed indemnity;

(d) disability;

(e) long-term care; and

(f) vision coverage.

(5) Medicaid managed care organizations provide claims data to the New Mexico human services division (HSD), and who will then submit that data to the department of health.

(6) Health insurance carriers covering less than 500 individuals are not required to submit files to the database but are required to report the number of individuals with coverage during the previous year on March 1st.

B. Data submission procedures:

(1) The department shall:

(a) utilize an internet-based user interface (or similar technology) that allows for secure submission and acceptance of data submissions;

(b) perform quality assurance and validation of all submitted data and provide feedback to the data providers; and

(c) provide data submissions procedures to data providers in a data submission guide that is based on a current version of the APCD-Common Data Layout.

(2) Data submission frequency: data shall be submitted at least monthly.

(3) Data providers shall make every effort to initially submit complete, accurate, and valid data in the APCD-Common Data Layout and shall correct all identified errors within the timelines established by the department or its designee.

(4) An initial test submission of data may be required.

(5) Data dating to January 1, 2020 must be submitted initially.

(6) The department may sanction data providers who do not comply with this rule.

(7) Data shall be submitted beginning January 1, 2023.

[7.1.31.9 NMAC - N, 04/20/2021; A, 4/25/2023]

7.1.31.10 CLAIMS DATA AND DATABASE - EXEMPTIONS FROM PUBLIC DISCLOSURE:

Public record:

A. The claims data provided to the database, the database itself, including the data compilation, and any raw data received from the database are not public records and are generally exempt from public disclosure in accordance with the Inspection of Public

Records Act, Subsections A and H of Section 14-3-1, NMSA 1978, the Health and Hospital Records Act, 14-6-1, NMSA 1978, and the Health Information Systems Act, Sections 24-14A-6 and 8, NMSA 1978.

B. Claims data obtained, distributed, or reported in the course of activities undertaken pursuant to or supported under this rule are strictly confidential and shall not be a matter of public record or accessible to the public. The department shall not disclose data except to the extent that they are included in a compilation of aggregate data. Any forms of data collected by and furnished for the department shall not be public records subject to inspection pursuant to Section 14-2-1 NMSA 1978. The department may release or disseminate aggregate data, which 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. In accordance with Paragraph (6) of Subsection D of Section 24-14A-3 NMSA 1978, Section 24-14A-4.3 NMSA 1978, and Subsection D of Section 24-14A-6, NMSA 1978 of the HIS Act, data may be reported routinely to authorized federal, state, and local public agencies.

[7.1.31.10 NMAC - N, 04/20/2021]

7.1.31.11 GENERAL PROVISIONS ON ACCESS TO THE CLAIMS DATABASE DATA:

A. Access requirements: Data and reports based on the claims database may be obtained only in accordance with the requirements of the HIS Act and this rule. Any request for information that would not be contained in previously prepared and published reports will require a data request from the department.

B. Evaluation of requests: In addition to other requirements stated in this rule, all requests for claims data and reports, other than routine reports, shall be evaluated by the department and shall not be released unless the requests satisfy the following criteria for approval.

(1) The specific intended use of the data shall comport with the purposes of the HIS Act, as stated in 24-14A-3A, NMSA 1978 and rules promulgated pursuant to the HIS Act, including use of data to assist in:

(a) the performance of health planning, policy making functions, and research conducted for the benefit of the public;

(b) informed health care decision making by consumers;

(c) surveillance for the control of disease and conditions of public health significance as required by Public Health Act, Subsection C of 24-1-3 NMSA 1978, and

(d) administration, monitoring, and evaluation of a statewide health plan.

(2) The request shall be consistent with the responsibilities of the department in accomplishing the priorities of the HIS.

C. Request procedures: All requests for data shall be made to the department.

D. Fees: Fees for access to data and reports shall be paid pursuant to the requirements of this rule.

E. Time period to fulfill request: The department will endeavor to fulfill requests within one month of receiving the request, although the time period for fulfillment of a request may vary depending on the complexity of the request and other factors.

F. Restrictions on access to confidential sensitive data: The department shall deny access to

information from the claims database where the use or disclosure of the information could result in a violation of health information confidentiality or purposes for which the department has determined is not consistent with the purposes or intent of the act.

G. Compliance with other laws: The department shall ensure that any access to data that is subject to restrictions on use pursuant to state, federal, or tribal law or regulation, or any other legal agreement, complies with those restrictions.

H. Disclaimer: The department shall include a disclaimer in all claims data and reports released pursuant to this rule stating that the accuracy of the original data is the responsibility of the submitting data provider and that the department assumes no responsibility for any use made of or conclusions drawn from the data.

I. Agency contractors:

(1) A state or federal agency that receives claims data or reports under an agreement with the department pursuant to this rule shall be solely responsible for fulfillment of the agreement, including responsibility for the actions of any subcontractor engaged to perform services that require access to claims data or reports.

(2) A state or federal agency subcontractor that is provided access to claims data or reports shall be subject to the full provisions of the HIS Act and this rule.

J. Proprietary and confidential information:

(1) Proprietary information and protected health information shall not be disclosed in or as part of a public health information report by the department.

(2) A data provider that objects to the potential release of its reported data or information derived from its reported data shall submit to the department a written request to exempt its data from such disclosures. By the end of each fiscal year (June

30th), data providers must notify the department in writing regarding data items that they deem proprietary. Application for an exemption must be addressed by a representative of the data provider to the department.

[7.1.31.11 NMAC - N, 04/20/2021]

7.1.31.12 ACCESS TO HEALTH CARE DATA REPORTS:

A. Access to routine and published reports: The department shall release reports to the public on a periodic schedule as determined by the department and in accordance with the HIS Act.

B. Access to aggregate data and reports for individuals: Pursuant to the requirements of the NM Inspection of Public Records Act (IPRA), any person may obtain access to existing aggregate data or reports based on the subset or portion of the claims database that is relevant to the individual's stated purpose. Any access to aggregate data or reports that have not yet been generated is subject to approval by the department pursuant to the requirements of this rule.

C. Access to data and reports for state agencies: The department shall establish policies and procedures for access to data and reports by state agencies.

[7.1.31.12 NMAC - N, 04/20/2021]

7.1.31.13 FEES FOR DATA AND REPORTS:

A. Fees for routine reports:

(1) Generally: The fees for copies of available reports produced for public use shall be as follows:

(a) single copies of any claims data reports or annual reports shall be provided free of charge upon request; and

(b) all other reports shall be provided for a fee of no more than $1.00 per page.

(2) Data providers: Data providers may receive one free copy of the department's routine reports upon request.

B. Previously-prepared reports: The fee for copies of available previously-prepared, non-routine reports provided to persons other than the original requestor for whom the report was prepared shall be $20.00 per report.

C. Fees for data and non-routine reports: The fee for preparing data and non-routine reports that have not been previously prepared shall be charged at the hourly rate of the analyst(s) preparing the data or report, as follows:

(1) data providers shall be charged a rate of $50.00 per analyst hour;

(2) state agencies shall be charged a rate of $75.00 per analyst hour; and

(3) all others shall be charged a rate of $100.00 per analyst hour.

D. Electronic media reports: Fees for reports made available on electronic media may include charges for the cost of the magnetic tape, diskette, CD-ROM, or other electronic media, in addition to the fees required by this section.

E. Waiver or reduction of fees:

(1) Standard for waiver or reduction: The department may reduce or waive the fee for routine reports, data, and non-routine reports when the department determines that the requestor's proposed use of the information would be of value to the department in fulfilling its statutory mandates to a degree equal to or greater than the fee reduction or waiver.

(2) Payment upon failure to perform: When a fee waiver or reduction has been granted, and the research for which the fee was waived or reduced is not completed or the product for which the fee was waived or reduced is not delivered to the department, the full fee shall be assessed in accordance with this rule.

F. Statement of fees: The department shall prepare a statement of the fee for requests made pursuant to this rule and provide it to the requestor prior to tender of the requested data or report. Payment is required in advance of the requestor receiving the data or report.

[7.1.31.13 NMAC - N, 04/20/2021]

PART 32 LONG-TERM CARE FACILITY DEMENTIA TRAINING [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.11 NMAC.]

CHAPTER 2: VITAL STATISTICS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: VITAL RECORDS AND STATISTICS

7.2.2.1 ISSUING AGENCY:

Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics.

[7.2.2.1 NMAC - Rp, 7.2.2.1 NMAC, 12/27/2022]

7.2.2.2 SCOPE:

These regulations govern the creation and maintenance of a system of vital records and health statistics in New Mexico and insure the integrity of all vital records and health statistics issued or maintained by the department of health.

[7.2.2.2 NMAC - Rp, 7.2.2.2 NMAC, 12/27/2022]

7.2.2.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated by the secretary of the department of health by the authority of Subsection F of Section 9-7-6 NMSA 1978 and implement the Vital Statistics Act, Sections 24-14-1 to 24-14-31 NMSA 1978, as amended. These regulations also implement certain sections of the Uniform Parentage Act, Section 40-11-1 et seq., NMSA 1978 at Sections 40-11-5 and 40-11-6 NMSA 1978. These regulations also implement reporting for medical aid in dying, Section 24-1-43 NMSA 1978.

[7.2.2.3 NMAC - Rp, 7.2.2.3 NMAC, 12/27/2022]

7.2.2.4 DURATION:

Permanent.

[7.2.2.4 NMAC - Rp, 7.2.2.1 NMAC, 12/27/2022]

7.2.2.5 EFFECTIVE DATE:

12/27/2022, unless a later date is cited at the end of a section.

[7.2.2.5 NMAC - Rp, 7.2.2.5 NMAC, 12/27/2022]

7.2.2.6 OBJECTIVE:

These regulations are promulgated pursuant to statute for the purpose of installing, maintaining and operating a system of vital statistics throughout this state.

[7.2.2.6 NMAC - Rp, 7.2.2.6 NMAC, 12/27/2022]

7.2.2.7 DEFINITIONS:

As used in these regulations.

A. Definitions beginning with "A": "Act" means the Vital Statistics Act, Sections 24-14-1 to 24-14-31, NMSA 1978 as amended.

B. Definitions beginning with "B": "Bureau" means the vital records and health statistics bureau, epidemiology and response division) within the department of health, which was formerly and in the statute referred to as the vital statistics bureau. Vital Statistics Act Section 24-14-1 et seq., NMSA 1978.

C. Definitions beginning with "C":

(1) "Certificate of still birth" means a certificate created by the BVRHS at the request of a parent named on a report of spontaneous fetal death which captures data from a report of a spontaneous fetal death reported in accordance with New Mexico law. The certificate is intended to memorialize a stillbirth event, but cannot be used as proof of a live birth, for identification or other legal purposes.

(2) "Certifier", for purposes of death records means a person authorized to certify cause of death pursuant to the laws of New Mexico.

(3) "Court ordered custodian" means the New Mexico children youth and families department when that department has legal custody of the child pursuant to a court order issued by a court of competent jurisdiction in the state of New Mexico.

D. Definitions beginning with "D":

(1) "Dead body" means a human body or such parts thereof other than skeletal remains which cannot be classified as artifacts; dead within the meaning of Section 12-2-4 NMSA 1978.

(2) "Department" means the department of health.

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F":

(1) "Fetal death" means death prior to complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

(a) "Induced termination of pregnancy" means the purposeful interruption of pregnancy with the intention other than to produce a live-born infant or to remove a dead fetus, and which does not result in a live birth; induced abortion.

(b) "Spontaneous fetal death" means the expulsion or extraction of a product of human conception resulting in other than a live birth and which is not an induced termination of pregnancy; still birth.

(2) "File" means to present a vital record for registration by the state registrar.

(3) "Final disposition" means the burial, interment, cremation, removal from the state or other authorized disposition of a dead body or fetus.

(4) "Forms" means all certificates, forms, electronic media, reports, and records, and any safety paper used in their production, which are vital records.

(5) "Fraud manager" means an employee or representative of the bureau whose responsibilities include liaison with law enforcement, immigration, passport, embassy and consular officials, or other agencies, and who investigates or coordinates the investigation of any incidence or suspected incidence of fraud, or violation of statute or regulation, and who reports on these investigations to the state registrar.

G. Definitions beginning with "G":

(1) "Gender" means a person's internal sense of being male, female, some combination of male and female, or neither male nor female.

(2) "Given name" means a name that precedes one's surname.

H. Definitions beginning with "H":

(1) "Healthcare provider" for the purposes of medical aid in dying means an authorized individual pursuant to the End-of-Life Options Act to prescribe medical aid in dying including a physician licensed pursuant to the Medical Practice Act, an osteopathic physician licensed pursuant to the Osteopathic Medicine Act; A nurse licensed in advanced practice pursuant to the Nursing Practice Act, or a physicians assistant licensed pursuant to the Physicians Assistant Act or the Osteopathic Medicine Act.

(2) "Homeless" means the following:

(a) lacking a fixed, regular, and adequate nighttime residence;

(b) living in the housing of another person due to the individual's loss of housing, economic hardship or other reason related to that individual's lack of residence;

(c) living in a motel, hotel, trailer park or camping ground due to the lack of alternative adequate accommodation;

(d) living in an emergency or transitional shelter;

(e) sleeping in a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings; or

(f) living in an automobile, a park, a public space, an abandoned building, substandard housing, a bus station, a train station or similar setting.

I. Definitions beginning with "I":

(1) "Immediate family" means any of the following: mother, father, grandmother, grandfather, grandchild, sibling, child or current spouse.

(2) "Institution" means any establishment, public or private, which provides in-patient or out-patient medical or surgical, or diagnostic care or treatment or nursing, custodial, or domiciliary care, or to which persons are committed by law.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": "Live birth" means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

M. Definitions beginning with "M":

(1) "Medical aid in dying" means the medical practice wherein a health care provider prescribes medication to a qualified individual who may self-administer that medication to end that individual's life in accordance with the provisions of the End-of-Life Options Act.

(2) "Minor error" means transposition of letters in words of common knowledge, typographical errors, or omissions of letters and numbers.

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": "OMI" means the office of the medical investigator.

P. Definitions beginning with "P": "Physician" means a person authorized or licensed to practice medicine or osteopathy pursuant to the laws of New Mexico.

Q. Definitions beginning with "Q": [RESERVED]

R. Definitions beginning with "R": "Registration" means the acceptance by the state registrar and the incorporation into his or her official records of vital records provided for in the act.

S. Definitions beginning with "S":

(1) "Sex" means the biological anatomy of an individual's reproductive system, and secondary sex characteristics.

(2) "State" means the state of New Mexico.

(3) "State registrar" means the person appointed under the Vital Statistics Act, Section 24-14-14, et seq., NMSA 1978, and whose duties are described in the act at Section 24-14-4 NMSA 1978.

(4) "System of vital statistics" means the registration, collection, preservation, amendment and certification of vital records; the collection of other reports required by this act; and activities related thereto, including the tabulation, analysis and publication of vital statistics.

T. Definitions beginning with "T": [RESERVED]

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V":

(1) "Vital records" means certificates, records, reports, or registration forms of birth and death, and supporting documentation.

(2) "Vital statistics" means the data derived from certificates and reports of birth, death, spontaneous fetal death, induced termination of pregnancy and related reports.

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": "X" means a gender other than male or female, or an undesignated gender.

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[7.2.2.7 NMAC - Rp, 7.2.2.7 NMAC, 12/27/2022]

7.2.2.8 BUREAU OF VITAL RECORDS FORMS:

All forms used in the system of vital statistics are the property of the department, and shall be returned to the state registrar upon demand. Only those forms prescribed, distributed and approved by the state registrar shall be used in the reporting of vital records and statistics or in making copies thereof. Such forms shall be used for official purposes only.

A. Requirements for the preparation of forms:

(1) All certificates, registration forms, reports and records relating to vital statistics must either be prepared in approved electronic form or on a typewriter or printer which prints in unfading ink. All signatures required shall be entered electronically, or in unfading ink, unless otherwise instructed in these or related regulations.

(2) Unless otherwise directed by the state registrar, no certificate, registration form, record or report shall be complete and acceptable for registration that:

(a) does not have the certifier’s name typed or printed legibly with his or her signature;

(b) does not supply all items of information called for thereon or satisfactorily account for their omission;

(c) does not contain handwritten or approved electronic signatures, as required;

(d) includes alterations, including all manner of erasures, the use of correction fluids, and other correction devices;

(e) is marked "copy" or that is a carbon or photo or other copy;

(f) is prepared on an improper form;

(g) contains improper or inconsistent data;

(h) contains an indefinite cause of death which denotes only symptoms of disease or conditions resulting from disease;

(i) is not prepared in conformity with regulations or instructions issued by the state registrar.

B. Missing or unknown information: The state registrar shall request and be provided information from applicants, informants, or other interested parties if the registrar finds that information is missing, inconsistent, or listed as "unknown".

C. Copies of vital records: It is unlawful pursuant to Section 24-14-27 NMSA 1978 to copy or issue a copy of all or part of any record except as authorized by law.

[7.2.2.8 NMAC - Rp, 7.2.2.8 NMAC, 12/27/2022]

7.2.2.9 REGISTRATION OF BIRTH:

A certificate of birth registration form for each live birth which occurs in this state shall be filed with the bureau within 10 days after the birth and shall be registered if it has been completed and filed in accordance with the Vital Records Act and related regulations. Exceptions shall be only those noted in the Vital Records Act or related regulations, or upon written authorization of the state registrar.

A. Infants of unknown parentage: Foundling registration. The report for an infant of unknown parentage shall be registered on a foundling report, and:

(1) show the required facts as determined by approximation and show parentage information as "unknown";

(2) show the signature and title of the custodian in lieu of the attendant.

B. Safe haven registration: If parentage information is known for a safe haven baby under the Safe Haven For Infants Act, Sections 24-22-1 to 24-22-8 NMSA 1978, (it shall be entered on the certificate of birth registration form for filing with the state registrar. If no parentage information is known, the certificate of birth registration form shall be completed as a foundling registration.

C. Birth registration - 11 days to one year: Birth registrations forms filed after 10 days, but within one year from the date of birth, shall be filed on the certificate of birth registration form in the manner prescribed in Section 24-14-13 NMSA 1978. Certificates issued pursuant to the section shall not be marked "delayed."

(1) In any case where the certificate of birth registration form is signed by someone other than the licensed attendant or person in charge of the institution where the birth occurred, a notarized statement setting forth the reason therefore must be attached to the certificate. The state registrar may require additional evidence in support of facts of birth or an explanation why the certificate of birth registration form was not filed within the required 10 days.

(2) Out-of-hospital births not attended by a licensed medical attendant (physician, licensed certified nurse midwife, licensed midwife, emergency medical technician) must be signed by the mother as certifier, and sworn by any other person in attendance (if any other person was in attendance), and must be accompanied by notarized documents which prove both that a birth occurred and the New Mexico county in which the birth occurred. The state registrar will issue instructions containing a list of documents which will be acceptable as proof of birth, and as proof of residency.

[7.2.2.9 NMAC - Rp, 7.2.2.9 NMAC, 12/27/2022]

7.2.2.10 DELAYED CERTIFICATE OF BIRTH:

All births presented for registration one year or more after the date of birth are to be filed on an application for delayed certificate of birth form or other format prescribed by the state registrar. No application for a delayed birth certificate shall be approved except by the state registrar or the deputy state registrar. No delayed certificate of birth shall be prepared for a person who is deceased.

A. Who may request the registration of and sign an application for a delayed birth certificate. Any person whose birth is not registered in this state, or his/her parent, or legal guardian, may request the registration of a delayed certificate of birth, subject to these regulations, evidentiary requirements and instructions issued by the state registrar. The application for each delayed certificate of birth shall be signed and sworn to before an official authorized to administer oaths, by the person whose birth is to be registered if such person is 18 years of age or over and is competent to sign and swear to the accuracy of facts stated therein; otherwise, the application shall be signed and sworn to by one of the following:

(1) one of the parents of the applicant for registration; or

(2) the legal guardian or court ordered custodian of the applicant for registration.

B. Facts to be established for a delayed registration of birth. The minimum facts which must be established by documentary evidence shall be the following:

(1) the full name of the person at the time of birth;

(2) the date of birth;

(3) the place of birth;

(4) the full maiden name of the mother; and

(5) the full name of the father, if paternity has been established pursuant to the Vital Records Act and related regulations or the Uniform Parentage Act.

C. Delayed registration following a legal change of status. When evidence is presented and accepted reflecting a legal change of status by adoption, legitimation, paternity determination, denial of paternity, or acknowledgment of paternity; an amended, delayed certificate may be established to reflect such change. The existing certificate and the evidence upon which the amended, delayed certificate was based shall be placed in a special file. Such file shall not be subject to inspection except upon order of a court or by the state registrar for purposes of properly administering the vital statistics program.

D. Documentary evidence requirements for delayed birth registration: To be acceptable for filing the following is needed to support a delayed registration of birth:

(1) to establish the name of the registrant; at least two pieces of documentary evidence;

(2) to establish the date of birth; at least two pieces of documentary evidence;

(3) to establish the place of birth; at least two pieces of documentary evidence.

(4) to establish facts of parentage; at least one piece of documentary evidence.

E. Documentary evidence - acceptability: The state registrar may establish a priority of the best evidence, and will determine the acceptability of any document submitted as evidence.

(1) Documents presented such as census, hospital, church and school records must be from independent sources and shall be in the form of the original record or a duly certified copy thereof.

(2) All documents submitted in evidence must have been established at least five years prior to the date of the first application for a delayed birth certificate, or have been established prior to the applicant's 10th birthday, and may not have been established for the purpose of obtaining a certificate.

(3) Affidavits of personal knowledge are not acceptable as evidence to establish a delayed certificate of birth.

(4) All documents submitted to support a delayed certificate of birth are subject to verification.

(5) If any fraudulent document is submitted in evidence, no delayed birth certificate shall be prepared, and the fraud manager shall be notified of the attempt.

(6) Examples of acceptable documentary evidence include but are not limited to the following:

(a) enrollment of service records;

(b) tribal records from tribal authorities;

(c) social security proof of application (NUMIDENT or SS 5 form);

(d) first application for marriage;

(e) first application for voter registration;

(f) medical records from a licensed hospital for a child five years and younger if the child was born in that facility and no other documentation is available.

(g) documents mentioned in Paragraph (1) of Subsection E of this section.

(7) Children five years or younger born outside of a licensed hospital without a midwife may not use the delayed birth registration process and must obtain an order from a court of competent jurisdiction to establish facts of birth pursuant to Section 24-14-16 NMSA 1978.

F. Documentary evidence - retention of copies, abstracts: The state registrar, or his or her designated representative, shall attach to the application for a delayed birth certificate, photo copies or an abstract and description of each document submitted to support the facts shown on the delayed birth certificate. All documents submitted in support of the delayed birth registration shall be returned to the applicant after review and use by the state registrar. The application and a copy of the documents submitted and accepted to support the delayed birth certificate shall be maintained in a permanent, confidential file.

If an abstract is used in lieu of photo copies it shall include the following information:

(1) the title or description of the document;

(2) the name and address of the custodian, if the document is an original or certified copy of a record;

(3) the date of the original filing of the document being abstracted;

(4) the information regarding the birth facts contained in the document.

G. Certification by the state registrar: The state registrar shall, by signature, certify that:

(1) no prior birth certificate is on file for the person whose birth is to be recorded;

(2) he or she has reviewed and accepted the evidence submitted to establish the facts of birth;

(3) the list of documents accepted as evidence which is entered on the delayed certificate of birth accurately reflects the documents accepted as evidence.

H. Rejection of applications for a delayed birth registration: If an applicant for a delayed registration of birth fails to submit the minimum documentary evidence required for a delayed registration of birth or if the state registrar finds reason to question the validity or adequacy of the certificate or the documentary evidence, the state registrar shall not register the delayed certificate and shall advise the applicant of the reason for such by final rejection letter, signed by the state registrar. The final rejection letter with notice of such will be deemed the rejection of the application and related certificate for purposes of Section 24-14-16 NMSA 1978. Applicants initially submitting evidence for a delayed certificate of birth may receive preliminary letters from the bureau requesting additional documentary evidence; such letters however shall not be considered the final rejection letter.

I. Court order for delayed certificates of birth. If an order from a court of competent jurisdiction to establish a delayed certificate of birth pursuant to Sections 24-14-15 and 24-14-16 NMSA 1978 is entered the state registrar shall require the applicant for the delayed certificate of birth to provide a duly certified copy of the court order and the related petition and supporting documents presented to the court to obtain such order, if the documents have not been previously received by the department. If the department was not given notice as required by statute of a hearing on a delayed birth certificate, the department and state registrar may seek legal redress.

J. Dismissal in six months: Applications for delayed certificates which have not been completed within six months from the date of initial application may be dismissed at the discretion of the state registrar. Upon dismissal, the state registrar shall so advise the applicant. A dismissal pursuant to this section shall not be considered a final rejection letter.

[7.2.2.10 NMAC - Rp, 7.2.2.10 NMAC, 12/27/2022]

7.2.2.11 THE CREATION OF AMENDED CERTIFICATES OF BIRTH FOLLOWING ADOPTION, LEGITIMATION, DENIALS OF PATERNITY AND ACKNOWLEDGEMENTS OF PATERNITY, AND OTHER LEGALLY RECOGNIZED DETERMINATIONS OF PARENTAGE:

A. Paternity: Upon receipt of a sworn acknowledgement of paternity signed by both parents, if no other person is shown as the father on the original certificate, a new certificate shall be prepared. A written request by both parents, if made within the 18

years of the child's birth, (unless acceptable proof is submitted that the mother is deceased, then by the father) that the minor child's surname be changed, and if no other person is shown as the father on the original certificate, a revised certificate shall be prepared. For a child aged 14 years or older, the child must give notarized consent to the change.

B. Court orders: If a person claims a change in paternity but cannot provide acknowledgement or denial of paternity as prescribed in the Uniform Parentage Act Section 40-11A-3 NMSA 1978, the person will be advised to seek a court adjudication of paternity.

C. An new certificate of birth shall be prepared by the state registrar for a child born in this state upon receipt of a certified copy of a court determination of parentage or other acceptable evidence of parentage as required by the state registrar pursuant to the provisions of the Vital Records Act and related regulations and the Uniform Parentage Act.

D. Creation of new certificate:

(1) The new certificate of birth prepared after adoption, a denial of paternity, legitimation, a determination of parentage, or an acknowledgement of paternity shall be prepared on the form in use at the time of its presentation, and shall include the following items and such other information necessary to complete the certificate:

(a) the name of the child;

(b) the date and place of birth as transcribed from the original certificate;

(c) the names and required personal information about the adoptive parent(s), the natural parent(s) or other legally recognized parents, whichever is applicable; and

(d) the original filing date.

(2) The information necessary to locate the existing certificate and to complete the amended certificate shall be submitted to the state registrar on a form prescribed by 7.2.2.8 NMAC.

E. Existing certificate - special filing of: Upon preparation of the amended certificate, the existing certificate and the evidence upon which the amended certificate was based shall be placed in a sealed file. Such file shall not be subject to inspection except upon order of a court of competent jurisdiction or by the state registrar for purposes of properly administering the vital statistics program.

[7.2.2.11 NMAC - Rp, 7.2.2.11 NMAC, 12/27/2022]

7.2.2.12 ADOPTION OF FOREIGN BORN:

A. Final Decree Requirements. On proof of adoption, a certificate of foreign birth shall be established by the state registrar for a person born in a foreign country who was not a citizen of the United States at the time of birth, provided the following conditions exist:

(1) the adopting parents are legal residents of New Mexico or members of the United States armed forces on active duty within the state of New Mexico;

(2) the child is adopted in New Mexico;

(3) a New Mexico court has issued an order recognizing the foreign adoption, if required;

(4) the department is provided a certified copy of the report of adoption and related court order;

(5) the final decree of adoption includes or is amended to include the following court findings:

(a) the probable country of birth;

(b) the year (and if known), the date and place of birth;

(c) a provision directing the state registrar to establish a certificate of birth.

B. Citizenship- limitations. The birth certificate form used by the state registrar in cases of foreign birth shall state on its face "this certificate is not evidence of United States citizenship."

C. Confidentiality. The evidence of adoption shall be sealed by the state registrar and shall not be subject to public inspection. The information shall be opened for inspection only upon court order, or upon the authorization of the state registrar in accordance with the Adoption Act.

D. Applicability. This section applies only to individuals born in foreign countries and who were neither born to U.S. citizens residing abroad nor naturalized as citizens prior to the adoption.

[7.2.2.12 NMAC - Rp, 7.2.2.12 NMAC, 12/27/2022]

7.2.2.13 REGISTRATION OF DEATH:

A. Registration.

(1) When a death occurs in this state, a certificate of death shall be filed through the state's approved electronic system within five days after the death and prior to final disposition.

(a) The medical certification of death must be completed in the state's approved electronic system by the individual responsible for the medical certification.

(b) The demographic section of the certificate od death must be completed in the state's approved electronic system by the funeral practitioner or the person acting as such.

(2) Cases completed by tribal and federal entities will have up to 30 days after the receipt of medical records or autopsy, including toxicology results, to complete the medical certification section of the certificate of death in the state's approved electronic system with manner and cause of death. If these entities need additional time to complete the medical certification, they must contact the registrar within 30 days of death to request an extension.

(3) Cases referred to the office of the medical examiner will have up to 30 days after the receipt of medical records or autopsy, including toxicology results, to complete the medical certification section of the certificate of death in the state's approved electronic system with a manner and cause of death other than "pending". If the office of medical examiner needs additional time to complete the medical certification with manner and cause of death, they shall contact the state registrar prior to the expiration of time to request an extension.

(4) Certificates of death for indigent cases referred to a county shall be completed by the county through the state's approved electronic system within 30 days of the indigent case assignment to the county.

(5) An extension of the required filing times for any portion of a certificate of death may be granted at the discretion of the state registrar to prevent undue hardship in accordance with Section 24-14-24 NMSA 1978.

(6) In all cases the medical certification must be signed by the person responsible for such certification. If the cause or manner of death is unknown or undetermined, each shall be listed as such on the certificate.

B. Incomplete certificate of death. If all the information necessary to complete the certificate of death is not available within the time prescribed for filing of the certificate, the funeral service practitioner shall file the certificate completed with all information that is available, and attach a note explaining why the incomplete items cannot be completed at the time of submission.

(1) The affidavit providing the information missing from the original certificate shall be filed with the state registrar as soon as possible, but in all cases within 30 days

of the date of the death occurred unless otherwise specifically approved by the state registrar.

(2) When the affidavit results in changes to the existing certificate of death, such affidavit shall be considered an amendment; the certificate of death shall be marked "amended," and the affidavit shall be attached to the original certificate which is retained by the bureau.

C. Amendment of a certificate of death. Unless otherwise provided for in these regulations, the certificate of death may be amended only in the following manner:

(1) Statistical items: non-medical statistical items, including but not limited to: ethnicity, education, race and occupation may be amended when new facts become available. The affidavit/change procedure described in Paragraphs (1) and (2) of Subsection B of 7.2.2.13 NMAC shall be used. Additional evidence may be required by the state registrar.

(2) Date of death, place of death, time of death, date pronounced, time pronounced, manner of death, and any portion of the cause of death may not be changed through the use of an amended certificate. These items shall only be changed by the preparation and filing of a medical affidavit signed by the certifier.

(3) The amendment of medically related items and items related to injury may only be submitted by the office of the medical investigator or equivalent military or tribal authorities and only on the form prescribed by the state registrar. Should the certificate of death be revised, resulting in changes of referenced material, the state registrar shall advise customary users of the certificate of the changes.

(4) An amendment of the marital status at time of death shall be made only if it is:

(a) requested by the person listed as informant on the certificate of death, upon completion of the prescribed notarized affidavit form and presentation of acceptable documentation proving marital status at the time of death.

(b) requested by the funeral practitioner who provides an affidavit that the information as filed with the bureau was inconsistent with the information provided to such practitioner by the informant; or

(c) accompanied by a certified copy of a district court order directing the change in marital status, along with a copy of the petition for such order and evidence submitted to the court in support of the requested amendment, if such information was not previously supplied to the bureau.

D. Certificate of death occurring in a hospital or other institution and not under the jurisdiction of OMI. When a death occurs in a hospital or other institution,

and the death is not under the jurisdiction of the office of the medical investigator, the person in charge of such institution, or his or her designated representative, may initiate the preparation of the certificate of death as follows.

(1) place the full name of the decedent and the date and place of death on the certificate of death, and obtain information on the method and place of disposition and enter on the disposition part of the certificate, and obtain from the certifier the medical certification of cause of death and the certifier's signature;

(2) present the partially completed certificate of death to the funeral service practitioner or person acting as such and advise them that they need to complete the missing items on the certificate and file it with the bureau of vital records and health statistics.

(3) for all deaths in which OMI assumes jurisdiction, including but not limited to a death without medical attendance and presumptive death, see OMI administrative rules at OMI 86-1.

E. Effect on other vital records.

(1) Upon death of a registrant, the registrant's birth certificate shall be marked with the word "deceased".

(2) If the death of an infant born alive occurs within two months of the date of the infant's birth, a family may receive one copy of a birth certificate without the "deceased" mark if the request is made with vital records state office within thirty days of the date of the infant's death.

(3) Unnamed birth certificates shall not be issued pursuant to this section. The child must be named at birth to obtain a birth certificate under this section.

(4) Amendments to a birth certificate, including but not limited to paternity, may not be made to a birth certificate after that registrant's death certificate is registered.

[7.2.2.13 NMAC - Rp, 7.2.2.13 NMAC, 12/27/2022]

7.2.2.14 DELAYED REGISTRATION OF DEATH:

The delayed registration of a death shall be registered in the manner prescribed below.

A. If the certifier, at the time of death and the attending funeral services practitioner or person who acted as such are available to complete and sign the certificate of death, it may be completed without additional evidence and filed with the state registrar. For those certificates of death filed one year or more after the date of death, the certifier or office of the medical investigator and the funeral service practitioner or person who

acted as such must state in accompanying affidavits that the information on the certificate of death is based on records kept in their files.

B. In the absence of the certifier or office of the medical investigator and the funeral service practitioner or person who acted as such, the prescribed delayed certificate of death form may be filed by the immediate family of the decedent and shall be accompanied by:

(1) an affidavit of the person filing the certificate swearing to the accuracy of the information on the certificate;

(2) two documents which identify the decedent and his or her date and place of death, a summary of which shall be placed on the certificate.

C. The state registrar may reject a certificate of death or require additional documentary evidence to prove the facts of death, or in his or her discretion refer the case to the office of the medical investigator.

[7.2.2.14 NMAC - Rp, 7.2.2.14 NMAC, 12/27/2022]

7.2.2.15 DISPOSITION OF REPORTS OF INDUCED TERMINATION OF PREGNANCY:

Reports of induced termination of pregnancy are statistical reports only and are not to be incorporated into the official records of the vital records and health statistics bureau, nor to be issued in any manner. The state registrar is authorized to dispose of the reports when all statistical processing of the records has been accomplished. However, the state registrar may establish a file of the records so they will be available for future statistical and research projects provided the file is not made a part of the official records and the reports are not made available for the issuance of certified copies. The file shall be retained for as long as the state registrar deems necessary, but in no case shall any report of induced termination of pregnancy be retained for longer than 18 months, and it shall then be destroyed. The file may be maintained by photographic, electronic, or other means as determined by the state registrar, in which case the original report from which the photographic, electronic or other file was made shall be destroyed. The provisions of Section 15 shall also apply to all records of induced termination of pregnancy filed prior to the adoption of this part.

[7.2.2.15 NMAC - Rp, 7.2.2.15 NMAC, 12/27/2022]

7.2.2.16 AUTHORIZATION FOR FINAL DISPOSITION:

A. Disposition of body. Before final disposition of a dead body or a fetus, the funeral service practitioner or person acting as such shall.

(1) Obtain assurance from the certifier that death is from natural causes and that the certifier will assume responsibility for certifying the cause of death or fetal death.

(2) For any case which comes under the jurisdiction of the office of the medical investigator, notify the office of the medical investigator and obtain authorization for removal and final disposition of a dead body or fetus.

B. Disposition of a dead body not under the supervision of a licensed New Mexico funeral service practitioner, direct disposer. When a death occurs in a hospital or other institution, and the disposition is not under the supervision of a licensed New Mexico funeral service practitioner, or direct disposer, the person in charge of such an institution or his or her designated representative shall:

(1) initiate the certificate of death or burial as follows:

(a) place the full name of the decedent and the date of death on the certificate of death registration form;

(b) obtain the information from the person to whom the body is being released and complete on the disposition section of the form the method and place of disposition; and

(c) obtain the medical certification of the cause of death from the certifier and the certifier's signature;

(2) obtain and verify through identification the full name and address of the person to whom the dead body is being released for disposition, and the place of disposition; and

(3) advise the person taking charge of the dead body of the statutory requirements to file the certificate of death registration form within 5 days, and prior to final disposition;

(4) send a photocopy of the partially completed certificate of death along with the name and address of the person who is not a funeral service practitioner, but who is acting as such, to the bureau of vital records and health statistics within five days;

(5) the original, partially completed copy of the registration form shall be completed by the person who is not a funeral service practitioner, but who is acting as such, to file within five days with the bureau of vital records and health statistics.

C. Filing of fetal death report. For any fetal death in which the fetus has attained at least twenty-week gestation or if gestational age is unknown, when the fetus weighs no less than 350 grams occurring in the state, a fetal death report shall be filed by the hospital, institution, physician, or, in the event the fetal death was unattended by any of

the former, by the office of the medical investigator within 10 days and prior to final disposition. If a fetal death occurs with a midwife in attendance, the office of the medical investigator must be notified since New Mexico law limits pronouncement of death to a physician, certified nurse practitioner, or the office of the medical investigator. If a funeral service practitioner is aware that a fetal death occurred without medical attention, the funeral services provider shall notify the office of the medical investigator to initiate the report of fetal death. In all circumstances, a fetal death report must be initiated before the fetus is released for disposition.

D. Authorization for disinterment and reinterment. An authorization for disinterment and reinterment of a dead body shall be issued by the state registrar or state medical investigator on the form prescribed, upon receipt of a written request from the immediate family and the person who is in charge of the disinterment or upon receipt of an order of a court of competent jurisdiction directing the disinterment. and a certified copy of the death certificate if the death did not occur in New Mexico. A disinterment/reinterment permit can only be issued to a licensed funeral service practitioner or direct disposer.

(1) Upon receipt of a court order or signed permission of the owner of the cemetery or burial ground, the state registrar or state medical investigator may issue one authorization to permit disinterment and reinterment of all remains in a mass disinterment. Insofar as possible, the remains of each body should be identified. The place of disinterment and reinterment shall be specified, including the cemetery name, the city, county and state of burial. The authorization shall be permission for disinterment, transportation and reinterment.

(2) Authorization shall be obtained from the state archaeologist for disinterment subject to the provisions of Section 18-6-11 NMSA 1978.

(3) A dead body properly prepared by an embalmer and deposited in a receiving vault shall not be considered a disinterment when removed from the vault for final disposition.

(4) No permit shall be issued for disinterment/reinterment of a dead body within the boundaries of a single cemetery, but notice of such should be provided to the immediate family of the decedent.

[7.2.2.16 NMAC - Rp, 7.2.2.16 NMAC, 12/27/2022]

7.2.2.17 AMENDMENT OF LIVE BIRTH AND DEATH CERTIFICATES:

This section is intended to supplement previous sections regarding the amendment of live birth and death records.

A. Who may apply to amend a certificate - birth and death.

(1) To amend a birth certificate, application may be made by both parents, the legal guardian or court ordered custodian, the registrant if 18 years of age or over, a legal representative for the registrant or parents, or the individual responsible for filing the original certificate. On any request not made by the registrant for a child age fourteen years of age or older, the child must sign the application or give notarized consent to the change unless an amendment has been issued by a court of competent jurisdiction, and Subsection D of 7.2.2.17 NMAC of these regulations applies. This excludes Subsection F of 7.2.2.17 NMAC.

(2) To amend a certificate of death, application may be made by the informant or the funeral service practitioner or person acting as such who signed the certificate of death. Applications to amend the medical certification of cause of death shall be made only by the certifier who signed the medical certification or the office of the medical investigator. Other requested amendments shall be in conformance with these regulations and the Vital Records Act.

B. Minor errors.

(1) Correction of minor errors by the state registrar of a birth or death certificate: Correction of obvious minor errors, transposition of letters in words of common knowledge, or omissions may be made by the state registrar either upon his or her own observation or query.

(2) Correction of minor errors may be made upon request of the parents, legal guardian, or court ordered custodian of the registrant during the first year after birth. The certified certificate shall not be marked "amended."

C. Amendments of first or middle name. Unless otherwise provided for in these regulations or in statute, all applications for amendment to change the first or middle name on a vital record shall be supported by.

(1) An affidavit setting forth information to identify the certificate; the incorrect data as it is listed on the certificate; the correct data as it should appear, together with two or more items of acceptable documentary evidence which support the alleged facts and which were established at least five years prior to the date of the first application for amendment. For individuals five years or younger, acceptable documentary evidence shall be at the discretion of the state registrar.

(2) When minor corrections are made by the state registrar, a notation as to the source of the information, together with the date the change was made and the initials of the authorized agent making the change shall be made on the computer file, but shall not become a part of any certificate issued.

(3) The state registrar shall evaluate the evidence submitted in support of any amendment, and when they find reason to doubt its validity or adequacy the amendment may be rejected and the applicant advised of the reasons for this action.

(4) The bureau may also amend a record upon receipt of a certified court order for a name change made pursuant to the provisions of Section 40-8-1 NMSA 1978.

D. Other amendments.

(1) any application for amendment to change a last name on a vital record, except as otherwise provided in these regulations, shall be accompanied by a certified order from a court of competent jurisdiction;

(2) upon the receipt and acceptance of an acknowledgment of paternity affidavit, vital records will add the adjudicated father and if requested on the affidavit, the name of the child;

(3) amendment to the date of birth on a birth certificate shall be addressed as follows:

(a) the day of birth can be corrected with an affidavit upon proper submission of acceptable documentary evidence as long as the day of birth is not after the date the certificate is originally filed;

(b) changes to the month and year of birth shall be at the discretion of and in a manner prescribed by the state registrar; or

(c) as stated in a certified order by a court of competent jurisdiction.

(4) No name may be removed from a vital record without a court order;

(5) No amendments may be made to a birth certificate after the registrant is deceased without a court order.

(6) Any amendment to a vital record not addressed in these regulations shall be at the discretion of and in the manner prescribed by the state registrar.

E. Addition of given names - birth certificates. Given names, for a child whose birth was recorded without given names, may be added to the certificate upon written request of the registrant; or

(1) both parents; or

(2) the mother in the case of a child with no legally recognized father; or

(3) the father in the case of the death or incapacity of the mother; or

(4) the mother in the case of the death or incapacity of the father; or

(5) the guardian or agency having evidence of legal custody of the registrant; or

(6) any other legally recognized parent, legal guardian or court ordered custodian of a minor; or

(7) upon the receipt of an order by a court of competent jurisdiction.

F. Amendment of gender.

(1) A registrant if 18 years of age or older, born in New Mexico, or a registrant's parent, guardian, or legal representative, may amend the birth certificate to indicate a designated gender by providing the following:

(a) a completed gender designation change form provided by the bureau, along with a birth search application form;

(b) the statutorily required fee for the revision of a vital record pursuant to the New Mexico Vital Statistics Act. This fee shall include one certified copy of the amended record;

(c) a certified copy of an order from a court of competent jurisdiction changing the name of the registrant if applicable.

(2) Upon receipt of the required documentation, the gender designation will be changed to indicate male, female, or X.

(3) On any request not made by the registrant for a child age fourteen years of age or older, the child must sign the application or give notarized consent to the change unless an amendment has been issued by a court of competent jurisdiction.

G. Amendment of the same item more than once. Once an amendment of an item is made on a vital record, that item shall not be amended again except upon receipt of a certified court order.

H. When an applicant or informant does not submit the minimum documentation required in the regulations for issuing or amending a vital record, or when the state registrar has reasonable cause to question the validity or adequacy of the applicant's sworn statements or the documentary evidence submitted, the state registrar shall not issue or amend the vital record and shall advise the applicant of the reason for the action.

[7.2.2.17 NMAC - Rp, 7.2.2.17 NMAC, 12/27/2022]

7.2.2.18 CERTIFICATES OF STILL BIRTH:

A. Form of Fetal Death Report: The state registrar shall prescribe the form and content of a spontaneous fetal death report.

B. Application: The state registrar shall prescribe the form and content of an application for a certificate of still birth which shall specify the information necessary to prepare the certificate.

C. Form of certificate of still birth: The state registrar shall prescribe the form of a certificate of still birth and such form shall be distinct from the form for a certificate of live birth.

(1) A certificate of still birth shall include the state file number of the corresponding spontaneous fetal death report.

(2) The certificate of still birth shall contain the phrase *"This certificate of still birth cannot be used as proof of a live birth or for any other purpose"*.

D. Information on certificate of still birth: If requested, the state registrar shall create a certificate of still birth based on the information contained in a report of spontaneous fetal death filed with the bureau in accordance with New Mexico law. The items listed in Section 24-14-22 1978 NMSA are not limited and may include the name of the father or second parent if the woman was married at the time of delivery or within 300 days. If the mother is not married, then the name of the biological father of the fetus can be added by completing an Acknowledgement of Paternity form.

E. Who may request a certificate of still birth: Only a person designated as a parent on a report of spontaneous fetal death may request and receive a certificate of still birth pertaining to that spontaneous fetal death.

F. Cost: Certificates of still birth will be issued upon receipt of the statutory fee to the requesting parent.

G. Amendments: The bureau will not accept or process requests for substantive amendments to a certificate of still birth. Minor or clerical errors may be remedied if information on the application for a certificate of still birth differs from the report of spontaneous fetal death filed with the bureau.

H. Retroactivity: The bureau shall create certificates of still birth for still birth events that occurred from January 1980 forward if a report of spontaneous fetal death was filed with the bureau. The bureau does not have information to create certificates of still birth for still birth events prior to January 1980. If data held by the bureau for the creation of retroactive certificates of still birth is incomplete, supplemental information may be provided by the mother at the time of application for a retroactive certificate and such information will be accepted at the discretion of the state registrar.

I. Retention of fetal death reports: Spontaneous fetal death reports filed after the finalization of this rule Section 7.7.2.18 NMAC shall be maintained as permanent records of the bureau. Spontaneous fetal death reports filed prior to the finalization of this rule, 7.2.2.18 NMAC, but maintained by the bureau pursuant to 7.2.2.15 NMAC (prior to amendment) shall be permanently maintained by the bureau to support the creation of retroactive certificates of still birth.

[7.2.2.18 NMAC - Rp, 7.2.2.18 NMAC, 12/27/2022]

7.2.2.19 RECORD PRESERVATION AND DESTRUCTION:

When an authorized reproduction of a vital record has been properly prepared by the state registrar and when all steps have been taken to ensure the continued preservation of the information, the record from which the authorized reproduction was made may be disposed of by the state registrar. The record may not be disposed of, however, until the quality of the authorized reproduction has been tested to ensure that acceptable certified copies can be issued and until a security copy of the document has been placed in a secure location removed from the building where the authorized reproduction is housed. When no longer required for administrative use, the state registrar shall offer the original documents from which the authorized reproductions are made to the state records center and archives which shall be allowed to permanently retain the records pursuant to the restrictions in the vital statistics law and regulations related to access to such records. If the state records center and archives does not wish to place the records in its files the state registrar shall be authorized to destroy the documents upon receipt of written permission from state records and archives. The destruction shall be by approved methods for disposition of confidential or sensitive documents.

[7.2.2.19 NMAC - Rp, 7.2.2.19 NMAC, 12/27/2022]

7.2.2.20 DISCLOSURE OF RECORDS:

A. To protect the integrity of vital records the state registrar or other authorized custodian of vital records shall not permit inspection of, nor disclose information contained in vital statistics records, or copy or issue a copy of all or part of any vital record unless he or she is satisfied that the applicant has a direct and tangible interest in the record.

(1) The registrant, a member of the registrant's immediate family, the registrant's legal guardian or court ordered custodian, or any of their respective legal representatives, or an official of a federal or state government or of a political subdivision of the state charged by law with detecting or prosecuting crime, shall be considered to have a direct and tangible interest. Others may demonstrate a direct and tangible interest at the discretion of the registrar by providing certified documentary proof of such interest.

(2) The term "legal representative" shall include an attorney, executor of the estate, physician, funeral service practitioner, trust officer or other corporate fiduciary or other authorized agent acting on behalf of the registrant or his or her family.

(3) The natural parents of adopted children, when neither has custody, and business firms or other agencies requesting listings of names and addresses shall not be considered to have a direct and tangible interest.

B. The state registrar may permit the use of data from vital statistics records for statistical or research purposes, subject to those conditions the state registrar may impose. No data shall be furnished from records for research purposes until the state registrar has prepared or accepted, in writing, the conditions under which the records or data will be used, and the estimated or actual charges therefore and has received an agreement signed by a responsible agent of the agency or research organization agreeing to meet with and conform to the conditions.

C. The state registrar in their discretion may disclose copies or data from vital statistics records in accordance with the Vital Records Act and to federal, state, county, or tribal governments, or municipal agencies of government which the request data in the conduct of their official duties, except that any costs incurred by the bureau shall be the responsibility of the receiving agency.

D. Information from vital statistics records indicating a birth occurred to an unmarried woman may be disclosed only if it can be shown that disclosure of the information will be of benefit to the registrant.

E. The state registrar or authorized local custodian shall not issue a certified copy of a record until a signed application has been received from the applicant. Whenever the state registrar shall deem it necessary to establish an applicant’s right to information from a vital record, the state registrar or local custodian may also require acceptable identification of the applicant or a sworn statement.

F. Nothing in this part shall be construed to permit disclosure of information contained in the "information for medical and health use only" section of the birth certificate unless specifically authorized by the state registrar for statistical or research purposes.

G. When 100 years have elapsed after the date of birth, provided the registrant is deceased, or 50 years have elapsed after date of death, the records in the custody of the state registrar shall become public records and any person may obtain copies of the record upon submission of an application containing sufficient information to locate the record and the payment of the proper fee.

H. No person except the parent or parents designated on a report of spontaneous fetal death shall be considered to have direct and tangible interest concerning that record of spontaneous fetal death and any resulting certificate of still birth.

[7.2.2.20 NMAC - Rp, 7.2.2.20 NMAC, 12/27/2022]

7.2.2.21 VITAL RECORDS: FORM AND REPRODUCTION OF RECORDS, VERIFICATION AND FRAUD:

A. Reproduction of records. Copies of vital records may be made by mechanical, electronic, or other reproductive process, except that the information contained in the "information for medical and health use only" section of the birth certificate shall not be included, except as provided by statute or regulation.

B. Form of records. The format of all certificates shall be at the discretion of the state registrar. Each non-memorial certificate to be authentic shall contain the seal of the state of New Mexico, the signature of the state registrar or authorized delegate, and a certification as prescribed.

C. Verification. Confidential verification of the facts contained in a vital record may be furnished by the state registrar to any federal, state, county or municipal government agency, or to any other agency representing the interest of the registrant, subject to and any limitations as provided for in these regulations. Verifications shall be on forms prescribed and furnished by the state registrar, or on forms furnished by the requesting agency and acceptable to the state registrar; or, the state registrar may authorize the verification in other ways when it shall prove in the best interests of his or her office. Costs incurred in the provision of the verification shall be the responsibility of the receiving agency.

D. Fraud. When the state registrar finds evidence that a certificate was requested or registered through misrepresentation or fraud, he or she shall have authority to withhold the issuance of the certificate. If any certificate has already been issued and cannot be recalled, the state registrar shall tag the record for non-issuance, and notify all concerned agencies of the presumption of fraud.

[7.2.2.21 NMAC - Rp, 7.2.2.21 NMAC, 12/27/2022]

7.2.2.22 MISSING CHILD REPORTING:

Upon notification of the state registrar by a law enforcement agency that a child born in this state is missing, the record shall be flagged "M.C., do not issue" or electronically flagged.

A. Upon notification by a law enforcement agency that a child born outside this state is missing, the state registrar shall notify the corresponding officer in the state where the child was born that the child has been reported missing.

B. In response to any inquiry or request for a certificate, the state registrar or any appointed local registrar appointed by the state registrar shall not provide a copy of a birth certificate or information concerning the birth record of any missing child whose

record is flagged, except following the notification of the law enforcement agency having jurisdiction over the investigation of the missing child.

C. Upon notification by a law enforcement agency that a missing child has been recovered, the state registrar shall remove the flag from the child's birth record.

[7.2.2.22 NMAC - Rp, 7.2.2.22 NMAC, 12/27/2022]

7.2.2.23 FEES FOR COPIES, SEARCHES AND OTHER SERVICES:

No copy of a birth certificate or certificate of death shall be issued until the fee for the copy is received unless specific approval has been obtained from the state registrar or otherwise provided for by statute or regulation.

A. Each search for a birth certificate, death certificate, or certificate of still birth will be conducted upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978. The fee shall include one certified copy of the record, if available, and if no record is found the fee shall be non-refundable.

B. Delayed birth or death registration. A delayed record will be created upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978, and shall include one certified copy of the delayed record.

C. An individual may have all fees waived by signing a form approved by the bureau attesting to the fact that they are homeless at the time of the request.

D. Amendments.

(1) Minor corrections. For the amendment of a record due to obvious errors, omissions on birth records (other than the name of the father), or transposition of letters in words of common knowledge, there shall be no charge.

(2) Major corrections. For the amendment of a record requiring the creation of an affidavit of correction or the submission of documentary evidence to support a change or correction to a record, the amendment will be made upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978, and shall include one certified copy of the amended record.

E. Multiple copies. Additional copies, after those provided for in Subsections A. and B., and Paragraph (2) of Subsection C, of this section will be provided upon receipt of the statutorily required fee pursuant to Section 24-14-29 NMSA 1978.

F. Other. For any statistical research, other agency verification, data provision service or permit not specified in statute, the state registrar shall determine the fee for service on the basis of the costs of providing such services and determine the manner in which such costs must be paid.

G. Unnamed birth certificates: Birth certificates that were registered without a given name for the registrant will not be issued until the registrant is named, except to a government agency for their administrative use for a pending adoption of the child.

H. Administrative closures: All orders that have not been completed will be closed within six months of no activity and a new request must be made after an administrative closure. No fees will be returned or applied to the new request after an administrative closure.

[7.2.2.23 NMAC - Rp, 7.2.2.23 NMAC, 12/27/2022]

7.2.2.24 COURT ORDERS:

A. Court orders received by the bureau which order the amendment or creation of a vital records which are inconsistent with information known or maintained by the bureau may require the formal or other challenge of such if the bureau was not given notice of the related hearing or otherwise made aware of the proceeding prior to receiving the court order or was not provided with supporting documentary evidence relied on by the court to support its findings. Such action is necessary to protect the integrity and accuracy of the vital records held by the state registrar pursuant to state law.

B. The bureau will work cooperatively with tribal courts and authorities to meet the requirements of state law and the needs of the tribes.

C. Changes contained in a court order are only applicable to the person or persons specifically mentioned in the court order. A court ordered name change is only applicable to the registrant and will not operate as a method to amend any other vital record unless otherwise specified in the order.

[7.2.2.24 NMAC - Rp, 7.2.2.25 NMAC, 12/27/2022]

7.2.2.25 NAMING:

For all parts of this section, any document in which a name is created or amended, the name given must comply with the following requirements:

A. must include a first and last name;

B. must be a full name and may not include initials;

C. may not be obscene, offensive, bizarre, or unduly lengthy;

D. may not be used for fraudulent purposes; and

E. may only use the 26 letters of the English alphabet and may not contain characters except hyphens, apostrophes, and periods.

[7.2.2.25 NMAC - N, 12/27/2022]

7.2.2.26 REPORTING; MEDICAL AID IN DYING:

A. A healthcare provider who prescribes medical aid in dying medication to an individual must fully complete the designated online form as soon as possible but in no case later than 30 days of issuing the prescription. The submitted form will be assigned a number for administrative purposes, and the form number will be sent to the healthcare provider who completed the designated form. The current version of the medical aid in dying reporting forms will be available for completion on the department website.

B. If after making reasonable efforts within 30 days of issuing the prescription, the healthcare provider is not aware of whether the prescription has been ingested, or if the prescription has not yet been ingested, the provider must complete the designated online form and mark either "not yet ingested" or "unknown".

C. If a healthcare provider marks "not yet ingested" or "unknown" on the form, the healthcare provider must update that information online using the number assigned on the original form within 6 months of issuing the prescription. "Unknown" will not be accepted on the updated form. The department will send a reminder to the healthcare provider if an update has not been provided within 4 months of the initial online form submission.

[7.2.2.26 NMAC, 12/27/2022]

PART 3: PUTATIVE FATHER REGISTERY

7.2.3.1 ISSUING AGENCY:

Department of Health, Public Health Division, Bureau of Vital Records and Health Statistics.

[10/31/96; Recompiled 10/31/01]

7.2.3.2 SCOPE:

These regulations provide a process to protect the parental rights of fathers who affirmatively assume responsibility to children they have fathered and to expedite the adoption of children whose biological fathers have not assumed responsibility for their children. A listing in the registry does not replace or supersede the acknowledgment of paternity provisions of the vital statistics regulations (7 NMAC 2.2) [now 7.2.2 NMAC].

[10/31/96; Recompiled 10/31/01]

7.2.3.3 STATUTORY AUTHORITY:

The regulations set forth here are promulgated by the secretary of health by the authority of Sections 24-1-3, 24-1-5 and 9-7-6 and implements the Putative Father Registry (Section 32A-5-20 NMSA 1978) and shall be known as the Putative Father Registry Regulations.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.4 DURATION:

Permanent.

[10/31/96; Recompiled 10/31/01]

7.2.3.5 EFFECTIVE DATE:

10-31-96, unless a later date is cited at the end of a Section or Paragraph.

[10-31-96; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.2.3.6 OBJECTIVE:

These regulations are promulgated pursuant to statute for the purpose of installing, maintaining and operating the putative father registry. The purpose of the putative father registry is to protect the parental rights of fathers who affirmatively assume responsibility for children they may have fathered and to expedite adoption of children whose biological fathers are unwilling to assume responsibility for their children by registering with the putative father registry or otherwise acknowledging their children. The registry does not relieve the obligation of mothers to identify known fathers. The registry does not replace the filing of an acknowledgment of paternity.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.7 DEFINITIONS:

As used in these regulations:

A. "Bureau" means the bureau of vital records and health statistics, which was formerly and in statute referred to as the vital statistics bureau. (Vital Statistics Act, Section 24-14-1 et sequens NMSA 1978 as amended)

B. "Putative father registry" is a registry of the fathers who affirmatively assume or who have been ordered by the court to assume responsibility for children they have

fathered and whose names and other information have been entered into the registry pursuant to Section 32A-5-20 NMSA 1978.

C. "State registrar" means the person appointed under Section 24-14-4 NMSA 1978 of the Vital Statistics Act to fulfill the duties defined in Section 24-14-5 of the Act.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.8 LOCATION OF THE REGISTRY AND AUTHORITY FOR ITS OPERATION:

The putative father registry shall be located in the bureau. The state registrar shall be responsible for its installation, operation and maintenance.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.9 WHO SHALL BE ENTERED INTO THE REGISTRY:

The names, addresses and other required information of only the following persons shall be recorded in the registry:

A. any person adjudicated by a court of this state to be the father of a child; or

B. any person who has filed with the registry, before or after the birth of a child out-of-wedlock, a notice of intent to claim paternity of the child; or

C. any person who has filed with the registry an instrument acknowledging paternity; or

D. any person adjudicated by a court of another state or territory of the United States to be the father of an out-of-wedlock child, when a certified copy of the court order has been filed with the registry.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.10 WHO SHALL NOT BE ENTERED INTO THE REGISTRY:

Persons filing an affidavit of paternity with the bureau under the provisions of the Vital Statistics Act or any other legislation or regulations promulgated therefor will not be recorded in the registry unless they meet the requirements set forth in Section 9 [now 7.2.3.9 NMAC] or specifically request their inclusion in the registry under Sections 9.2 - 9.4 [now Subsections B - D of 7.2.3.9 NMAC] of the regulations governing the putative father registry. Requestors must provide all information required by these regulations on a form provided for that purpose by the state registrar.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.11 FILING AN ACKNOWLEDGMENT OF PATERNITY WITH BUREAU DOES NOT ENTER NAME INTO PUTATIVE FATHER REGISTRY:

Persons filing an acknowledgment of paternity with the bureau under the Vital Statistics Act and regulations promulgated for the Act will not be entered into the putative father registry unless they meet the requirements set forth in Section 9.2 - 9.4 [now Subsections B - D of 7.2.3.9 NMAC] of these regulations and provide the requisite information described in Section 12 [now 7.2.3.12 NMAC].

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.12 HOW TO FILE WITH THE REGISTRY:

The following must be provided to the bureau by/for a person who is to be entered into the registry:

A. For a father who is being entered as a result of a court order, a certified copy of a court order from a court of competent jurisdiction ordering the inclusion of the father's name in the registry and the information called for in Section 12.3 [now Subsection C of 7.2.3.12 NMAC].

B. For affirmative requests from persons requesting inclusion in the registry, a signed notarized statement on a form provided by the bureau that he wishes to be entered into the registry and the information specified in Section 12.3 [now Subsection C of 7.2.3.12 NMAC] shall be provided.

C.

(1) The putative father's full name, complete address and complete telephone number; and

(2) The putative father's date of birth and place of birth, including state and county; and

(3) The date (or expected date) of birth of the child for whom the registrant is affirmatively assuming responsibility, the place (or expected place) of birth of the child and (if born) the child's full name; and

(4) The full maiden name of (and any other name which may be used by) the mother of the child, her date and place of birth if known and last known full address of the mother; and

(5) Other information as required by the state registrar to make retrieval of the information possible and to serve the ends for which the registry was created.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.13 CHANGE OF ADDRESS NOTIFICATION AND FORM:

It is the responsibility of the person filing with the registry to notify the bureau of any change of address on a form or in a format required by the bureau. All requested information necessary to link the addressee with the child shall be provided.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.14 REVOCATION OF INTENT TO CLAIM PATERNITY:

Any father who has filed a notice of intent to claim paternity with the registry (but not fathers entered as a result of a court order) may revoke his notice at any time by communicating his intent in writing to the registry on the form prescribed by the state registrar. Upon receipt by the registry of the notarized notice of revocation, the notice of intent to claim paternity shall be removed from the registry and deemed never to have been registered. Court orders finding paternity and acknowledgments of paternity filed under the Vital Statistics Act shall not be affected by this regulation (Section 24-14-1 et sequens).

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.15 SEARCH OF THE REGISTRY: FOR OTHER AGENCIES, COURTS, DEPARTMENTS, PETITIONER'S ATTORNEY OR MOTHER OF THE CHILD:

A. The department shall, upon request, provide the names and addresses of fathers listed with the registry to any court of competent jurisdiction, department that by law is authorized to take actions affecting the child's health safety or welfare, agency, the petitioner's attorney or the mother of the child.

B. The information shall not be divulged to any other person, except upon order of the court for good cause shown.

C. If the registry has not received a notice of intent to claim paternity or an acknowledgment of paternity, the department shall provide a written statement to that effect to the person making the authorized inquiry.

D. A search of the registry is not a search of records maintained under the Vital Statistics Act. Information relating to acknowledgments of paternity or court ordered paternities filed before July 1, 1993 under the Vital Statistics Act (Chapter 24-14-1 et seq. NMSA 1978) will not be a part of this search and information regarding these paternities shall not be released under these regulations. Acknowledgments of paternity filed after July 1, 1993 which are not accompanied by an affirmative request for inclusion in the registry and court ordered paternities which do not contain the information required by these regulations will not be included in the registry.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.16 FORMS:

Forms required to install, maintain and operate the registry will be developed solely by the bureau. The forms are the property of the bureau. Forms will be made available upon request to the bureau of vital records and health statistics, New Mexico department of health, P. O. Box 26110, Santa Fe, New Mexico 87502 or at any subsequent address where the registry is maintained.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.17 FEES:

There shall be no fee charged for registering or revoking the intent to claim paternity of a child nor shall there by any charge for individual forms requested by a prospective registrant.

A. The fees for the search of the registry shall be as follows:

(1) Fee for a normal search and reply: The fee for a normal search of the registry, completed within 10 working days of receipt if all information required to located therecord has been provided, will be twelve dollars ($12.00.)

(2) Fee for an expedited search: The fee for an expedited search, which will be competed within two working days, will be thirty-five dollars ($35.00). The cost of any credit card processing fee, overnight delivery charge, fax service, cost of additional information search or other service provided will be added to the thirty-five dollars ($35.00) fee.

B. Other fees: Any other fees required to install, maintain or operate the registry shall be established by the state registrar. Such fees shall be charged pursuant to a list of fees published on or before July 1st of each year.

C. Payment of fees: Payment of fees or estimated fees shall be made prior to the search of the registry, release of information or other service for which a fee is established. Fees may be paid by any method acceptable to the state registrar of vital records.

D. A service charge of $25.00 shall be imposed upon the maker of any dishonored check. No service shall be provided to any person or firm who has uncollectible obligations or who has failed to pay for prior services while those obligations to the state attorney general or any other party for collection at her discretion.

E. Fees collected in the provision of this service shall be paid to the bureau of vital records and health statistics. These fees shall be used to install, maintain and operate the registry and will be deposited into a bureau revenue account established for that purpose.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.18 PENALTIES:

Any person who intentionally and unlawfully releases information from the putative father registry to the public or makes any other unlawful use of the information in violation of the provisions of this section is guilty of a petty misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978.

[9/7/94, 10/31/96; Recompiled 10/31/01]

7.2.3.19 OTHER LAW AND REGULATIONS:

These regulations are subject to the provisions of the department of health's regulations governing the promulgation of regulations, regulations and statutes governing public access to department records and the Vital Statistics Act.

[9/7/94, 10/31/96; Recompiled 10/31/01]

CHAPTER 3: STATE MEDICAL INVESTIGATOR'S OFFICE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: POLICIES OF THE OFFICE OF THE MEDICAL INVESTIGATOR

7.3.2.1 ISSUING AGENCY:

Office of the Medical Investigator.

[Recompiled 10/31/01]

7.3.2.2 SCOPE:

[RESERVED]

[Recompiled 10/31/01]

7.3.2.3 STATUTORY AUTHORITY:

[RESERVED]

[Recompiled 10/31/01]

7.3.2.4 DURATION:

[RESERVED]

[Recompiled 10/31/01]

7.3.2.5 EFFECTIVE DATE:

[RESERVED]

[Recompiled 10/31/01]

7.3.2.6 OBJECTIVE:

This document is a compilation of the duties of the staff of the office of the medical investigator as outlined in the statutes of New Mexico and certain regulations of official agencies involved in death investigation. It discusses those policies that have been formulated under the supervision of the board of medical investigation to carry out the designated responsibilities of this office. It is intended to assist interested parties in understanding the basic structure of the New Mexico system of death investigation. John E. Smialek, M.D., Chief Medical Investigator.

[Recompiled 10/31/01]

7.3.2.7 DEFINITIONS:

[RESERVED]

7.3.2.8 DUTIES OF THE OFFICE OF THE MEDICAL INVESTIGATOR:

In all cases of reportable deaths as defined in this document, the OMI will:

A. receive all reports of sudden, unexpected or unexplained deaths;

B. respond to all sudden, unexpected or unexplained deaths;

C. in the absence of a physician, pronounce death;

D. take custody of the body and all articles on or near the body;

E. maintain the chain of custody of the body and all articles obtained therefrom;

F. conduct an investigation leading to the determination of the cause and manner of death;

G. obtain toxicology samples from the body when indicated, and arrange for necessary tests upon those samples that will aid in the determination of cause and

manner of death; maintain the proper chain of custody and evidence on those samples; store those samples for an appropriate period of time;

H. certify the cause and manner of death; forward written certification to designated agencies;

I. properly dispose of human remains through release to family or designated and authorized entities;

J. provide accurate identification of all human remains when possible;

K. cooperate with authorized agencies having involvement with death investigation;

L. provide professional, objective testimony in state and local courts of law;

M. define procedures that establish fees for services and material provided by the office of the medical investigator;

N. define procedures to reimburse all parties providing services to the office of the medical investigator;

O. establish and maintain a disaster plan outlining the role of OMI staff;

P. maintain records of each official death investigation and provide reports to official agencies.

[Recompiled 10/31/01]

7.3.2.9 ADMINISTRATION - ORGANIZATION:

A. Citations and regulations:

(1) 24-11-1 NMSA 1978 - There is created the "board of medical investigators" consisting of the dean of the medical school at the university of New Mexico, the secretary of health and environment, the chief of the state police and the chairman of the state board of thanatopractice of the state of New Mexico. The members of the board of medical investigators shall receive no compensation for their services as board members other than as provided in the Per Diem and Mileage Act [10-8-1 to 10-8-8 NMSA 1978].

(2) 24-11-2 NMSA 1978:

(a) The board of medical investigations shall meet at least annually and as often as necessary to conduct the business of the board. Additional meetings may be called by the chairman or by a majority of the members of the board.

(b) At the first annual meeting of the board, the members shall elect one of their number as chairman.

(c) The board of medical investigations shall formulate broad policy for the operation of the office of the state medical investigator and the offices of the district medical investigators.

(d) The board of medical investigations shall employ and fix the compensation of a qualified state medical investigator who shall be assigned as an employee of the university of New Mexico school of medicine.

(3) 24-11-3 NMSA 1978:

(a) The state medical investigator shall be a physician licensed to practice in New Mexico. Insofar as practicable, the medical investigator shall be trained in the fields of pathology and forensic medicine.

(b) The state medical investigator shall maintain his office at the school of medicine at the university of New Mexico.

(c) The state medical investigator shall appoint district medical investigators and, where necessary, deputy medical investigators who shall serve at his pleasure. The state medical investigator may assign deputy medical investigators to districts to work under the supervision of a district medical investigator. The district medical investigator shall be a licensed physician. When deemed necessary by the state medical investigator, he may direct a deputy or district medical examiner to enter another district for the purpose of carrying out medical investigations.

(d) Any district created by the state medical investigator to be staffed by a district medical investigator shall be co-extensive with one or more counties.

(e) The state medical investigator may enter into agreements for services to be performed by persons in the cofurse of medical investigations.

(f) The state medical investigator shall, subject to the approval of the board of medical investigations, promulgate rules and regulations for the proper investigation of deaths occurring within this state.

(g) The state medical investigator shall maintain records of the deaths occurring within this state which are investigated by either state or district medical investigators.

(h) In addition to other duties prescribed in this section, the state medical investigator shall also serve as the district medical investigator for Bernalillo county.

(i) Funds for the operation of the state and district medical investigators' offices shall be appropriated to and administered by the university of New Mexico school of medicine.

B. Policy: Board of medical investigators: By statute, four individuals sit on this board and convene when required for development of matters of policy. The members are the dean of the school of medicine, university of New Mexico; the secretary of health and environment; the chief of the New Mexico state police; and the chairman of the New Mexico state board of thanatopractice. The board appoints the state medical investigator. Certain positions are described in the statute.

(1) State medical investigator: A licensed physician appointed by the board responsible for developing the rules and regulations for the proper investigation of deaths occurring within the state of New Mexico.

(2) Medical investigator: A forensic pathologist who assists the state medical investigator in the performance of his duties.

(3) District medical investigator: A licensed physician appointed by the state medical Investigator who is responsible for directing the investigations within a particular district in which they practice. This physician is responsible for the certification of death of those OMI cases within his district that remain in that district. This physician is appointed by and serves as requested by the state medical investigator. He is called for assistance in OMI cases and is reimbursed for each case in accordance with the fee schedule maintained by the central office.

(4) Medical investigator district: An area designated by the state medical investigator that generally coincides with boundaries of the respective judicial districts.

(5) Designated pathologist: A licensed physician who is state certified and duly qualified as a pathologist and is appointed by the state medical Investigator. This physician conducts those examinations within his jurisdiction as directed by the state medical Investigator, reporting those findings to the central office of the OMI. Reimbursement for each case is in accordance with the fee schedule maintained by the central office.

(6) Deputy medical investigator: A lay individual appointed and trained by the OMI who responds to the scenes of reportable deaths in order to perform the duties enumerated by law. This individual is specially trained in essential aspects of forensic medicine and death investigation. Deputy medical investigators are required to be available to respond to the scene of an OMI jurisdictional death. More than one deputy medical investigator can be assigned to a district. Deputy medical investigators may also serve as full-time employees who, in addition to performing the stated duties of the deputy medical investigator, perform specialized duties required in the central office. Annual review and biannual training are required for continued certification.

(7) Central office: The central office of the OMI was established within the university of New Mexico, school of medicine, in Albuquerque. The administrative office and repository of official records of the forensic pathology services are provided at this location.

[Recompiled 10/31/01]

7.3.2.10 REPORTING DEATHS:

A. Citations and Regulations:

(1) 24-11-5 NMSA 1978: When any person comes to a sudden, violent or untimely death or is found dead and the cause of death is unknown, anyone who becomes aware of the death shall report it immediately to law enforcement authorities or the office of the state or district medical investigator. The public official so notified shall in turn notify either, or both, the appropriate law enforcement authorities or the office of the state or district medical investigator. The state or district medical investigator, or a deputy medical investigator under his direction, shall, without delay, view and take legal custody of the body.

(2) 24-11-10 NMSA 1978:

(a) It is unlawful to:

(i) wilfully and without good cause neglect or refuse to report a death to law enforcement authorities or the office of the state or district medical investigator as required by law; or

(ii) willfully and unnecessarily touch, remove or disturb any dead body required by law to be reported to the state or district medical investigator, or any article on or near the body or disturb its surroundings until authority is granted by the state, district or deputy medical investigator.

(b) Any person violating this section is guilty of a petty misdemeanor.

(3) Physicians' Handbook on Medical Certification: Death, Birth, Fetal Death. U.S. Department of Health, Education, and Welfare, DHEW Publication No. (PHS) 78-1108, Section IId.

B. POLICY:

(1) Responsibility for Reporting: Anyone who becomes aware of any death falling into the category enumerated here under "Reportable Deaths" must report it immediately to either law enforcement officers or to a representative of the office of the medical investigator. It will be the responsibility of that agency to notify the other of the report. The designated representative of the OMI shall then respond to that scene of

death without delay, view and take legal custody of the body. See Section D [now 7.3.2.11 NMAC] for responsibilities of representatives of the OMI.

(2) Reportable deaths: Those deaths to be reported to the office of the medical investigator include all deaths occurring in New Mexico as outlined below regardless of where or when the initial injuring event occurred.

(a) any death that occurs suddenly and unexpectedly, that is, when the person has not been under medical care for significant heart, lung or other disease;

(b) any death suspected to be due to violence, that is, suicidal, accidental or homicidal injury, regardless of when or where the injury occurred;

(c) any death suspected to be due to alcohol or intoxication the result of exposure to toxic agents;

(d) any deaths of residents housed in county or state institutions, regardless of where death occurs. This refers to any ward or individual placed in such a facility by legal authorization;

(e) any deaths of persons in the custody of law enforcement officers;

(f) any deaths in nursing homes or other private institutions without recent medical attendance;

(g) any deaths that occur unexpectedly during, in association with, or as a result of diagnostic, therapeutic, surgical, or anesthetic procedures;

(h) deaths alleged to have been caused by an act of malpractice;

(i) deaths suspected to be involved with the decedent's occupation;

(j) deaths unattended by a physician;

(k) any death due to neglect;

(l) any still birth of 20 or more weeks' gestation unattended by a physician;

(m) any death of an infant or child where the medical history has not established some pre-existing medical condition;

(n) deaths which are possibly directly or indirectly attributable to environmental exposure not otherwise specified;

(o) any death suspected to be due to infectious or contagious disease wherein the diagnosis and extent of disease at the time are undetermined;

(p) any death occurring under suspicious circumstances;

(q) any death in which there is doubt as to whether or not it is a medical investigator's case should be reported;

(r) a list of reportable deaths will be provided to all state agencies, hospitals and other public and private facilities that require the services of the OMI.

C. Procedure for reporting death: Deputy medical investigators are assigned by the central office of the OMI to be the responders and investigators to and of the reports of all sudden, unexpected and unexplained deaths. A list of these assignments is sent to the sheriff's office, chief of police, the local district attorney, funeral directors, and emergency medical personnel within each respective district. The central office of the OMI shall keep these lists current. Each district medical investigator, in conjunction with the central office of the medical investigator, shall determine appropriate on-call schedules for the deputy medical investigators, and shall provide that schedule to each of the agencies and offices cited above to provide each agency and office with the immediate means of notifying the OMI of a death included in the category of "Reportable Deaths". This list shall include the on-call deputy medical investigator, then shall show the names of any backup deputy medical investigators, then the name of the district medical investigator, and finally, the 24-hour telephone number of the central office of the OMI.

D. Jurisdiction: The OMI will respond and take custody of a body in those reportable deaths that occur within the state of New Mexico, excluding Indian reservations and military installations. On Indian reservations and military installations, the OMI will respond as investigative consultants when so invited and when reimbursed for the service as defined in a legal contract or by agreement. In cases where the event leading to the death occurs on state land, but the individual is taken to a federal facility for emergency treatment, and is pronounced dead there, the death is to be reported to the OMI representative if the circumstances of the event are reportable, as defined in this manual.

[Recompiled 10/31/01]

7.3.2.11 INVESTIGATION - SCENE OF DEATH:

A. Citations and Regulations:

(1) 12-2-4 NMSA 1978:

(a) For medical, legal and statutory purposes, death of a human being occurs when, and "death," "dead body," "dead person" or any other reference to human death means that:

(i) based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, there is no reasonable possibility of restoring respiratory or cardiac functions; in this event, death occurs at the time respiratory or cardiac functions ceased; or

(ii) in the opinion of a physician, based on ordinary standards of medical practice: a) because of a known disease or condition there is the absence of spontaneous brain function; and b) after reasonable attempts to either maintain or restore spontaneous circulatory or respiratory functions in the absence of spontaneous brain function, it appears that further attempts at resuscitation and supportive maintenance have no reasonable possibility of restoring spontaneous brain function; in this event death will have occurred at the time when the absence of spontaneous brain function first occurred. Death is to be pronounced pursuant to this paragraph before artificial means of supporting respiratory or circulatory functions are terminated and before any vital organ is removed for purposes of transplantation in compliance with the Uniform Anatomical Gift Act [24-6-1 to 24-6-9 NMSA 1978].

(b) The alternative definitions of death in Paragraphs 1 and 2 of Subsection A [now (i) and (ii) of Subparagraph (a) of Paragraph (1) of Subsection A of 7.3.2.11 NMAC] of this section are to be utilized for all purposes in this state, including but not limited to civil and criminal actions, notwithstanding any other law to the contrary.

(2) 24-11-5 NMSA 1978: When any person comes to a sudden, violent or untimely death or is found dead and the cause of death is unknown, anyone who becomes aware of the death shall report it immediately to law enforcement authorities or the office of the state or district medical investigator. The public official so notified, shall in turn notify either, or both, the appropriate law enforcement authorities or the office of the state or district medical investigator. The state or district medical investigator, or a deputy medical investigator under his direction, shall, without delay, view and take legal custody of the body.

(3) 24-11-9 NMSA 1978: The state, district or deputy medical investigator may administer and may issue a subpoena to compel the attendance and production of evidence by any necessary witness, and the subpoena may be enforced in the district court. Any subpoena shall be served without cost by the sheriff or any deputy or by any member of the New Mexico state police.

(4) 24-11-10 NMSA 1978:

(a) It is unlawful to:

(i) willfully and without good cause neglect or refuse to report a death to law enforcement authorities or the office of the state or district medical investigator as required by law; or

(ii) willfully and unnecessarily touch, remove or disturb any dead body required by law to be reported to the state or district medical investigator, or any article on or near the body or disturb its surroundings until authority is granted by the state, district or deputy medical investigator.

(b) Any person violating this section is guilty of a petty misdemeanor.

B. Policy:

(1) Pronouncement of death - OMI cases: When there is no physician present, the representative of the office of the medical investigator shall immediately pronounce death and shall provide the time of pronouncement to the law enforcement official present.

(2) Authority at the scene: At scenes of reportable deaths when the initial determination is that criminality exists, the police agency shall be primarily responsible for conducting the investigation at the scene. This investigation shall include the representatives of the office of the medical investigator who will view the scene and take appropriate photographs prior to disturbance of any item within the scene. Only when both the law enforcement official having jurisdiction and the OMI representative are satisfied that the investigation is complete enough to warrant moving the body shall the body then be examined by the OMI representative. During this examination, the representative of the OMI will provide as much information as possible to the law enforcement agency regarding a possible cause and manner of death. Nothing shall be done at this point that will taint, tamper with or disturb any item on the body that may subsequently require examination by a specified pathologist during the course of his external or internal examination. When the initial determination at a scene is that no criminality exists, the representative of the OMI shall assume primary responsibility and may direct the law enforcement agency to provide security for the scene. In cases of vehicular deaths, the law enforcement agency remains the primary investigator of the circumstances.

(3) Evidence at the scene: Any item deemed evidentiary by law enforcement definition, whether criminal charges exist or not, shall belong to that law enforcement agency having jurisdiction; such evidence at a death scene may be requested by the state medical investigator to accompany the body to aid in the examination and subsequent findings. The chain of custody is to be maintained and documented by the OMI, and all items shall be receipted back to that law enforcement agency. No item identified as evidence by a law enforcement agency shall remain in the custody of the state medical investigator longer than is required to examine that evidence.

(4) Preservation of the evidence: In assuming custody of a body, the OMI is authorized to remove anything that is on or in the body, to secure and analyze that material where appropriate, and to be responsible for the formal reporting of that analysis, the safekeeping of that material, and the receipting of that material to a law enforcement agency, where appropriate, for their retention and analysis. Specimens

retained by the OMI are held for specified periods of time. Prior to disposal, the respective district attorney is advised.

(5) Body not at the scene: When the body has been removed from the scene of the death for medical examination, the first responsibility of the representative of the OMI shall be to respond to the location of the body in order to pronounce death (if not performed by a physician) and to assume custody of the body. Any subsequent scene investigation is to be performed after the body is secured, sealed and held within a morgue facility or turned over to an authorized transport company. There will be cases where no scene investigation is possible.

(6) Removal from a scene: Only a representative of the OMI may order a body removed from the scene.

(7) Subpoena of records: A representative of the OMI may issue and serve a subpoena within the state of New Mexico for the production of evidence by any necessary witness.

[Recompiled 10/31/01]

7.3.2.12 INVESTIGATION - EXAMINATION:

A. Citations and Regulations:

(1) 24-11-7 NMSA 1978: If the deceased is unidentified, the state, district or deputy medical investigator may order the body fingerprinted and photographed. When the state, district or deputy medical investigator suspects a death was caused by a criminal act or omission or if the cause of death is obscure, he shall order an autopsy performed by a qualified pathologist certified by the state board of medical examiners who shall record every fact found in the examination tending to show the identity and condition of the body and the time, manner and cause of death. The pathologist shall sign the report under oath and deliver it to the state, district or deputy medical investigator within a reasonable time. The state, district or deputy medical investigator may take the testimony of the pathologist and any other persons, and this testimony, combined with the written report of the pathologist, constitutes an inquest.

(2) 24-12-4 NMSA 1978:

(a) An autopsy or postmortem examination may be performed on the body of a deceased person by a physician or surgeon whenever consent to the procedure has been given:

(i) by written authorization signed by the deceased during his lifetime;

(ii) by authorization of any person or on behalf of any entity whom the deceased designated in writing during his lifetime to take charge of his body for burial or other purposes;

(iii) by authorization of the deceased's surviving spouse;

(iv) by authorization of an adult child, parent or adult brother or sister of the deceased if there is no surviving spouse or if the surviving spouse is unavailable, incompetent or has not claimed the body for burial after notification of the death of the decedent.

(v) by authorization of any other relative of the deceased if none of the persons enumerated in Paragraphs 2 through 4 [now (ii) through (iv) of Subparagraph (a) or Paragraph (2) of Subsection A of 7.3.2.12 NMAC] of this subsection are available or competent to give authorization; or

(vi) by authorization of the public official, agency or person having custody of the body for burial if none of the persons enumerated in Paragraphs 2 through 5 [now (ii) through (v) of Subparagraph (a) or Paragraph (2) of Subsection A of 7.3.2.12 NMAC] of this subsection are available or competent to give authorization.

(b) An autopsy or postmortem examination shall not be performed under authorization given under the provisions of Paragraph 4 of Subsection A [now (iv) of Subparagraph (a) or Paragraph (2) of Subsection A of 7.3.2.12 NMAC] of this section by any one of the persons enumerated if, before the procedure is performed, any one of the other persons enumerated objects in writing to the physician or surgeon by whom the procedure is to be performed.

(c) An autopsy or postmortem examination may be performed by a pathologist at the written direction of the district attorney or his authorized representative in any case in which the district attorney is conducting a criminal investigation.

(d) An autopsy or postmortem examination may be performed by a pathologist at the direction of the state, district or deputy medical investigator when he suspects the death was caused by a criminal act or omission or if the cause of death is obscure.

B. Policy: The examination of the body is external only, or both external and internal.

(1) Criteria for examination: In cases where the office of the medical investigator has assumed jurisdiction, the representative of the OMI shall present the results of his initial investigation to the central office to determine whether further investigation is required in determining a cause and manner of death. In all cases where the OMI assumes jurisdiction, regardless of whether or not an autopsy is to be

performed, the viewing of the body and taking custody of the body sustains the validity and legality of any report generated by that individual representative of the OMI. In cases where it is determined that an autopsy is to be performed, all the documents produced by the representative of the OMI must accompany the body to the location of the autopsy. These documents, in particular the report of death, provide the authorization for the assigned pathologist to perform the autopsy. Reasons for which medicolegal autopsies are conducted include the following:

(a) determination of the cause and manner of death;

(b) establishment of the identity of the deceased;

(c) to aid in the discovery and prosecution of crime;

(d) protection of innocent persons accused of crime;

(e) disclosure of possible hazards to public health such as:

(i) dangerous drugs, chemicals, food;

(ii) communicable, contagious or infectious disease;

(iii) occupational disease,

(iv) environmental hazards.

(f) to aid in the administration of civil justice including:

(i) life and accident insurance questions;

(ii) worker's compensation liability;

(iii) other problems involving questions of civil liability.

(2) Authorization for autopsy: An autopsy under the jurisdiction of the OMI may be authorized by the state medical investigator or the district attorney. No other authorization or consent is required. Family objections will be considered but will not preclude an autopsy when it is clearly required to fulfill the OMI's legal responsibility. In OMI jurisdiction cases where an autopsy is not required to determine cause and manner of death, the attending physician or family may request that an autopsy be performed. In these cases, the autopsy may be performed at the direction of the attending physician after the family has signed the "Consent to Autopsy." A copy of the findings shall be supplied to the OMI.

(3) Autopsy not required: In cases where the investigator supplies adequate information indicating an autopsy is not required, the district or deputy medical

investigator will be advised by the OMI central office of the specific examination procedures to perform upon the body. Termed the "External Examination," the OMI investigator will observe the conditions of the body, document the findings with narrative, drawings and appropriate photographs, and extract from the body the specimens required to ultimately document a cause and manner of death. Specific step-by-step guidelines to this exam are included under "Examination" in the procedures manual.

[Recompiled 10/31/01]

7.3.2.13 CERTIFICATION OF DEATH:

A. Citations and Regulations:

(1) 24-11-6 NMSA 1978: If, after reviewing the body, notifying the law enforcement agency with jurisdiction and making an investigation, the state or district medical investigator is satisfied that the death was not caused by criminal act or omission and that there are no suspicious circumstances about the death, he shall execute a death certificate in the form required by law. He shall also execute a certificate on a form prescribed by the health and social services department [health and environment department], authorizing release of the body to the funeral director for burial. In those cases in which the investigation is performed by a deputy medical investigator, if, after viewing the body, notifying the law enforcement agency with jurisdiction and making an investigation, he is satisfied that the death was not caused by criminal act or omission and that there are no suspicious circumstances about the death, he shall report this finding to the state or district medical investigator under whose direction he is working. Upon receipt of a report from a deputy medical investigator under this subsection, the state or district medical investigator may execute a death certificate and a certificate authorizing release of the body for burial.

(2) 24-14-20 NMSA 1978:

(a) A death certificate for each death which occurs in this state shall be filed within five days after the death and prior to final disposition. The death certificate shall be registered by the state registrar if it has been completed and filed in accordance with this section, subject to the exception provided in Section 24-14-24 NMSA 1978; provided that:

(i) if the place is unknown, but the dead body is found in this state, a death certificate shall be filed with a local registrar within ten days after the occurrence. The place where the body is found shall be shown as the place of death. If the date of death is unknown, it shall be approximated by the state medical investigator; and

(ii) if death occurs in a moving conveyance in the United States, and the body is first removed from the conveyance in this state, the death shall be registered in this state and the place where the body is first removed shall be considered the place

of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in this state, the death shall be registered in this state but the certificate shall show the actual place of death insofar as can be determined by the state medical investigator.

(b) The funeral service practitioner or person acting as funeral service practitioner who first assumes custody of a dead body shall file the death certificate. He shall obtain the personal data from the next of kin or the best qualified person or source available. He shall obtain the medical certification of cause of death.

(c) The medical certification shall be completed and signed within forty-eight hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death except when inquiry is required by law. In the absence of the physician, or with his approval, the certificate may be completed and signed by his associate physician, the chief medical officer of the institution in which death occurred or the physician who performed an autopsy on the decedent, provided such individual has access to the medical history of the case, views the deceased at or after death and death is due to natural causes.

(d) When death occurs without medical attendance as set forth in Paragraph C of this section [now Subparagraph (c) of Paragraph (2) or Subsection A of 7.3.2.13 NMAC], or when death occurs more than ten days after the decedent was last treated by a physician, the case shall be referred to the state medical investigator for investigation to determine and certify the cause of death.

(e) An amended death certificate based on an anatomical observation must be filed within thirty days of the completion of an autopsy.

(3) 24-14-21 NMSA 1978:

(a) When a death occurring in this state has not been registered, a certificate may be filed in accordance with regulations of the board of medical investigators. The certificate shall be registered subject to evidentiary requirements as prescribed by regulation to substantiate the alleged facts of death.

(b) Certificates of death registered one year or more after the date of death shall be marked "delayed" and shall show on their face the date of the delayed registration.

(4) 24-14-24 NMSA 1978:

(a) The department may, by regulation and upon conditions as it may prescribe to assure compliance with the purposes of the Vital Statistics Act [24-14-1 to 2414-20 to 24-14-31 NMSA 1978], provide for the extension of the periods prescribed in Sections 24-14-20, 24-1423 NMSA 1978 for the filing of death certificates, spontaneous

fetal death reports, medical certifications of cause of death and for the obtaining of burial-transit permits in cases where compliance with the applicable prescribed period would result in undue hardship.

(b) Regulations of the department may provide for the issuance of a burial-transit permit prior to the filing of a certificate upon conditions designed to assure compliance with the purposes of the Vital Statistics Act in cases where compliance with the requirement that the certificate be filed prior to the issuance of the permit would result in undue hardship.

(5) 24-14-25 NMSA 1978:

(a) A certificate or report registered under the Vital Statistics Act [24-14-1 to 24-14-17, 24-14-20 to 2414-31 NMSA 1978] may be amended only in accordance with that act and regulations thereunder adopted by the department to protect the integrity and accuracy of vital statistics records.

(b) A certificate or report that is amended under this section shall be marked "amended," except as otherwise provided in this section. The date of the amendment and a summary description of the evidence submitted in support of the amendment shall be endorsed on or made a part of the record. The department shall prescribe by regulation the conditions under which additions or minor corrections may be made to certificates or records within one year after the date of the event without the certificate or record being marked "amended."

B. Policy: The certificate of death is the permanent record required by the bureau of vital statistics of the New Mexico department of health and environment. The office of the medical investigator is responsible for the completion of the certificate in all deaths reported to that office in which jurisdiction is assumed. This certification is to the cause (the anatomic condition causing death) and the manner (accident, suicide, accidental, homicide). The cause and manner of death shall be finally determined by the designated pathologist, in accordance with the findings and recommendations of the district and deputy medical investigators.

(1) Time limit for completion: The certificate (relating to a decedent at the central office), when completed by the pathologist assigned to the central office, shall be completed and released with the body. Where toxicology results are not available, a letter indicating that the case is pending shall be sent with the body. The certificate of death for all reportable deaths where the body is not brought to the central office must be completed immediately by the district medical investigator of that district and provided to the funeral director chosen by the family.

(2) Place of death unknown: The place where the body is found shall be the place of death. If the date is unknown, it may be approximated by the state medical investigator.

(3) Body in moving conveyance: If the body is in a moving conveyance on land and is first removed in this state, this state shall be considered the place of death. If the body is in a moving conveyance in international waters or air space, or in a foreign country, and the body is removed in this state, death is to be registered in this state, but certification can show the actual place of death if it can be determined by the state medical investigator.

(4) Death without medical attendance: A death occurring without medical attendance, including hospice cases, are reported to the office of the medical investigator. The office of the medical investigator shall certify the cause of death only in those cases in which the OMI retains jurisdiction. In all such unattended cases where the physician of record will certify to the cause of death, the OMI shall not prepare the certificate of death.

(5) Presumptive death: In cases where no body is located following a witnessed fatal event, an order issued by the court in which the presumed death occurred must be presented to the OMI in order for the death certificate to be issued.

(6) Amended death certificate: Amended death certificates based on anatomical observation must be filed within 30 days after completion of the autopsy.

[Recompiled 10/31/01]

7.3.2.14 RECORDS:

A. Citations and Regulations:

(1) 24-11-6 NMSA 1978 B: In those cases where the death resulted from a motor vehicle accident on a public highway, and the state, district or deputy medical investigator performs or causes to be performed a test or tests to determine the alcoholic content of the deceased's blood, a copy of the report of this test shall be sent to the planning division of the state highway department for the department's use only for statistical purposes. The copy of the report sent to the planning division of the state highway department of the results shall not contain any identification of the deceased and shall not be subject to judicial process.

(2) 24-11-8 NMSA 1978 - The state or district medical investigator shall promptly report his findings, or the findings of a deputy medical investigator that has performed an investigation under his direction, to the district attorney in each death investigated. Upon request of the district attorney, the state or district medical investigator shall send a complete record of the medical investigation in any case, including a transcript of the testimony of witnesses examined at any inquest.

(3) Memorandum: "Records of the office of the medical investigator" legal opinion, university of New Mexico legal counsel, September 1983: Public records:

Internal correspondence is protected by executive privilege; Records from other agencies are exempt.

(4) COMPLIANCE GUIDE - The Inspection of Public Records Act, Sections 14-2-1, to 14-2-3, NMSA 1978, state of New Mexico, office of the attorney general, September 30, 1980.

B. Policy: Records documenting the investigation and subsequent findings of those investigations of deaths reported to the OMI are prepared and stored and made available for appropriate and legitimate requests. The central OMI is the record repository, and all reports, investigative findings, slides and photography and any other material gathered during a death investigation anywhere in the state shall be forwarded to the central office. The information gathered in the course of these investigations is compiled at public expense. Therefore, any person having a legitimate cause for requesting specific reports or any information concerning the cause and manner of death, may do so from the central OMI and shall receive the reports after prepaying an administrative processing fee. Computer generated statistics are available upon legitimate request and prepayment of a designated fee. Internal correspondence, represented by reports, memoranda, opinions, photographs or other parts of a case file are protected by executive privilege and may be released only by specific authorization of the chief medical investigator when a legitimate purpose has been demonstrated and an administrative processing fee has been received. Records within case files obtained from other agencies, including hospitals, mental health facilities, law enforcement agencies, or physicians' records, may not be released by the OMI. These documents must be requested from the primary source of the record.

(1) Maintain records - provide reports: A subpoena duces tecum is a court order to appear at a court hearing and to bring specified records to that hearing. The term "all files and/or records" shall mean the entire file. When records within the OMI file are copies of records generated by other agencies, such as a hospital or law enforcement agency, the subpoenaing agency must be so advised. The records and reports of the OMI that are created at public expense and, therefore, are considered public record, are the final report of death, the autopsy report, and the toxicology report. The final report of death contains the summary of the investigation and lists the appropriate district attorney and law enforcement agency having jurisdiction. Both of these agencies are routinely provided, copies of these reports at no charge. It is prepared by the responsible deputy medical investigator and recorded in final form at the central office. The cause and manner of death are provided on this report. The autopsy report is prepared by the designated pathologist following an internal examination. The toxicology report is prepared by the state laboratory eivision at the request of the OMI. It reflects results of only those tests requested. In those cases where the death resulted from a motor vehicle accident on a public highway, a copy of the report of any test made upon the deceased for blood alcohol shall be provided to the planning division of the state highway department for statistical purposes. The report shall contain no identification of the deceased and shall not be subject to the judicial process.

(2) Information to the public: The information gathered in the course of an OMI investigation forms a public record. Any person having a legitimate reason to review the information may do so at the office of the medical investigator. Police, hospital or physicians' records acquired by the OMI in the course of the investigation are exempt from public viewing and must be obtained from the originating agency. Once the identification of an individual has been determined by the OMI or any other agency, it is the responsibility of the local law enforcement agency to assure that next of kin has been notified prior to releasing the identity to the media.

[Recompiled 10/31/01]

7.3.2.15 COURT:

A. Citations and Regulations:

(1) 24-11-8 NMSA 1978: The state or district medical investigator shall promptly report his findings, or the findings of a deputy medical investigator that has performed an investigation under his direction, to the district attorney in each death investigated. Upon request of the district attorney, the state or district medical investigator shall send a complete record of the medical investigation in any case, including a transcript of the testimony of witnesses examined at any inquest.

(2) Memorandum #1790: 9/30/82 from department of finance and administration, budget division, subject: expert witness fee guidelines: Expert witness fees are all expenses charged by a witness who is called for court testimony as a direct result of that persons' expertise or specialized skill. An expert witness is not a character witness or witness-of-fact. In most cases, the prosecution or the defense will call the expert witnesses; however, a judge may also occasionally choose to call an expert witness for testimony.

(a) The office of the medical investigator (OMI) is not to charge the state professional fees for consultation or testimony by its staff or faculty. However, it may charge mileage and per diem, or chartered plane costs as necessary. Therefore, the agency using OMI is responsible for notifying OMI immediately if a plea bargain or cancellation occurs to avoid unnecessary travel expenses to the state and inconvenience to OMI.

(b) An OMI faculty forensic pathologist will participate in all autopsies and will sign the report along with the resident who assisted in the autopsy. Therefore, either the resident or the faculty member may be subpoenaed to testify. The OMI would prefer to have the resident testify if he/she is still available as part of his/her training in forensic pathology. When preparing the subpoena, please contact OMI to determine if the resident is still with OMI. If the resident has left OMI, the supervising faculty member is to be subpoenaed for court testimony. Use of former OMI staff or faculty should only occur as a last resort.

(c) In general, the agency which calls the expert witness will be responsible for payment of the fees.

(d) Criminal proceedings:

(i) Criminal proceedings in district court: Whoever calls an expert witness shall pay the fees of that witness.

(ii) Preliminary hearings and bond arraignments in magistrate court: Whoever calls an expert witness shall pay the fees of that witness. Since the purpose of a preliminary hearing is to determine probable cause, and not determine guilt or innocence, the need for expert witnesses in magistrate court should be minimal.

(iii) Criminal grand jury proceedings: Whoever calls an expert witness shall pay the fees of that witness. The administrative office of the courts shall pay for any expert who is called specifically by the grand jury and who conducts an examination testimony at the direct request of the judge. Since the purpose of a grand jury is to determine probable cause, and not to determine guilt or innocence, the need for an expert witness in a Grand Jury proceeding should be minimal.

B. Policy:

(1) All representatives of the office of the medical investigator may be subpoenaed to a variety of legal hearings to provide information in a particular case.

(2) Subpoenas may be issued by prosecution or defense; at times, the representative of the OMI can be subpoenaed by both for the same case.

(3) The testimony of the representative of the OMI is based on the factual observations of that individual. As such, the testimony is neutral testimony. The supporting or refuting of an allegation is the responsibility of the counsels in the case, based on the hearing of the neutral testimony.

(4) Failure to respond to a subpoena represents contempt of court, and a bench warrant may be issued for the subpoenaed person at the discretion of the judge.

(5) ALL representatives of the OMI upon receiving subpoenaes must notify the central office. The only official file on any OMI case is at the central office. Any notes made by the DMI at the scene of a death are considered original source materials and may be used during court testimony.

(6) Any representative receiving a subpoena duces tecum is to bring designated records or documents with him to the court appearance. Only records at the central office will be used in this matter, and they are to be reproduced and certified by central office personnel prior to the court appearance.

(7) See also - Records, Section G [now 7.3.2.14 NMAC]

[Recompiled 10/31/01]

7.3.2.16 TRANSPORTATION:

A. Citations and regulations:

(1) 24-11-5 NMSA 1978: When any person comes to a sudden, violent or untimely death or is found dead and the cause of death is unknown . . . . the state or district medical investigator, or a deputy medical investigator under his direction, shall, without delay, view and take legal custody of the body.

(2) Regulation - state corporation commission of New Mexico, New Mexico ambulance tariff no. 3-B, June 8, 1972. Containing rates, rules, regulations and charges governing the transportation of persons alive or dead or dying en route by means of ambulance service in the state of New Mexico.

B. Policy:

(1) Only the medical investigator or his/her representative may authorize removal of a body from the scene of death.

(a) Authority may be granted by telephone or other means of communication when he/she does not attend the actual scene of death.

(b) Authority may be granted by the medical investigator to remove the body to a hospital or other medical facility for official pronouncement of death prior to transportation to the designated place for examination or subsequent funeral arrangements.

(2) Transportation may be conducted by:

(a) a funeral director designated by the family to conduct subsequent funeral arrangements.

(b) public conveyance designated for the purpose of transporting bodies.

(c) a licensed commercial ground carrier holding a valid permit for such transportation within the state of New Mexico.

(d) a licensed commercial air carrier with an operating certificate issued by the FAA.

(3) The office of the medical investigator does not contract with any individual or agency for transportation services. Service providers are chosen based on cost,

availability and timeliness. Authority for all such transportation will originate with the medical investigator.

(4) Payment for all transportation authorized by the medical investigator will originate at the central office of the medical investigator in Albuquerque, New Mexico. Payment will be approved only upon receipt of the original invoice itemizing the following:

(a) the name of the deceased;

(b) date of transportation;

(c) location from which the body was transported;

(d) location to which the body was transported;

(e) total loaded miles of transportation;

(f) response charge;

(g) charge per mile;

(h) name of the deputy or district medical investigator who authorized such removal.

(5) The medical investigator pays only those transportation charges incurred to conduct the investigation and subsequent examination. This does not include any charge ordinarily incurred when the OMI does not assume jurisdiction.

(6) Authorized payments for transport:

(a) must be submitted by agencies chartered by New Mexico state corporation commission to transport dead bodies.

(b) transportation from the scene of death to a designated place for storage and examination other than a mortuary designated to conduct subsequent preparation or funeral arrangements;

(c) transportation to return remains from the place of examination to the locality where the remains were initially discovered.

(7) Unauthorized pay:

(a) any transportation by a transport other than those chartered by the New Mexico state corporation commission to transport dead bodies.

(b) transportation from the scene of death to a mortuary designated to conduct subsequent preparation or funeral arrangements;

(c) transportation from the place of examination to a mortuary within the same locality for subsequent preparation for funeral arrangements;

(d) transportation from the place of examination to a mortuary outside the locality of the place of death;

(e) waiting time unless authorized by the central office.

(8) Miscellaneous transportation fees: The medical investigator may require that bodies be transported in sealed bags or containers for the purpose of preservation of evidence.

(a) Medical investigator will usually supply body bags, if needed, for preserving evidence or to avoid contamination of the transporting vehicle.

(b) If such body bags are supplied by the transporting agency at the request of the medical investigator, the OMI reserves the option of payment for the bag or replacement of the bag with a bag of similar quality.

(c) Body bags or containers supplied by agencies for the purpose of preventing odors and contamination will be returned to those agencies ultimately receiving the body.

[Recompiled 10/31/01]

7.3.2.17 REMAINS:

A. Citations and Regulations:

(1) 24-11-6 NMSA 1978 A: Upon receipt of a report from a deputy medical investigator under this subsection, the state or district medical investigator may execute a death certificate and a certificate authorizing release of the body for burial.

(2) 24-11-7 NMSA 1978: If the deceased is unidentified, the state, district or deputy medical investigator may order the body fingerprinted and photographed.

(3) 24-12-1 NMSA 1978:

(a) State, county or municipal officials having charge or control of bodies to be buried at public expense shall use due diligence to notify the relatives of the deceased.

(b) If no claimant is found who will assume the cost of burial, the official having charge or control of the body shall notify the medical investigator stating, when

possible, the name, age, sex and cause of death of any person required to be buried at public expense.

(c) The body shall be embalmed according to regulations of the state agency having jurisdiction. After the exercise of due diligence required in Subsection A [now Subparagraph (a) of Paragraph (3) of Subsection A of 7.3.2.17 NMAC] of this section, and the report to the medical investigator required in Subsection B [now Subparagraph (b) of Paragraph (3) of Subsection A of 7.3.2.17 NMAC] of this section, the medical investigator shall be furnished detailed data demonstrating such due diligence and the fact that no claimant has been found. When the medical investigator has determined that due diligence has been exercised and that reasonable opportunity has been afforded relatives to claim the body and that the body has not been claimed, he shall issue his certificate determining that the remains are unclaimed. In no case shall an unclaimed body be disposed of in less than two weeks from the date of the discovery of the body.

(4) 24-12-2 NMSA 1978:

(a) Upon the issuance of his certificate that the remains are unclaimed, the medical investigator shall retain the body for use only for medical education or shall certify that the body is unnecessary or unsuited for medical education and release it to the state, county or municipal officials having charge or control of the body for burial.

(b) If the body is retained for use in medical education, the facility or person receiving the body for such use shall pay the costs of preservation and transportation of the body and shall keep a permanent record of bodies received.

(c) If a deceased person was an inmate of a public institution, the institution shall transmit, upon request of the medical investigator, a brief medical history of the unclaimed dead person for purposes of identification and permanent record. The records shall be open to inspection by any state or county official or district attorney.

(5) 24-12-3 NMSA 1978:

(a) Any person who conducts a postmortem examination on an unclaimed body without express permission of the medical investigator is guilty of a misdemeanor and shall be punished by imprisonment in the county jail for not more than one year or by the imposition of a fine of not more than one thousand dollars ($1,000), or both such imprisonment and fine.

(b) Any person who unlawfully disposes of, uses or sells an unclaimed body is guilty of a fourth degree felony and shall be punished by imprisonment in the state penitentiary for a term of not less than one year nor more than five years or by the imposition of a fine of not more than five thousand dollars ($5,000), or both such imprisonment and fine.

(6) 24-13-1 NMSA 1978: It shall be the duty of the board of county commissioners of each county in this state to cause to be decently interred, the body of any dead person having no visible estate out of which to defray the cost of his burial, and when no relative or friend of such decedent will undertake to bury him.

(7) 24-13-2 NMSA 1978: No deceased person shall be considered to be an indigent if there are any sums, no matter how small, with which to defray the cost of such burial.

(8) 24-13-3 NMSA 1978: The expenses for the burial or cremation of an indigent person shall be paid by the county out of the general fund in the amount of one hundred dollars ($100) for the burial of any adult or minor over the age of six years and seventy-five dollars ($75) for the burial of any minor up to the age of six years.

(9) 24-13-4 NMSA 1978: The board of county commissioners, after proper investigation, shall cause any deceased indigent to be decently interred or cremated. The cost of opening and closing a grave shall not exceed thirty-five dollars ($35), which sum shall be in addition to the sums enumerated in Section 24-13-3 NMSA 1978.

(10) 24-14-22 NMSA 1978:

(a) Each spontaneous fetal death, where the fetus has a weight of five hundred grams or more, which occurs in this state shall be reported to the state registrar.

(b) When a dead fetus is delivered in an institution, the person in charge of the institution or his designated representative shall prepare and file the report.

(c) When the spontaneous fetal death occurs on a moving conveyance and the fetus is first removed from the conveyance in this state, or when a dead fetus is found in this state and the place of fetal death is unknown, the fetal death shall be reported in this state. The place where the fetus was first removed from the conveyance or the dead fetus was found shall be considered the place of fetal death.

(d) When a spontaneous fetal death required to be reported by this section occurs without medical attendance at or immediately after the delivery or when inquiry is required by law, the state medical investigator shall investigate the cause of fetal death and shall prepare and file the report.

(e) The names of the parents shall be entered on the spontaneous fetal death report in accordance with the provisions of Section 24-14-13 NMSA 1978.

(f) Except as otherwise provided in this section, all spontaneous fetal death reports shall be completed and filed with the state registrar within ten days following the spontaneous fetal death.

(11) 24-14-23 NMSA 1978:

(a) For deaths or spontaneous fetal deaths which have occurred in this state, no burial-transit permit shall be required for final disposition of the remains if such disposition occurs in this state and is performed by a funeral service practitioner or if disposition takes place in an institution with authorization from the next of kin.

(b) A burial-transit permit shall be issued by the state registrar or a local registrar for those bodies which are to be transported out of the state for final disposition or when final disposition is being made by a person other than a funeral service practitioner.

(c) A burial-transit permit issued under the law of another state or foreign country which accompanies a dead body or fetus brought into this state shall be authority for final disposition of the body or fetus in this state.

(d) A permit for disinterment or reinterment shall be required prior to disinterment of a dead body or fetus except as authorized by regulation or otherwise provided by law. The permit shall be issued by the state registrar or state medical investigator to a licensed funeral service practitioner.

(e) A permit for cremation of a dead body shall be required prior to the cremation. The permit shall be issued by the state medical investigator to a licensed funeral service practitioner.

(12) 24-14-24 NMSA 1978:

(a) The department may, by regulation and upon conditions as it may prescribe to assure compliance with the purposes of the Vital Statistics Act [24-14-1 to 2414-17, 24-14-20 to 24-14-31 NMSA 1978], provide for the extension of the periods prescribed in Sections 24-1420, 24-14-22 and 24-14-23 NMSA 1978 for the filing of death certificates, spontaneous fetal death reports, medical certification of cause of death and for the obtaining of burial-transit permits in cases where compliance with the applicable prescribed period would result in undue hardship.

(b) Regulations of the department may provide for the issuance of a burial-transit permit prior to the filing of a certificate upon conditions designed to assure compliance with the purposes of the Vital Statistics Act in cases where compliance with the requirement that the certificate be filed prior to the issuance of the permit would result in undue hardship.

(13) Regulation - state board of thanatopractice of the state of New Mexico regulations, adopted 2/2/79 and revised 1984, No. 22.

(a) Subject to the provisions of Subsection G of Section 61-29A-23, NMSA 1978, all human and fetal remains shall be embalmed in accordance with the Thanatopractice License Law, where;

(i) required by an applicable regulation of the office of the medical investigator or of the secretary of the health and environment department or by an order of the state or a district medical investigator;

(ii) the remains are not stored under refrigeration at a temperature not exceeding 5 degrees C (40 degrees F) when Subsection A of Section 61-29A-21, NMSA 1978, is applicable; or

(iii) Subsection F of Section 61-29A-23, NMSA 1978, is applicable.

(b) When embalming is not required under the preceeding paragraph A [now Subparagraph (a) of Paragraph (13) of Subsection A of 7.3.2.17 NMAC], then no human or fetal remains shall be embalmed without the oral or written authorization by the:

(i) surviving spouse or next of kin; or

(ii) legal agent or personal representative; or

(iii) person assuming responsibility for final disposition.

(c) Where embalming is not required under paragraph A [now Subparagraph (a) of Paragraph (13) of Subsection A of 7.3.2.17 NMAC] and prior to obtaining authorization under paragraph B [now Subparagraph (b) of Paragraph (13) of Subsection A of 7.3.2.17 NMAC], remains may be washed and other health procedures, such as closing the orifices, preparatory to actual embalming, may be performed.

B. Policy:

(1) In all cases where the OMI has assumed jurisdiction, the remains will be released for burial or other means of disposal only after the investigation of the death is concluded.

(2) All permits for cremation on any death occurring within the State are issued by the OMI.

(3) In cases where the remains are unidentified, all means of recording features of the remains shall be used prior to release of the remains.

(4) In cases where the remains are identified but unclaimed, the body shall be released no sooner than two weeks after death with the assurance that due diligence has been put forth to find a claimant for the body. This release is granted by the office of the medical investigator.

(5) In cases where the remains are identified but ruled indigent, the cost of the burial shall be assumed by the county authority in which the death occurred. Personal property of an unidentified person will be turned over to the county assuming responsibility for burial. In all cases where the OMI has assumed jurisdiction, there shall be no charge for transportation and storage imposed on any common carrier or funeral director.

(6) The office of the medical investigator and the state registrar may issue disinterment permits. This permit will be issued to a licensed funeral director who will be in charge of the disinterment procedure. A request for a disinterment permit can be made by a district attorney or any private individual with a legitimate purpose. In any case where the disinterment is requested for purposes requiring legal documentation of the procedure, the OMI shall be present and shall assure the chain of custody upon removal and transportation to the office of the medical investigator for any subsequent examination.

(7) In the event that unidentified skeletal remains are discovered, the office of the medical investigator shall respond and conduct an investigation to determine if there is medicolegal significance to the remains.

(8) In any case where the cause of death is deemed dangerous to the public health, the office of the medical investigator may require that the body be embalmed or be encased in an airtight container.

[Recompiled 10/31/01]

7.3.2.18 DISASTER:

A. Citations and Regulations:

(1) 24-11-5 NMSA 1978: When any person comes to a sudden, violent or untimely death or is found dead and the cause of death is unknown, anyone who becomes aware of the death shall report it immediately to law enforcement authorities or the office of the state or district medical investigator. The public official so notified, shall in turn notify either, or both, the appropriate law enforcement authorities or the office of the state or district medical investigator. The state or district medical investigator, or a deputy medical investigator under his direction, shall, without delay, view and take legal custody of the body.

(2) Document - department of transportation, federal aviation administration, "Aircraft Accident and Incident Notification, Investigation, and Reporting", JULY, 1976, document #8020.11. In carrying out its duties under this title, the board is authorized to examine and test to the extent necessary any civil aircraft, aircraft engine, propeller, appliance, or property aboard an aircraft involved in an accident in air commerce. In the case of any fatal accident, the board is authorized to examine the remains of any deceased person aboard the aircraft at the time of the accident, who dies as a result of

the accident, end to conduct autopsies or such other tests thereof as may be necessary to the investigation of the accident: Provided, that to the extent consistent with the needs of the accident investigation, provisions of local laws protecting religious beliefs with respect to autopsies shall be observed.

(3) Obtaining autopsy. A strong attempt should be made to obtain an autopsy on the crew and members in every fatal general aviation accident. It is also desirable to obtain complete skeletal x-rays in certain accidents. Even in extreme cases of incineration, blood and tissue can often be obtained for studies. The heart in such cases is often intact and will be found to contain blood suitable for carbon monoxide, cyanide, ethyl alcohol, and other studies. In "survivable" accidents, a general x-ray survey of the body is desired. Simple fractures are often missed on autopsy. Many fatal accidents in general aviation fall in the survivable category.

(a) Pre-crash planning. Embalming invalidates most toxicological studies. Obtaining the early cooperation and understanding of the local coroner/medical examiner results in smoother operation in this area of the investigation.

(b) When the AME is the first federal representative at the scene, he should request that local authorities guard the wreckage.

(c) The coroner/medical examiner should be contacted to arrange for autopsy/toxicology studies. The state or local police may be of help in this communication. Good communication is the key to a well-conducted investigation and the local law enforcement agency, e.g., state police, is an effective place for the AME to keep in contact concerning the whereabouts of the coroner/medical examiner.

(i) If the AME does not personally know the coroner or mortician, he should introduce himself as the authorized AME of the federal aviation administration. This will establish the proper rapport. The coroner can be of great assistance to the investigation but sometimes is not fully oriented to the aviation medical aspects.

(ii) After autopsy permission has been secured, it is then determined whether it will be done by a local pathologist or by an FAA consultant pathologist.

(4) Federal Aviation Act of 1958, Title 7, Aircraft Accidents. Procedures.

(5) National Transportation Safety Board, Public Notice PN-1. Scope of authority.

B. Policy:

(1) When a situation occurs that causes death to individuals and presents complications that prevent the timely retrieval of bodies and/or the subsequent identification of those bodies, a disaster can be stated to have occurred.

(2) The office of the medical investigator is charged with taking custody of all bodies in situations deemed disasters, with the responsibility for the identification of those remains, the determination of a cause and manner of death, and the timely release of those remains to the family.

(3) The office of the medical investigator shall establish and maintain a current written disaster plan and shall supply a copy to appropriate individuals or agencies. Further, a list of all agencies that may be required to respond to the scene of a particular disaster shall be maintained in the central office of the medical investigator, and all telephone numbers and contact directions shall be kept in an up-to-date fashion.

[Recompiled 10/31/01]

7.3.2.19 FEES: POLICY:

A. Fees are charged by the medical investigator for reports and services. A current list of such fees is available from the central office.

B. Fees are paid by the medical investigator for services provided by field personnel and common carriers. Fees will only be paid upon receipt of an itemized bill for those services. A current list of such fees is available from the central office.

[Recompiled 10/31/01]

7.3.2.20 AGENCIES:

A. Citations and regulations:

(1) 50-9-4 NMSA 1978: The agency is the state occupational health and safety agency for all purposes under federal legislation relating to occupational health and safety and may take all action necessary to secure to this state the benefits of that legislation.

(2) 69-5-17 NMSA 1978: The state mine inspector shall proceed immediately upon notification to the site of any mine accident causing the loss of life or imminent danger and assist in the rescue of persons within the mine, investigate the causes of the accident, conduct a closeout conference and make necessary recommendations for the present and future safety of the miners. So far as possible, the operator shall not change the surroundings of an accident until the state mine inspector has made his investigation, provided, however, that such investigation is made within a reasonable time.

(3) Document - Department of Transportation, Federal Aviation Administration, Aircraft Accident and Incident Notification, Investigation and Reporting, 7/76, Document #8020.11. Provided, that to the extent consistent with the needs of the

accident investigation, provisions of local laws protecting religious beliefs with respect to autopsies shall be observed.

(a) Pre-crash Planning. Embalming invalidates most toxicological studies. Obtaining the early cooperation and understanding of the local coroner/medical examiner results in smoother operation in this area of the investigation. The state or local police may be of help in this communication. Good communication is the key to a well-conducted investigation and the local law enforcement agency, e.g., state police, is an effective place for the AME to keep in contact concerning the whereabouts of the coroner/medical examiner.

(i) If the AME does not personally know the coroner or mortician, he should introduce himself as the authorized AME of the federal aviation administration. This will establish the proper rapport. The coroner can be of great assistance to the investigation but sometimes is not fully oriented to the aviation medical aspects.

(ii) After autopsy permission has been secured, it is then determined whether it will be done by a local pathologist or by an FAA consultant pathologist.

(b) The coroner/medical examiner should be contacted to arrange for autopsy/toxicology studies.

(4) Regulation - bureau of Indian affairs 1968, IAM 3.13 AND 3.13.2, Relations with Other Services and Agencies.

(a) Autopsy service. The policy is that where the United States attorney requests a postmortem autopsy on a human body and the case comes within the purview of the federal courts, the FBI will pay the expenses for the transportation of the corpse, the use of an operating room (usually a mortician's facility), and the fees of the medical officer performing the examination. The expenses incident to autopsy service prior to referral to the U. S. attorney may not be the responsibility of the FBI. The FBI will not pay burial expenses incident to such cases.

(b) Land surveys. In substantially all cases where the FBI investigates a crime on an Indian reservation pursuant to special laws applicable to Indian reservations, it is necessary to establish legal jurisdiction by determining the focus and status of the land on which the crime occurred. The bureau of Indian affairs has the responsibility to determine this requirement and for the payment of any land surveys incident thereto. Bureau officers should familiarize themselves with the location, custody, and availability of land records and the identity of Indian bureau or bureau of land management personnel who are qualified to testify thereto. Working arrangements should be established within Indian bureau facilities to provide for these surveys and to provide personnel qualified to make and testify to land surveys in court. This is an important prerequisite in federal and state prosecutions and cannot be overlooked. This information shall be made available to the FBI and the United States attorney. It will also

be furnished to state prosecuting attorneys where such surveys develop that crimes being investigated occurred on non-federal jurisdiction lands.

(5) 32-1-15 NMSA 1978:

(a) Any licensed physician, resident or intern examining, attending or treating a child, any law enforcement officer, registered nurse, visiting nurse, schoolteacher or social worker acting in his official capacity or any other person knowing or suspecting that a child is an abused or neglected child shall report the matter immediately to:

(i) the criminal prosecution division of the office of the district attorney.

(ii) the county social services office of the human services department in the county where the child resides; or

(iii) the probation services office of the judicial district in which the child resides.

(b) An oral report shall be made promptly by the recipient of the report under Paragraph 2 or 3 of Subsection A [now (ii) and (iii) of Subparagraph (a) or Paragraph (5) of Subsection A of 7.3.2.20 NMAC] of this section to the district attorney by telephone or in person, and a written report shall be submitted to the district attorney as soon thereafter as possible. The written report shall contain the names and addresses of the child and his parents, guardians or custodian, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and other information that the maker of the report believes might be helpful in establishing the cause of the injuries and the identity of the person or persons responsible for the injuries.

(6) Memorandum 6-6 - Veteran's administration, medical center, Albuquerque, NM, April 18, 1984

(7) Responsibility to report deaths to the office of the medical investigator.

B. Policy: The office of the medical investigator shall appear and assume custody of the body in all cases of sudden and unexpected deaths occurring within the state of New Mexico. In addition to the local law enforcement agency of jurisdiction, certain state and federal agencies are, by law and regulation, to be notified when the specific incident is related to their area of specialization.

(1) Aircraft: In the case of civil aircraft disasters, the federal aviation administration (FAA) and national transportation safety board (NTSB) are to be notified and permitted into the scene of investigation.

(2) Industrial: In the case of work-related industrial accidents, (excluding mining and vehicular) officials of the occupational safety and health agency are to be notified and permitted into the scene of investigation.

(3) Mining: In the case of mining deaths, the state mine inspector (mining safety agency) is to be notified and permitted into the scene of investigation.

(4) Contagious disease: In cases of contagious diseases, in particular botulism, meningococcal infections and the plague, but including the entire list of notifiable diseases/conditions published by the epidemiology office of the New Mexico health and environment department, that department is to be notified and supplied with information of the incident.

(5) Consumer product: In cases of consumer products being involved or present, the consumer product safety commission is to be notified and supplied with information of the incident.

(6) Federal jurisdiction: In cases where the death appears to be on federal land, the FBI or appropriate branch of the military shall be notified.

(7) Child abuse: In all cases of suspected child abuse, the human services department of the local county shall be notified and supplied with information of the incident and postmortem examination.

(8) Current list: The agencies cited here are required to provide the OMI with a current list of representatives to be notified for response within the state of New Mexico.

[Recompiled 10/31/01]

7.3.2.21 CENTRAL OFFICE — POLICY:

Established by authority of the board of medical investigators, the central office of the state medical investigator:

A. receives all reports of death reported to any deputy medical investigator in the state;

B. receives all bodies for autopsy except those designated by the central office to remain within the jurisdiction of death for autopsy by a designated pathologist;

C. receives all toxicology specimens removed from a body by a deputy medical investigator;

D. receives and is the sole possessor of film and subsequent slides and photographs taken of a body or surrounding death scene by any representative of the OMI;

E. is responsible for all payments for services rendered by any representative of the OMI or their service provider, upon receipt of the itemized bill described under "FEES", SECTION L [now 7.3.2.19 NMAC];

F. receives all payments for services or reports and maintains all fiscal records pertaining to same;

G. generates all final reports;

H. enters all pertinent data into the central facility computer data base;

I. is responsible for all information disseminated to the media unless directed otherwise;

J. maintains final authority over the disposition of a dead body and the processing of that body in all cases where jurisdiction is assumed;

K. assumes responsibility for all hiring and termination of deputy medical investigators, district medical investigators, and designated pathologists;

L. develops, maintains and distributes to the deputy medical investigators a list of authorized transportation providers and mortuary services within each jurisdiction;

M. is responsible for all body storage required in the processing of any case, for all unidentified remains, and for unclaimed remains under OMI jurisdiction;

N. directs deputy medical investigator personnel to districts other than their own for assignment when required;

O. provides all training for deputy medical investigators;

P. allocates supplies for field deputy medical investigators.

[Recompiled 10/31/01]

CHAPTER 4: DISEASE CONTROL (EPIDEMIOLOGY)

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: ANIMAL CONTROL REQUIREMENTS

7.4.2.1 ISSUING AGENCY:

New Mexico Department of Health.

[8/27/79; 10/31/96; 7.4.2.1 NMAC - Rn, 7 NMAC 4.2.1, 5/30/2003]

7.4.2.2 SCOPE:

Together with a network of mandatory and discretionary municipal and county ordinances prescribed at Section 5 and 7, to provide for the control of animals by mandatory rabies vaccination of dogs and cats, confinement of rabies suspect animals, laboratory rabies testing, rabies quarantine, confinement or destruction of animals exposed to rabies, confinement or destruction of vicious dogs, confinement or destruction of animals with symptoms of rabies, control of animals running at large, regulations of the possession of skunks, licensure of dogs and providing for regulations of the animal control officers and impounding facilities.

[8/27/79; 10/31/96; 7.4.2.2 NMAC - Rn, 7 NMAC 4.2.2, 5/30/2003]

7.4.2.3 STATUTORY AUTHORITY:

These regulations are promulgated by the secretary of the department of health pursuant to sections 77-1-3 and 9-7-6 (E) NMSA 1978.

[8/27/79; 10/31/96; 7.4.2.3 NMAC - Rn & A, 7 NMAC 4.2.3, 5/30/2003]

7.4.2.4 DURATION:

Permanent.

[8/27/79; 10/31/96; 7.4.2.4 NMAC - Rn, 7 NMAC 4.2.4, 5/30/2003]

7.4.2.5 EFFECTIVE DATE:

October 31, 1996, unless a later date is cited at the end of a section.

[8/27/79; 10/31/96; 7.4.2.5 NMAC - Rn & A, 7 NMAC 4.2.5, 5/30/2003]

7.4.2.6 OBJECTIVE:

To protect humans and animals from rabies by vaccination of dogs and cats and the confinement, destruction and testing of rabies suspect animals. To protect humans and livestock from dog bites by controlling animals running at large and by providing for the licensure of dogs, impoundment of animals and confinement or destruction of vicious dogs.

[8/27/79; 10/31/96; 7.4.2.6 NMAC - Rn, 7 NMAC 4.2.6, 5/30/2003]

7.4.2.7 DEFINITIONS:

A. "Animal" means any vertebrate member of the animal kingdom excluding man.

B. "Animal destroyed" means the administration of an agent which shall cause the death of an animal. Such method shall not destroy brain tissue necessary for laboratory examination for rabies.

C. "Bite" means the puncture or tear of the skin inflicted by the teeth of an animal.

D. "Confined" means restriction of an animal at all times by an owner or keeper to an escape proof building or other enclosure away from other animals and the public.

E. "Department" means the department of health of the state of New Mexico.

F. "District health officer" means the person designated by the director of the public health division to be responsible for district health operations in a district organized by the public health division.

G. "Division" means the office of epidemiology of the department of health of the state of New Mexico.

H. "Exposure to rabies" means the exposure resulting from a bite by an animal susceptible to rabies or from contact of the saliva of such animal with any break or abrasion of the skin.

I. "Field health office" means the health office(s) located in each county and administered by the public health division of the department of health.

J. "Impounding facilities" means any animal control center, pound, animal shelter, kennel, veterinary hospital, lot premise or building maintained or contracted by a municipality or county for the care and custody of animals.

K. "Isolation" means the confinement of an animal in an escape proof run or cage so that there is no possibility of direct contact with other animals or humans.

L. "Laboratory" means the scientific laboratory division (SLD) of the New Mexico department of health, 700 Camino de Salud, Albuquerque, New Mexico, 87106.

M. "Livestock" means all domestic animals of the following genera: equine, bovine, ovine, caprine and porcine.

N. "Owner" means a person who owns, harbors, keeps, or knowingly permits an animal to be harbored or kept, or permits an animal to remain on his premises.

O. "Person" means any individual, household, firm, partnership, corporation, society, association and every officer, agent or employee thereof.

P. "Premises" means any parcel of land and structure(s) thereon.

Q. "Quarantine" means the strict containment of all animals specified in the order of the district health officer upon the private premises of the owner, or under restraint by leash, or within a closed cage or paddock and shall include other measures ordered by the district health officer to control the spread of rabies.

R. "Running at large" means to be free of physical restraint beyond the premises of the owner or keeper.

S. "Stray animal" means any animal running at large.

T. "Vaccination against rabies" means the injection of an approved rabies vaccine by or under the supervision of a licensed veterinarian.

U. "Veterinarian" means a person with a doctor of veterinary medicine degree licensed to practice veterinary medicine in the state of New Mexico.

V. "Vicious animal" means any animal which at any time without provocation shall bite, attack or injure any person who was peacefully conducting himself where he lawfully may be.

[8/27/79; 10/31/96; 7.4.2.7 NMAC - Rn & A, 7 NMAC 4.2.7, 5/30/2003]

7.4.2.8 VACCINATION OF DOGS AND CATS REQUIRED:

A. Dogs and cats over the age of three months shall be vaccinated against rabies. The animal shall receive a booster within the 12-month interval following the initial vaccination. Every domestic dog and cat shall be revaccinated against rabies within 12 months if a 1-year vaccine is administered or within 36 months if a 3-year vaccine is administered with a rabies vaccine licensed by the United States Department of Agriculture and administered according to label recommendations. The "compendium of animal rabies control (CARC)," published by the national association of public health veterinarians, Inc., shall be the reference for the route of inoculation and the type of vaccine. Copies are available upon request from the department.

B. Rabies vaccine shall not be distributed except to a veterinarian.

C. The veterinarian who administers rabies vaccine to a dog or cat shall issue to the owner a serially numbered vaccination certificate containing the name of the veterinarian, the type of vaccine used, the initials of the producer of the vaccine, the name and address of the owner, a description of the dog or cat vaccinated, the date of vaccination, and the expiration date for the period of immunity. The veterinarian shall also furnish the owner with a tag bearing the certificate number and the year of the vaccination. The tag shall be affixed to the vaccinated dog or cat and shall be worn at all times the animal is not on the premises of the owner or otherwise confined. A

combination rabies vaccination certificate and city/county license shall be permitted providing the certificate/license contains at least the above required information.

D. Approved rabies vaccine shall be administered to the species, by the route and in the amount recommended by the producer of the vaccine and the latest CARC.

E. Nothing herein shall prohibit the acceptance and recognition for purpose of compliance with this section of the administration of an approved rabies vaccine by a veterinarian licensed in another state.

[8/27/79; 10/31/96; 7.4.2.8 NMAC - Rn & A, 7 NMAC 4.2.8, 5/30/2003]

7.4.2.9 HUMAN EXPOSURE; ANIMALS WITH SYMPTOMS OF RABIES:

A. When any person is bitten by an animal, it is the duty of such person or his parent or guardian, or any person having knowledge of the whereabouts of the animal, to immediately notify the animal control officer or the field office of the public health division.

B. Any dog, cat or ferret which bites or otherwise exposes a person to rabies shall be either destroyed and the head sent to the laboratory for rabies testing or confined immediately at the owner's expense at a place and in a manner designated by the animal control officer and approved by the field health office. If the dog, cat or ferret shows signs or symptoms of rabies during the ten (10) day confinement and observation period, it shall be destroyed and the head sent to the laboratory for rabies testing.

C. Any skunk, bat, raccoon, coyote, bobcat or other wild animal not born or reared in captivity, with the exception of rodents (order rodentia) or rabbits (order lagomorpha), which bites or otherwise exposes a person to rabies shall be destroyed immediately and the head sent to the laboratory for testing. Rabbits and rodents do not normally transmit rabies.

D. Except for rodents and rabbits, the head of a susceptible animal suspected of having rabies, which bites or otherwise exposes a person to rabies and either dies or is destroyed within ten (10) days following the exposure shall be immediately sent to the laboratory for rabies testing. Rodent and rabbit specimens may be submitted with the consent of the state epidemiologist of the division of epidemiology, evaluation and planning division. A rabies submission form and instructions for shipping are available upon request from the scientific laboratory division, department of health.

[8/27/79; 10/31/96; 7.4.2.9 NMAC - Rn & A, 7 NMAC 4.2.9, 5/30/2003]

7.4.2.10 RABIES QUARANTINE AREA:

Any district health officer may declare a quarantine against rabies within the health district or any part thereof when rabies has been determined to exist to the extent that it is a danger to public health. Upon written findings of such danger and approval of the division director of the public health division, all animals designated in the quarantine order and living within the area specified in the order shall be confined as directed by the district health officer. Any reasonable effort to apprehend any dog or cat running at large and uncontrolled by its owner during a period of quarantine, any animal control officer or peace officer may destroy the dog or cat and properly dispose of the body. The district health officer may order other measures as may be necessary to prevent the spread of rabies. A quarantine shall not be removed except by order of the district health officer.

[8/27/79; 10/31/96; 7.4.2.10 NMAC - Rn, 7 NMAC 4.2.10, 5/30/2003]

7.4.2.11 ANIMALS EXPOSED TO RABIES:

When circumstances indicate an animal has been bitten by a known rabid animal, the following procedures shall apply:

A. Dogs, cats or ferrets bitten by a known rabid animal should be destroyed immediately. If the owner is unwilling to have this done, the animal should be vaccinated and quarantined according to the recommendations of the latest edition of the "compendium of animal rabies control (CARC)," published by the national association of public health veterinarians, Inc., at the owner's expense in a manner directed by the animal control officer and approved by the district health officer.

B. Domestic livestock known to have been bitten by a rabid animal shall be destroyed immediately. If the owner is unwilling to have this done, the animal should be vaccinated and quarantined according to the recommendations of the latest edition of the "compendium of animal rabies control (CARC)," published by the national association of public health veterinarians, Inc., in a manner approved by the district health officer. The exposed animal may be killed and its tissues eaten if the animal is slaughtered within seven (7) days after being bitten. Persons who slaughter an exposed domestic animal shall wear gloves. No animal tissue shall be retained for consumption from areas proximate to the bite. Neither tissues nor milk from a rabid animal should be used for human or animal consumption.

C. Other animals susceptible to rabies known to have been bitten by a rabid animal shall be destroyed immediately as directed by the district health officer.

[8/27/79; 10/31/96; 7.4.2.11 NMAC - Rn & A, 7 NMAC 4.2.11, 5/30/03]

7.4.2.12 POSSESSION OF SKUNKS:

Due to the presence of rabies in skunks and the hazard to the public health of rabies developing in skunks kept as pets, no person shall import into the state, nor capture

with intent to keep as a pet, nor buy, sell, trade nor possess any skunk except in connection with a recognized zoological park or research institution or by permit from the department. Permits may be approved only for skunks born in captivity. Application for permit shall be made on a form provided by the division.

[8/27/79; 10/31/96; 7.4.2.12 NMAC - Rn, 7 NMAC 4.2.12, 5/30/2003]

7.4.2.13 VICIOUS ANIMALS:

It is unlawful for any owner to fail to confine a vicious animal except:

A. an animal confined within an enclosed automobile, truck or other vehicle not being used as a public conveyance;

B. an animal in shipment on a public conveyance and properly confined in a shipping container conspicuously labeled "vicious animal" and constructed in such a manner as to prevent the animal from biting or attacking humans or other animals;

C. a vicious dog muzzled and on a leash of sufficient strength to keep such animal under control and held by a person capable of controlling the animal;

D. Any vicious animal not controlled as required herein shall be destroyed. If the vicious animal has bitten a person or animal within ten days prior to its destruction, the head shall be sent to the laboratory for rabies testing.

[8/27/79; 10/31/96; 7.4.2.13 NMAC - Rn, 7 NMAC 4.2.13, 5/30/2003]

7.4.2.14 ANIMALS RUNNING AT LARGE:

Municipal or county animal control ordinances shall provide for the seizure and disposition of dogs and cats that have bitten a person, vicious dogs and dogs molesting livestock, and may provide for the seizure and disposition of stray animals.

[8/27/79; 10/31/96; 7.4.2.14 NMAC - Rn, 7 NMAC 4.2.14, 5/30/2003]

7.4.2.15 DOG LICENSE:

A. Each county and municipality may provide by ordinance for the licensure of all dogs and cats over the age of three months.

B. Such ordinance shall require a serially numbered certificate and tag for each licensed animal. The certificate shall contain the name and address of the owner of the animal, a description of the animal, proof of rabies vaccination and the expiration date of the license.

C. A combination rabies certificate and city or county license shall be permitted.

D. License fees shall be set by the ordinance. All license fees collected shall be remitted or reported to the treasurer of the county or municipality and shall be used for animal control. No fee for licensure of dogs trained to assist the blind or deaf shall be charged.

[8/27/79; 10/31/96; 7.4.2.15 NMAC - Rn, 7 NMAC 4.2.15, 5/30/2003]

7.4.2.16 IMPOUNDING OF ANIMALS:

Every municipality and each county shall provide for the impoundment of animals as follows.

A. Impoundment facilities shall be provided for the confinement of all unowned animals susceptible to rabies which have bitten a person. The animal shall be either destroyed or confined for a period of ten (10) days and if the animal dies or is destroyed during the confinement period, the head shall be sent to the laboratory for rabies testing.

B. Impoundment facilities should be provided for the confinement of animals running at large, vicious animals and animals attacking livestock.

C. Impoundment facilities may be provided for by contract with a veterinary hospital, a kennel, an animal shelter or in cooperation with other municipalities or counties.

[8/27/79; 10/31/96; 7.4.2.16 NMAC - Rn, 7 NMAC 4.2.16, 5/30/2003]

7.4.2.17 ANIMAL CONTROL OFFICERS:

A. Every municipality and each county shall designate a part-time or full-time animal control officer who shall be deputized to enforce animal control laws, orders, ordinances and regulations.

B. The animal control officer shall prevent and control the spread of rabies within the municipality or county including but not limed to the capture and confinement or disposition of rabies suspect animals, the enforcement of quarantine orders, the destruction or confinement of animals exposed to rabies and the enforcement of pet skunk regulations.

C. Animal control officers should be provided with proper training to apprehend, handle and care for animals.

D. In carrying out the provisions of these regulations every deputized animal control officer is authorized to pursue a straying animal or a vicious dog or a dog molesting livestock or any animal with symptoms of rabies onto private premises unless permission to make such pursuit is explicitly refused by the occupant.

[8/27/79; 10/31/96; 7.4.2.17 NMAC - Rn, 7 NMAC 4.2.17, 5/30/2003]

PART 3: CONTROL OF DISEASE AND CONDITIONS OF PUBLIC HEALTH SIGNIFICANCE

7.4.3.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.4.3.1 NMAC - Rp, 7.4.3.1 NMAC, 04/30/2009]

7.4.3.2 SCOPE:

All physicians, laboratories, health care professionals, and other persons having knowledge of diseases or conditions covered by these regulations.

[7.4.3.2 NMAC - Rp, 7.4.3.2 NMAC, 04/30/2009]

7.4.3.3 STATUTORY AUTHORITY:

These provisions set forth herein are promulgated by the secretary of the department of health by authority of NMSA 1978 Section 9-7-6(E) and in conformity with the Public Health Act, particularly NMSA 1978 Sections 24-1-3C, 24-1-7, and 24-1-15 and pursuant to the Hospital-Acquired Infection Act, NMSA 1978, Sections 24-29-1 through 24-29-6. Administration and enforcement of these rules are the responsibility of the epidemiology and response division of the department of health.

[7.4.3.3 NMAC - Rp, 7.4.3.3 NMAC, 04/30/2009; A, 02/29/2012]

7.4.3.4 DURATION:

Permanent.

[7.4.3.4 NMAC - Rp, 7.4.3.4 NMAC, 04/30/2009]

7.4.3.5 EFFECTIVE DATE:

April 30, 2009, unless a later date is cited at the end of a section.

[7.4.3.5 NMAC - Rp, 7.4.3.5 NMAC, 04/30/2009]

7.4.3.6 OBJECTIVE:

The essential objective of these rules is the control of disease and conditions of public health significance through the prompt identification of disease, notification of responsible health authorities, and institution of preventive and ameliorative measures.

[7.4.3.6 NMAC - Rp, 7.4.3.6 NMAC, 04/30/2009]

7.4.3.7 DEFINITIONS:

As used in these provisions, the following terms shall have the meaning given to them, except where the context clearly requires otherwise.

A. "Acute care hospital" means a hospital providing emergency services, in-patient medical and nursing care for acute illness, injury, surgery or obstetrics; ancillary services such as pharmacy, clinical laboratory, radiology, and dietary are required for acute care hospitals.

B. "Cancer" means all malignant neoplasms and in situ neoplasms and all intracranial neoplasms, regardless of the tissue of origin.

C. "Carrier" means an infected person or animal that harbors a specific infectious agent without clinical symptoms and that serves as a potential source of infection for humans.

D. "Condition of public health significance" means a condition dangerous to public health or safety.

E. "Designee" means an agency or instititution designated by the department of health to receive reports of notifiable conditions on its behalf for the purpose of public health surveillance.

F. "Disease" means an illness, including those caused by infectious agents or their toxic products which may be transmitted to a susceptible host.

G. "Division" means the epidemiology and response division of the department of health, P.O. Box 26110, Santa Fe, NM 87502-6110.

H. "Health care professional" means any licensed doctor of medicine or osteopathy, nurse, physician’s assistant, midwife, veterinarian or other licensed health care provider.

I. "Isolation, detention or quarantine" means the complete separation or partial restriction of movement and association in such manner and for such period to prevent the direct and indirect transmission of the infectious agent.

J. "Laboratory" means the scientific laboratory division of the department of health or any other laboratory which performs diagnostic tests on specimens obtained from New Mexico sources for diseases and conditions covered by these rules.

K. "Notifiable condition" means a disease or condition of public health significance required by statute or these rules to be reported to the department of health.

L. "Other person" includes but is not limited to: laboratory staff; an official in charge of any health facility; hospital records or administrative personnel; the principal or person in charge of any private or public school, or child care center; teachers and school nurses; and a householder or any other person, in the absence of a health care professional having direct knowledge of a disease or condition of public health significance.

M. "Regional or local public health office" means a public health office designated by the public health division of the department of health.

N. "Report" means a notification to the department of health pursuant to these rules.

O. "Specimen" means any material derived from humans or animals for examination for diagnosis, prevention or treatment of any disease or condition of public health significance.

[7.4.3.7 NMAC - Rp, 7.4.3.7 NMAC, 04/30/2009; A, 02/29/2012; A, 06/15/2016]

7.4.3.8 NOTIFIABLE CONDITIONS:

A. Declaration of notifiable conditions: The division shall periodically issue a list of notifiable conditions according to reporting category designated as 7.4.3.13 NMAC. The list shall be reviewed on a regular basis and revised as necessary. Diseases shown in 7.4.3.13 NMAC are declared notifiable conditions as of the effective date.

B. Official listing: The list of notifiable conditions shall be issued in a quick reference format and shall show that it is the current official list and shall specify its effective date. The division shall routinely supply the current official list to health care professionals and health facilities and to other persons or entities on request.

C. Reporting of notifiable conditions: Reporting will be by means of the following:

(1) the division’s 24-hour telephone number as listed in the report, "*New Mexico epidemiology*," the division’s newsletter or by direct telephone contact with the regional or local public health office;

(2) the division’s toll-free telephone receiving and recording system telephone number listed in the report "*New Mexico epidemiology*";

(3) for specified conditions, reporting to the address/phone number published on the printed form of the "list of notifiable conditions";

(4) written report to the division; or

(5) electronic transmission, which includes facsimile and computer data transfers.

D. Reporting requirements - health care professionals: Every health care professional treating any person or animal having or suspected of having any notifiable condition shall report the condition within the time and in the manner set out in the list of notifiable conditions.

E. Reporting requirements - laboratories: All laboratories performing diagnostic tests for any notifiable condition shall report all positive findings within the time and in the manner set out in the list. Reports shall include the name of the reporting laboratory, the patient's name, date of birth/age, and address, the date of clinical diagnosis, if known, and the health care professional or hospital requesting the test.

F. Reporting requirement - other persons: Any other person, including all persons listed in Subsection L of 7.4.3.7 NMAC of these rules, having knowledge of any person having or suspected of having a notifiable condition, shall immediately report the condition to the division.

G. Conditions of public health significance: Any person, including health care professionals and persons listed in Subsection L of 7.4.3.7 NMAC of these rules, having knowledge of a notifiable condition shall immediately report the condition to the division.

[7.4.3.8 NMAC - Rp, 7.4.3.8 NMAC, 04/30/2009; A, 02/29/2012]

7.4.3.9 CONTROL OF DISEASE AND CONDITIONS OF PUBLIC HEALTH SIGNIFICANCE:

A. Responsibility for protection of public health: The department of health may take such measures as are deemed necessary and proper for the protection of the public health.

B. Coordination among agencies: The department of health shall coordinate the efforts of other concerned or interested federal, state and local agencies and shall cooperate with local health care professionals and health care facilities.

C. Imposition of isolation or quarantine: The department of health may establish or require isolation or quarantine of any animal, person, institution, community or region.

D. Case incidence in schools or health facilities: Where any case of communicable disease occurs or is likely to occur in a public, private, or parochial school, child care facility, or in a health care facility, the department of health may require the school or facility to:

(1) exclude infected persons and non-immune persons, whether students, patients, employees or other persons;

(2) close and discontinue operations if there is likelihood of an epidemic.

E. Refusal of voluntary treatment, detention or observation: When a person who is actively infectious with a threatening communicable disease refuses voluntary treatment, detention or observation, the department of health may seek a court order to detain the person pursuant to Section 24-1-15 NMSA 1978 of the Public Health Act until the person is no longer a contagious threat to the public or the person voluntarily complies with appropriate treatment and contagion precautions.

F. Other public health orders: The department of health may issue orders for the testing of particular populations or groups of persons or animals to identify carriers of disease, including immigrants, travelers, students or preschoolers and others who have been at risk of transmission or exposure. The department of health may require that all tests be done under the control of the scientific laboratory division or by a laboratory approved for that purpose.

G. Enforcement of public health orders: Any order issued by the department of health under the Public Health Act or these rules shall be enforceable as provided by law and violation is punishable in accordance with Section 24-1-21 NMSA 1978.

H. Medical records: To carry out its duties to investigate and control disease and conditions of public health significance, the department of health or designee shall have access to all medical records of persons with, or suspected of having, notifiable diseases or conditions of public health significance. The department of health is a "public health authority" as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Rule. The department of health is authorized to receive protected health information without patient authorization for purposes of public health surveillance, investigation and interventions and as otherwise required by law. The division or designee may periodically review medical records to ensure the completeness and quality of reporting.

I. Confidentiality of reports: All notifiable condition reports are confidential. Disclosure to any person of report information, except for disclosure for the purpose of prevention, treatment or control, is prohibited unless disclosure is required by law.

J. Research use of notifiable condition data: Researchers authorized by the division or its designee who certify to the satisfaction of the division that confidentiality of data will be maintained in accordance with applicable state and federal confidentiality requirements, may conduct studies utilizing notifiable condition data, including studies of the sources and causes of conditions of public health significance, evaluations of the cost, quality, efficacy and appropriateness of screening, diagnostic, therapeutic, rehabilitative and preventive services and programs relating to conditions of public health significance and other clinical or epidemiologic research.

[7.4.3.9 NMAC - Rp, 7.4.3.9 NMAC, 04/30/2009; A, 02/29/2012; A, 06/15/2016]

7.4.3.10 EMERGENCY DEPARTMENT REPORTING:

A. Reporting requirements: Hospitals shall report all emergency department visits electronically to the department of health in such a format, with such data elements and in accordance with such standards of quality, timeliness and completeness as established by the department of health.

B. Confidentiality: All emergency department visit reports are confidential. Disclosure to any person of report information, except for disclosure of a notifiable condition for the purpose of prevention or control of diseases and other health conditions, is prohibited unless disclosure is required by law.

[7.4.3.10 NMAC - Rp, 7.4.3.10 NMAC & 7.4.3.11 NMAC, 04/30/2009]

7.4.3.11 HEALTHCARE-ASSOCIATED INFECTION REPORTING:

Acute care hospitals only will submit data to the New Mexico department of health using the centers for disease control and prevention national healthcare safety network (NHSN) and confer rights to access the data to the New Mexico department of health for central line-associated bloodstream infections and clostridium difficile infections. All carbapenem-resistant enterobacteriaceae and carbapenem-resistant pseudomonas aeroginosa cases, including non-healthcare-associated, will be reported to the New Mexico department of health.

[7.4.3.11 NMAC - N, 02/29/2012; A, 06/15/2016]

7.4.3.12 REPEALER:

These requirements repeal and replace all previous rules, particularly rules governing the control of communicable disease of November 11, 1952, rules governing the reporting of notifiable disease of June 29, 1974 and rules governing the control of disease and conditions of public health significance of 1980.

[7.4.3.12 NMAC - Rp, 7.4.3.12 NMAC, 04/30/2009; 7.4.3.12 NMAC - Rn, 7.4.3.11 NMAC, 02/29/2012]

7.4.3.13 NOTIFIABLE DISEASES OR CONDITIONS IN NEW MEXICO:

A. All reports including electronic laboratory reports of notifiable conditions, must include:

(1) the disease or condition being reported;

(2) patient’s name, date of birth/age, gender, race/ethnicity, address, patient telephone numbers, and occupation;

(3) physician or licensed healthcare professional name and telephone number; and

(4) healthcare facility or laboratory name and telephone number, if applicable.

B. Laboratory or clinical samples for conditions marked with (*) are required to be sent to the scientific laboratory division.

C. Emergency reporting of diseases or conditions: The following diseases, confirmed or suspected, require **immediate reporting** by telephone to the epidemiology and response division at (505) 827-0006.

(1) Infectious diseases:

(a) anthrax*;

(b) avian or novel influenza*;

(c) bordetella species (including pertussis)*;

(d) botulism (any type)*;

(e) cholera*;

(f) diphtheria*;

(g) haemophilus influenzae invasive infections*;

(h) measles;

(i) Middle East respiratory syndrome;

(j) meningococcal infections, invasive*;

(k) plague*;

(l) poliomyelitis, paralytic and non-paralytic;

(m) rabies;

(n) rubella (including congenital);

(o) severe acute respiratory syndrome (SARS)*;

(p) smallpox*;

(q) tularemia*;

(r) typhoid fever*;

(s) viral hemorrhagic fever;

(t) yellow fever.

(2) Other conditions:

(a) suspected foodborne illness in two or more unrelated persons*;

(b) suspected waterborne illness or conditions in two or more unrelated persons*;

(c) illnesses or conditions suspected to be caused by the intentional or accidental release of biologic or chemical agents*;

(d) acute illnesses or conditions of any type involving large numbers of persons in the same geographic area;

(e) severe smallpox vaccine reaction;

(f) other illnesses or conditions of public health significance.

(3) Infectious diseases in animals:

(a) anthrax;

(b) plague;

(c) rabies;

(d) tularemia.

D. Routine reporting of diseases or conditions:

(1) Infectious diseases (report case within 24 hours to epidemiology and response division by fax at 505-827-0013 or by phone at 505-827-0006; or contact the local health office).

(a) arboviral disease;

(b) brucellosis;

(c) campylobacter infections*;

(d) chikungunya virus disease;

(e) clostridium difficile*;

(f) coccidioidomycosis;

(g) Colorado tick fever;

(h) cryptosporidiosis;

(i) cysticercosis;

(j) cyclosporiasis;

(k) dengue;

(l) E. coli 0157:H7 infections*;

(m) E. coli, shiga-toxin producing (STEC) infections*;

(n) encephalitis, other;

(o) giardiasis;

(p) group A streptococcal invasive infections*;

(q) group B streptococcal invasive infections*;

(r) Hansen's disease/leprosy;

(s) hantavirus pulmonary syndrome;

(t) hemolytic uremic syndrome;

(u) hepatitis A, acute;

(v) hepatitis B, acute or chronic;

(w) hepatitis C, acute or chronic;

(x) hepatitis E, acute;

(y) influenza-associated pediatric death;

(z) influenza, laboratory confirmed hospitalization only;

(aa) legionnaires' disease;

(bb) leptospirosis;

(cc) listeriosis*;

(dd) lyme disease;

(ee) malaria;

(ff) mumps;

(gg) necrotizing fasciitis*;

(hh) psittacosis;

(ii) q fever;

(jj) relapsing fever;

(kk) Rocky Mountain spotted fever;

(ll) salmonellosis*;

(mm) shigellosis*;

(nn) St. Louis encephalitis infections;

(oo) streptococcus pneumoniae, invasive infections*;

(pp) tetanus;

(qq) trichinellosis;

(rr) toxic shock syndrome;

(ss) varicella;

(tt) vibrio infections*;

(uu) west nile virus infections;

(vv) western equine encephalitis infections;

(ww) yersinia infections*.

(2) Infectious diseases in animals (report case within 24 hours to epidemiology and response division at 505-827-0006; or contact the local health office).

(a) arboviral, other;

(b) brucellosis;

(c) psittacosis;

(d) west nile virus infections.

(3) Tuberculosis*. Report suspect or confirmed cases to NM department of health tuberculosis program by fax at 505-827-0163 or by phone at 505-827-2471 or 505-827-2473: active disease within 24 hours; infection within 72 hours.

(4) Sexually transmitted diseases. Report to infectious disease bureau - STD program, NM department of health, P.O. Box 26110, Santa Fe, NM 87502-6110, fax 505-476-3638; or call 505-476-3636.

(a) chancroid;

(b) chlamydia trachomatis infections;

(c) gonorrhea;

(d) syphilis.

(5) HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome). Report to HIV and hepatitis epidemiology program, 1190 St. Francis Dr., N1350, Santa Fe, NM 87502, fax 505-476-3544 or call 505-476-3515.

(a) all confirmed positive HIV antibody tests (screening test plus confirmatory test);

(b) all tests for HIV RNA or HIV cDNA (‘-viral load tests-’);

(c) all tests to detect HIV proteins;

(d) all positive HIV cultures;

(e) all HIV genotype tests;

(f) all CD4 lymphocyte tests (count and percent);

(g) opportunistic infections, cancers and any other test or condition indicative of HIV or AIDS.

(6) Occupational illness and injury. Report to epidemiology and response division, NM department of health, P.O. Box 26110, Santa Fe, NM 87502-6110; or call 505-827-0006.

(a) asbestosis;

(b) coal worker's pneumoconiosis;

(c) hypersensitivity pneumonitis;

(d) mesothelioma;

(e) noise induced hearing loss;

(f) occupational asthma;

(g) occupational burn hospitalization;

(h) occupational injury death;

(i) occupational pesticide poisoning;

(j) occupational traumatic amputation;

(k) silicosis;

(l) other illnesses or injuries related to occupational exposure.

(7) Health conditions related to environmental exposures and certain injuries. Report to epidemiology and response division, NM department of health, P.O. Box 26110, Santa Fe, NM 87502-6110; or call 505-827-0006.

(a) Environmental exposures:

(i) all pesticide poisoning;

(ii) arsenic in urine greater than 50 micrograms/liter;

(iii) carbon monoxide poisoning;

(iv) infant methemoglobinemia;

(v) lead (all blood levels);

(vi) mercury in urine greater than 3 micrograms/liter or mercury in blood greater than 5 micrograms/liter;

(vii) uranium in urine greater than 0.2 micrograms/liter or 0.2 micrograms/gram creatinine;

(viii) other suspected environmentally-induced health conditions.

(b) Injuries:

(i) drug overdose;

(ii) firearm injuries;

(iii) fracture due to fall among older adults;

(iv) traumatic brain injuries.

(8) Adverse vaccine reactions. Report to vaccine adverse events reporting system, http://www.vaers.hhs.org. Send copy of report to immunization program vaccine manager, NM department of health, P.O. Box 26110, Santa Fe, NM 87502-6110; fax 505-827-1741.

(9) Healthcare-associated infections.

(a) Acute care hospitals only report through NHSN and confer rights to NM department of health.

(i) central line-associated bloodstream infections (CLABSI) events;

(ii) clostridium difficile infections.

(b) Report all infections, including non-healthcare-associated, within 24 hours to epidemiology and response division by fax at 505-827-0013 or by phone at 505-827-0006.

(i) carbapenem-resistant enterobacteriaceae*;

(ii) carbapenem-resistant pseudomonas aeruginosa*.

(10) Cancer. Report to designee. Report all malignant and in situ neoplasms and all intracranial neoplasms, regardless of the tissue of origin, using the prevailing standards promulgated by the national cancer institute, the centers for disease control and prevention, the North American association of central cancer registries, and the American college of surgeons.

(11) Human papillomavirus (HPV). Laboratories report the following tests to designee:

(a) papanicolaou test results (all results);

(b) cervical, vulvar and vaginal pathology results (all results);

(c) HPV test results (all results).

(12) Birth defects.

(a) Report to epidemiology and response division, NM department of health, P.O. Box 26110, Santa Fe, NM 87502-6110; or call 505-827-0006.

(b) All birth defects diagnosed by age 4 years, including:

(i) defects diagnosed during pregnancy;

(ii) defects diagnosed on fetal deaths;

(iii) defects found in chromosome testing on amniotic fluid, chorionic villus sampling and products of conception for trisomy 13, trisomy 18 and trisomy 21.

(13) Genetic and congenital hearing screening. Report to children's medical services, 2040 S. Pacheco, Santa Fe, NM 87505; or call 505-476-8868.

(a) neonatal screening for congenital hearing loss (all results);

(b) suspected or confirmed congenital hearing loss in one or both ears;

(c) all conditions identified through statewide newborn genetic screening;

(d) newborn critical congenital heart defects screening (all results).

[7.4.3.13 NMAC - Rn & A, 7.4.3.12 NMAC, 02/29/2012; A, 06/15/2016]

PART 4: [RESERVED]

PART 5: MATERNAL, FETAL, INFANT AND CHILD DEATH REVIEW

7.4.5.1 ISSUING AGENCY:

New Mexico Department of Health, Public Health Division, Family Health Bureau.

[01/01/98; Recompiled 10/31/01]

7.4.5.2 SCOPE:

These regulations shall apply to the operations of the New Mexico maternal mortality review team, fetal and infant mortality review team, child fatality review team *and any other team which is deemed necessary by the department* and their policies and procedures, confidentiality provisions, management of records, dissemination of

findings and recommendations; and to the public and private entities from whom data, information or records are requested for the purpose of mortality or fatality review.

[01/01/98; Recompiled 10/31/01]

7.4.5.3 STATUTORY AUTHORITY:

A. The regulation set forth herein is promulgated by the secretary of the department of health by authority of the Department of Health Act, Section 9-7-6.E. NMSA 1978 and the Public Health Act, Section 24-1-3 NMSA 1978, specifically Section 24-1-3. C. NMSA 1978, which states: *"The department has authority to: investigate, control and abate the causes of disease, especially epidemics, sources of mortality and other conditions of public health;* and Section 24-1-3. F. NMSA 1978, which states: *"The department has authority to: establish programs and adopt regulations to prevent infant mortality, birth defects and morbidity;* and Section 24-1-3. H. NMSA 1978, which states: *"The department has authority to: provide educational programs and disseminate information on public health."* The administration and enforcement of these regulations is the responsibility of the public health division of the department.

B. Related statutes and regulations: New Mexico law provides for other statutes and regulations that support or limit the statutory authority of the department to regulate the review of maternal, fetal, infant or child deaths.

[01/01/98; Recompiled 10/31/01]

7.4.5.4 DURATION:

Permanent

[01/01/98; Recompiled 10/31/01]

7.4.5.5 EFFECTIVE DATE:

January 1, 1998, unless a later date is cited at the end of a section or paragraph.

[01/01/98; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.4.5.6 OBJECTIVE:

The purpose of the retrospective case review of death in the maternal, fetal, infant and child population in New Mexico by a multidisciplinary team of experts is to reduce future rates of such deaths by identification of prevention factors, risk reduction factors and/or

systems failure factors and the dissemination of such information to policy makers, providers, communities and to the public.

[01/01/98; Recompiled 10/31/01]

7.4.5.7 DEFINITIONS:

A. "AAP" means the American academy of pediatrics

B. "ACOG" means the American college of obstetricians and gynecologists.

C. "CYFD" means the New Mexico children, youth and families department.

D. "Child fatality review" or "CFR" means a review that includes all reported deaths of children due to fatal injury or other undetermined cause from birth through 24 years of age, or a specific age range as determined appropriate by a special panel.

E. "Community based review" means the review that takes place in the community where the death occurs, is staffed by Team members approved by the department and may involve follow-back interview with informed consent to surviving family, providers of care or other relevant persons.

F. "Coordinator" means the person designated by the department to administer and manage the day to day operations of the review teams.

G. "Confidentiality" means the protection of the privacy of the decedent, the decedent's family, and any information pertaining to the fatality.

H. "Department" or "DOH" means the New Mexico department of health.

I. "Department designee for MCH death review" means the department staff person, usually an epidemiologist, authorized to receive information regarding deaths that fit the criteria for MMR, FIMR and CFR.

J. "Death investigation" means the investigation of a death by appropriate authorities for the purpose of establishing the manner and cause of death.

K. "Expert" means a person by whose training and present work-related activities or professional licensure has the requisite knowledge to review case information and contribute to an assessment of prevention factors, risk reduction factors and/or systems failure factors. The expert is bound by confidentiality policies and statute, and must be recognized by the department.

L. "Fetal and infant mortality review" or "FIMR" means a review including all reported deaths of fetuses (death prior to the complete expulsion or extraction from the

mother of a product of human conception, fetus and placenta, irrespective of the duration of pregnancy), and infants (any death at any time from birth through one year).

M. "MCH" means public health practice concerned with maternal and child health.

N. "Maternal mortality review" or "MMR" means the review of all reported deaths of the following: pregnant women who die from any cause during pregnancy, or who die within one calendar year of pregnancy termination.

O. "Multidisciplinary team" means a team of experts comprising, but not limited to, the disciplines essential to death review, such as medicine, nursing, social work, law enforcement, mental health, public health, education, domestic violence, and child advocacy.

P. "OMI" means the New Mexico office of medical investigator.

Q. "PHD" means the public health division of the department.

R. "Prevention factors" means the circumstances, events, exposures or products that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and/or educated for the prevention of future such death(s).

S. "Retrospective case review" means the gathering of case information and analysis of information after the manner and cause of death have been registered with vital records and health statistics. Retrospective case review is not a death investigation process. It is a public health function concerned with assessment, prevention, risk reduction and/or systems improvements.

T. "Risk reduction factors" means the circumstances, events, exposures or products that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and/or educated for the prevention of future such death(s).

U. "Secretary" means the secretary of the department or his/her designee.

V. "Special panel" means a group convened on a permanent or temporary basis for the MMR, FIMR or CFR Team, to review an aggregation of deaths by selected categories to increase the power of analysis and interpretation by reviewing several cases of a similar manner or cause of death.

W. "State level review" means the process whereby statewide quantitative and qualitative data, gathered either at the state level or by a local community death review team, are analyzed and used for development of public policy, public health recommendations, and/or implementation of prevention measures.

X. "System failure factors" means the community-based circumstances, events, resources including the lack thereof, and provider policies that are identified by the death review team as potential contributors to the death and about which providers, communities and/or the public need to be informed and or educated for the prevention of future such death(s).

Y. "Team" means one of the state or community level MMR, FIMR or CFR teams.

Z. "UNM" means the university of New Mexico.

AA. "VRHS/NM" means the department entity responsible for vital records and health statistics in New Mexico.

[01/01/98; Recompiled 10/31/01]

7.4.5.8 PROGRAM ADMINISTRATION:

MMR, FIMR, and CFR are administered by the public health division in the department in collaboration with the OMI of UNM. MMR, FIMR and CFR are coordinated by the MCH death review coordinator in the office of MCH epidemiology.

[01/01/98; Recompiled 10/31/01]

7.4.5.9 EXECUTIVE OVERSIGHT BOARD:

An executive oversight board will comprise department representatives designated by the secretary including but not limited to the office of the DOH chief medical officer, office of general counsel, offices of the PHD director, VRHS/NM, family health, MCH epidemiology; and a designated representative of OMI, ACOG and CYFD.

[01/01/98; Recompiled 10/31/01]

7.4.5.10 MEMBERSHIP:

The members of maternal mortality review team, the fetal and Infant mortality review team and child fatality review team will be state or local experts in their field and appointed by the department. Members are selected to achieve a culturally diverse, multidisciplinary team that may include but is not limited to representatives of the following disciplines: medicine and selected subspecialties, nursing, nurse-midwifery, forensic medicine, mental health, social work, specialists in child abuse and neglect, public health epidemiology, law enforcement, the judiciary, prosecution, traffic safety, education, child advocacy, grief intervention and support, domestic violence, health education, survivor or parent support groups. Membership will include representation from federal (military and Indian), state and local entities. Membership is voluntary and team members or special panel members shall not be remunerated by the department.

A. State level teams are organized for MMR, FIMR and CFR and are responsible for initial and/or final review of all cases, aggregate analysis of statewide data, and the identification and preparation of reports or other documents to address statewide and or local systems improvements, prevention, and risk reduction factors. State level teams are responsible for training, support and consultation to community level teams.

B. Community level teams shall be organized with training and support of state level teams, and shall abide by state level regulations, protocols and policies. The formation of community level teams shall be contingent upon available resources including consultation by specialists in appropriate disciplines. The purpose of a community team is to bring case review to the local level where identification of problems and development of interventions for systems improvements, risk reduction or prevention can take place

C. Special panels: Special ad hoc panels may be organized in response to any identified profile or cluster of fatalities that are identified by a team and the department, the OMI, or other appropriate entities as approved by the executive committee.

D. Maternal mortality review: The organizational membership of MMR shall seek to include, but not be limited to, representatives of the New Mexico section of ACOG; the New Mexico academy of family practice; the New Mexico hospital and health service association; the New Mexico association for women's health, obstetrics, and neonatal nursing; the New Mexico department of health, public health division; the New Mexico chapter of the American college of nurse midwives; the New Mexico vital records and health statistics entity; the Indian health service; the New Mexico office of the medical investigator; tertiary center perinatologists (institutions designated as level III neonatal intensive care unit); and community obstetricians and family practitioners.

E. Fetal and infant mortality review: The organizational membership of FIMR shall seek to include but not be limited to representatives from New Mexico units of the American academy of family physicians; the American academy of pediatrics; the American anthropological association; ACOG; the American college of nurse midwives; the New Mexico hospital and health service association; the MCH Title V entity of the department; the New Mexico vital records and health statistics entity; the association of state and territorial health officials; the college of American pathologists; the march of dimes birth defects foundation; the association for women's health, obstetric and neonatal nurses; and the society of perinatal obstetricians.

F. Child fatality review: The membership of CFR shall seek to include but not be limited to representatives of the following organizations and interest areas: law enforcement; prosecution; the medical and mental health communities; tribal governments; tribal social service agencies; military bases; a domestic violence program; a grief intervention program; the New Mexico traffic safety bureau; the New Mexico sudden infant death syndrome program; a child advocacy group; the unit responsible for the investigation and prevention of child abuse and neglect in CYFD; public health epidemiology, the New Mexico vital records and health statistics entity; the

MCH Title V entity in the department; a representative from OMI; a representative of the New Mexico not even one project, and a representative from the public school system.

[01/01/98; Recompiled 10/31/01]

7.4.5.11 CASE IDENTIFICATION:

Deaths of New Mexico residents which are registered with VRHS/NM will serve as the denominator or source file for MMR, FIMR and CFR. Deaths of non-residents which have occurred in New Mexico may not always be included.

A. MMR case identification: Deaths that meet criteria for maternal mortality review will be reported by OMI to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for MMR including a linked birth, death and fetal death file, will be reported by VRHS/NM to the department designee.

B. FIMR case identification: Deaths that meet criteria for fetal or infant mortality review will be reported by VRHS/NM to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for FIMR will be reported by VRHS/NM to the department designee.

C. CFR case identification: Deaths that meet criteria for child fatality review will be reported by OMI to the department designee on a monthly basis. At the closing of the VRHS/NM file for a calendar year, all deaths meeting criteria for child fatality review will be reported by VRHS/NM to the department designee for MCH death review.

[01/01/98; Recompiled 10/31/01]

7.4.5.12 DATA COLLECTION:

The department designee shall receive case identifiers from OMI and VRHS/NM and shall prepare the file for review by ascertaining what supplementary records are needed for a comprehensive case review. Case data and information are then requested from the relevant sources.

A. Non-federal sources: Relevant sources for FIMR, MMR, CFR review include but are not limited to: OMI records; providers of medical, health, nutrition and mental heath care; emergency department records; emergency transport records; hospital records; records of applicable law enforcement agencies; other public safety service records such as those maintained by fire departments; records of providers of social work care including child protective services; day care records; school-based records; motor vehicle crash reports.

B. Federal sources: Deaths meeting criteria for MMR, FIMR and CFR which have occurred on military reserves or Indian reservations will require collection of case

information from relevant federal agencies including but not limited to the federal bureau of investigation (FBI); the bureau of Indian affairs (BIA), the Indian health service (IHS), military and tribal police, and military and tribal social services.

C. Forms: A standard form to request information of private or public entities shall be used and which states the authority of the department with the signature of the chief medical officer of the department. The form shall be prepared, signed and dated by the department designee or the coordinator.

D. Collection of information by interview: Case review may include interviews with the decedent's family, care providers, and other relevant persons. These interviews will be conducted only with the informed consent of the interviewee.

E. Partial collection of information: In death review data collection where case information is sequestered, privileged, or confidential, the department will request information as required on the data form from appropriate agencies. Such deaths may be deferred for review until such time as the case file may be available for review.

[01/01/98; Recompiled 10/31/01]

7.4.5.13 CONFIDENTIALITY OF RECORDS, PROCEEDINGS AND FINDINGS:

MMR, FIMR and CFR involve the use of highly confidential case files which are protected by statute(s), regulation(s), departmental protocol, and policy.

A. Confidentiality of Information from VRHS/NM: Access to data constituting vital statistics as defined in the New Mexico Vital Statistics Act, Section 24-14-1, et seq. NMSA 1978, shall be in accordance with the Act and applicable department regulations.

B. Open records: All information and records accessed or in the possession of the MMR team, FIMR team, CFR team, or a special panel are confidential in accordance with the New Mexico Inspection of Public Records Act, Sections 14-2-1, et seq. NMSA 1978 and applicable law.

C. Member confidentiality statement: All members shall receive a training orientation regarding applicable statutes, protocols, and the rules for confidentiality. Each member is required to sign a confidentiality statement, the intent of which is to protect the confidentiality and privacy of the decedent, the decedent's family, and other individuals, agencies or providers cited in the case file. The confidentiality statement shall be signed by a team member prior to participation in case review and signed annually thereafter on July 1st or the first review session held for the state fiscal year. Experts invited for a special panel are to sign the confidentiality statement prior to participation in a case review.

D. Breach of confidentiality: Anyone who breaches confidentiality shall be subject to legal liability including, but not limited to, the provisions of the Vital Statistics Act at Sections 24-14-27 NMSA 1978 and 24-14-31 NMSA 1978.

E. Review team findings: The findings and recommendations of the MMR, FIMR, and CFR teams with respect to prevention, risk reduction or systems failures are the property of the department. They are based on retrospective case review. The process by which findings are derived is different from the understanding and judgment of a provider or any other person present at the time of caring for the decedent prior to the death. Findings and recommendations are prevention-oriented rather than investigatory. The opinions expressed are based upon an aggregate of information which has been compiled from a variety of sources post-mortem, and which was not available to any single provider at the time of death.

F. Closed meetings: Team meetings are not subject to the Open Meetings Act, Sections 10-15-1 through 10-15-4 NMSA 1978. Records of the team shall be confidential pursuant to the provisions of the Inspection of Public Records Act and Section 24-1-20 NMSA 1978 of the Public Health Act. Individuals who are not members of the team or special panel will not be allowed to be present at case reviews unless the individual is approved by the presiding chair with the consent of the panel or team, and that individual signs the confidentiality agreement.

G. Reports of findings: Statistical studies and research reports based upon the confidential information may be published, but they will not identify decedents, their families, or provide any other information that can be extrapolated to ultimately identify these individuals. Data will be published in the aggregate.

H. Follow-up to at-risk circumstances: In the event that a team or special panel finds that there are circumstances that may place others at risk for injury or untoward exposure, the department on behalf of the team or special panel shall inform the appropriate federal, state and/or community entity in accordance with procedures and protocols established by the department.

[01/01/98; Recompiled 10/31/01]

7.4.5.14 SECURITY OF RECORDS:

A. Statistical information: Information from forms completed by any of the teams or its special panels will be entered without personal identifiers into a data base dedicated solely to MMR, FIMR and CFR, and will be accessed only by the team coordinator, the department designee for MCH death review, and the individual who is responsible for data base management and data entry. Personal identifiers include first, middle, and last name, and the street address of decedent or other persons, including providers.

B. Administrative information: The review forms with personal identifiers will be kept in a secure, locked location which can be accessed only by the department designee for

MCH death review, the coordinator, and the individual responsible for data base management and entry.

C. Management of case documentation during review session: Team members are prohibited from leaving case reviews with any identifiable written review information that is related to cases under review, those cases which have been reviewed, and those cases which will be reviewed. All materials held by anyone other than the coordinator of the review team, the department designee for MCH death review, an OMI representative, or the designee of any of the aforementioned individuals will be collected and destroyed by the presiding chair of the team reviewing the case.

[01/01/98; Recompiled 10/31/01]

7.4.5.15 DISSEMINATION OF INFORMATION:

Non-identified, aggregate data and descriptive risk information will be disseminated by the MMR, FIMR or CFR team in annual reports, epidemiological bulletins to providers, informational releases to the public regarding preventable risk, and special reports to the New Mexico legislature and other appropriate groups.

[01/01/98; Recompiled 10/31/01]

PART 6: REQUIREMENTS GOVERNING THE HARM REDUCTION/SYRINGE EXCHANGE PROGRAM

7.4.6.1 ISSUING AGENCY:

Department of Health, Public Health Division, Bureau of Infectious Diseases.

[7.4.6.1 NMAC - Rp, 7.4.6.1 NMAC, 11/29/2022]

7.4.6.2 SCOPE:

These regulations govern the operation of harm reduction programs for the purpose of reducing overdose mortality and other negative health consequences associated with substance use.

[7.4.6.2 NMAC - Rp, 7.4.6.2 NMAC, 11/29/2022]

7.4.6.3 STATUTORY AUTHORITY:

The statutory authority for adopting these rules is found in Subsection E of Section 9-7-6 NMSA 1978, The Harm Reduction Act, Section 24-2C-1 to 24-2C-6 NMSA 1978, the Public Health Act, Section 24-1-3 NMSA 1978, and Section 30-31-25.1 NMSA 1978 of the Controlled Substances Act.

[7.4.6.3 NMAC - Rp, 7.4.6.3 NMAC, 11/29/2022]

7.4.6.4 DURATION:

Permanent.

[7.4.6.4 NMAC - Rp, 7.4.6.4 NMAC, 11/29/2022]

7.4.6.5 EFFECTIVE DATE:

November 29, 2022, unless a later date is cited at the end of a section.

[7.4.6.5 NMAC - Rp, 7.4.6.5 NMAC, 11/29/2022]

7.4.6.6 OBJECTIVE:

These Regulations implement the requirements of the Harm Reduction Act to establish and regulate the harm reduction program for the purpose of reducing overdose mortality and other negative health consequences of substance use, including preventing the transmission of infectious diseases and encouraging drug users to seek treatment.

[7.4.6.6 NMAC - Rp, 7.4.6.6 NMAC, 11/29/2022]

7.4.6.7 DEFINITIONS:

As used in these regulations:

A. "Blood borne pathogens" means the hepatitis B virus (HBV), hepatitis C virus (HCV), the human immunodeficiency virus (HIV) and any other blood borne disease.

B. "Department" means the New Mexico Department of Health.

C. "Harm Reduction Act" means Section 24-2C-1 to 24-2C-6, NMSA 1978.

D. "Harm Reduction ID Code" means a unique alpha-numeric code assigned to a participant through the process determined by the harm reduction program, this code shall not bear the participant's full name.

E. "Harm Reduction Participant Card" means a card issued to a participant by the department of health or HRPs which verify the participant is enrolled in the harm reduction program, this card shall contain the Harm Reduction ID Code and an expiration date.

F. "Harm Reduction Provider (HRP)" means a public health office, community agency, service provider, individual, or other location which has applied and been accepted by the New Mexico department of health to provide harm reduction activities

in accordance with the requirements of the Harm Reduction Act, these regulations and department of health protocols and guidelines.

G. "Harm Reduction Specialist" means an employee or volunteer of an HRP who has completed the department approved harm reduction certification curriculum.

H. "Hepatitis and Harm Reduction Program" means the team of staff members within the department public health division who have the primary responsibility to regulate and implement the provisions of the Harm Reduction Act, these regulations, and related department protocols and guidelines.

I. "Participant" means anyone enrolled for services at any Harm Reduction Provider and may receive supplies, devices or any other service provided by the Harm Reduction Provider.

[7.4.6.7 NMAC - Rp, 7.4.6.7 NMAC, 11/29/2022]

7.4.6.8 GENERAL PROVISIONS GOVERNING THE HRP APPLICATION APPROVAL AND REVOCATION PROCESSES:

A. Any entity, other than HRPs already designated herein, seeking to become a HRP must submit an application to the hepatitis and harm reduction program. The application must include, at a minimum:

(1) name of the entity;

(2) primary contact information, including: name, telephone number and email address;

(3) mailing address;

(4) definition of the geographic area to be served;

(5) a statement confirming that if approved, the entity will participate in training and evaluation activities as required by the harm reduction program;

(6) relevant experience in providing disease prevention services, health care services, social services or substance use treatment services to individuals injecting substances; and

(7) any other information required by the harm reduction program.

B. The hepatitis and harm reduction program shall review applications to determine whether they meet the statutory and regulatory requirements. Upon approval of the application, the entity will be authorized by the harm reduction program as an HRP.

C. All organizations that provide direct services to individuals who use substances, including law enforcement, emergency medical response, medical providers, substance use treatment programs, and correctional institutes shall be considered an HRP for the sole purpose of providing fentanyl test strips or other devices approved by the department to check for potential adulterants. Organizations utilizing this limited option do not need to meet the HRP requirements outlined in section 7.4.6.9 of these rules.

[7.4.6.8 NMAC - Rp, 7.4.6.8 NMAC, 11/29/2022]

7.4.6.9 HARM REDUCTION PROVIDER REQUIREMENTS:

A. The HRP shall maintain regular and consistent hours of service to ensure participant engagement.

B. The HRP may cancel a harm reduction session in the event of unforeseen circumstances which may impact service delivery such as lack of staffing, severe weather, threats or acts of violence, or other unforeseen emergencies which may create an unsafe environment.

C. The HRP must make available educational materials related to improving the health of individuals who use substances including information on substance use treatment, disease transmission and prevention, and overdose prevention strategies.

D. The HRP must notify the hepatitis and harm reduction program within 72 hours of any concerns or complaints received by community members about the HRP.

E. The HRP must have at least two staff members or volunteers present, or within voice or a direct line-of-sight visual signal range, or one staff member present and one staff member or volunteer able to communicate in real-time via telephone, radio, internet or other means at all times during harm reduction sessions. Staff members and volunteers may not be impaired during harm reduction sessions.

F. All harm reduction specialists shall be fully vaccinated against viral hepatitis or other transmissible disease in accordance with centers for disease control and prevention and department guidelines.

G. Staff and volunteers shall follow these regulations and the United States department of labor occupational safety and health administration standards and hepatitis and harm reduction program guidelines with regard to the proper handling and legal disposal of biohazardous material.

H. The HRP must record harm reduction activities conducted utilizing the forms approved by the hepatitis and harm reduction program and submit the forms to the hepatitis and harm reduction program.

I. The HRP must develop and maintain an accidental needle stick protocol. If a person experiences a needle stick accident, the HRP accidental needle stick protocol should be followed.

J. The HRP must report all unexpected harm reduction session cancellations, needle stick accidents, violent acts, incidents involving law enforcement agents, and arrests of participants or staff during a harm reduction session within 24 hours of the incident via email or phone.

K. The HRP must cooperate with the department in data collection, site visits and inspections, quality assurance, and other efforts to evaluate harm reduction activities.

(1) The HRP must keep all forms used to record and report activities either electronically or in hard copy for three years.

(2) All HRP must provide the harm reduction program with the with forms used to record and report activities monthly in a format determine by the hepatitis and harm reduction program.

L. The HRP must adhere to all other hepatitis and harm reduction guidelines related to program operation.

M. The HRP must comply with these regulations, including safety requirements, participant enrollment procedures, and confidentiality of participant information. Failure to do so is grounds for revocation of the authorization to conduct harm reduction activities.

[7.4.6.9 NMAC - Rp, 7.4.6.9 NMAC, 11/29/2022]

7.4.6.10 SUPPLIES PROVIDED:

Supplies which are permitted to be provided by the HRPs, listed below, include items which have been determined by the department to reduce negative health consequences associated with substance use, to prevent overdose mortality, and items designed to encourage participant engagement in other programming designed to improve overall community health. These items shall include:

A. Safer smoking supplies limited to screens, pipe covers, wooden pushers, copper scrub pads, uncoated foil, cured foil, or any other type of aluminum foil and straws designed to inhale substances.

B. Safer snorting supplies limited to clean spoons for measurement, clean plastic razors, clean flat surfaces.

C. Safer injecting supplies limited to syringes and needles, metal containers for cooking substances, cotton pellets or other filtration devices, twist ties, tourniquets,

sterile water and saline, ascorbic acid, and biohazard containers for disposal of used syringes and needles.

D. Supplies or devices used for testing controlled substances or controlled substance analogs for potentially dangerous adulterants, including fentanyl test strips.

[7.4.6.10 NMAC - N, 11/29/2022]

7.4.6.11 PARTICIPANT ENROLLMENT:

A. Each new participant who enrolls for services at an HRP shall be provided a harm reduction Participant card which shall have an expiration date of two years from the initial enrollment.

B. If a participant loses or misplaces their harm reduction participant card they shall be issued a new harm reduction participant card with an expiration date of two years from the day it was issued.

C. Once participants are enrolled at any HRP they enrolled in the statewide program and can participate with any HRP in the state of New Mexico. Participants do not need to re-enroll at each HRP where they seek services.

D. If a participant loses or misplaces their harm reduction participant card, they shall be issued a new harm reduction participant card with an expiration date of two years from the day it was re-issued. At the time of enrollment and re-enrollment participant should be instructed the harm reduction participant card is only for the use of the person to whom the card was issued.

E. Participants shall be informed harm reduction program participation will not prohibit their arrest or prosecution for the possession of residue in the supplies used to consume substances.

F. Individuals do not need to be enrolled as a HRP participant to receive testing supplies or testing devices from a HRP.

[7.4.6.11 NMAC - Rp, 7.4.6.10 NMAC, 11/29/2022]

7.4.6.12 HARM REDUCTION PROGRAM PARTICIPANT REQUIREMENTS:

A. Participants must provide their harm reduction participant card code to staff in order to supplies from the program.

B. Follow the hepatitis and harm reduction program and HRP guidelines, as informed by HRP staff, with regard to handling and disposing of potentially biohazardous material.

C. Participant must not carry weapons on them during a harm reduction session.

D. Refrain from threatening behavior and acts of violence at a harm reduction session. Failure to do so may result in suspension from the program.

[7.4.6.11 NMAC - Rp, 7.4.6.12 NMAC, 11/29/2022]

PART 7: HUMAN IMMUNODEFICIENCY VIRUS PARTNER SERVICES

7.4.7.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.4.7.1 NMAC - N, 4/29/2011]

7.4.7.2 SCOPE:

All physicians, health care professionals, and other persons having knowledge of persons diagnosed with human immunodeficiency virus infection covered by this regulation.

[7.4.7.2 NMAC - N, 4/29/2011]

7.4.7.3 STATUTORY AUTHORITY:

These provisions set forth herein are promulgated by the secretary of the department of health by authority of Sections 9-7-6(E) NMSA 1978 and 24-2B-6 NMSA 1978. Administration and enforcement of these rules are the responsibility of the department of health.

[7.4.7.3 NMAC - N, 4/29/2011]

7.4.7.4 DURATION:

Permanent.

[7.4.7.4 NMAC - N, 4/29/2011]

7.4.7.5 EFFECTIVE DATE:

April 29, 2011, unless a later date is cited at the end of a section.

[7.4.7.5 NMAC - N, 4/29/2011]

7.4.7.6 OBJECTIVE:

The objective of these rules is to offer early detection and intervention to those who may unknowingly be at risk of having HIV infection. The department hereby establishes a protocol to contact individuals known to be infected with HIV to offer them partner services, including assistance notifying people that the infected individual identifies as being exposed to HIV.

[7.4.7.6 NMAC - N, 4/29/2011]

7.4.7.7 DEFINITIONS:

A. "Department" means the department of health.

B. "Exposed person" means a person who is potentially at risk of acquiring infection with HIV through exposure to infectious blood or body fluids.

C. "Health care professional" means any licensed doctor of medicine or osteopathy, nurse, physicians assistant, midwife, or other licensed health care provider.

D. "HIV" means the human immunodeficiency virus.

E. "Partner s**ervices"** means a voluntary, confidential service offered to source persons and identified exposed persons that includes, but is not limited to, the provision of anonymous or confidential testing for HIV, assistance with disclosure regarding HIV infection status, partner notification regarding potential exposure and linkage to additional medical, social and public health services for both source and exposed persons.

F. "Source person" means a person who is identified as a confirmed source of exposure to HIV through transmission of potentially infectious blood or body fluids.

[7.4.7.7 NMAC - N, 4/29/2011]

7.4.7.8 ROLE OF HIV AND HEPATITIS EPIDEMIOLOGY PROGRAM (HHEP) OF THE DEPARTMENT OF HEALTH:

A. The HHEP receives all laboratory and morbidity case reports for identified cases of HIV infection.

B. Upon receipt of a reported case of HIV, the HHEP will verify if the case represents a previously unreported or unidentified case of HIV in the state of New Mexico.

C. For cases which were previously unreported or unidentified, the HHEP will make a reasonable attempt to contact the health professional ordering the diagnostic test or reporting the case in order to do the following:

(1) determine if the source person has been notified of their diagnosis;

(2) determine if partner services have already been initiated;

(3) obtain any available contact information for the source person for the purposes of offering partner services;

(4) notify the health care professional that partner services will be initiated by a department of health staff member, if partner services have not previously been initiated by the department of health;

(5) obtain any additional information as required under administrative rule reporting requirements for HIV cases.

D. The HHEP will then notify the designated department staff member of a source person who shall be offered partner services. Any information that the HHEP staff shares with department staff will be transferred, stored, and maintained according to security and confidentiality standards set by the department and in accordance with requirements from the federal centers for disease control and prevention (CDC).

[7.4.7.8 NMAC - N, 4/29/2011]

7.4.7.9 ROLE OF DEPARTMENT OF HEALTH PARTNER SERVICES STAFF:

A. The designated department staff member will make a reasonable attempt to contact the source person in order to offer partner services.

B. Any information that the department staff receives from the HHEP will be transferred, stored, and maintained according to security and confidentiality standards set by the department and in accordance with requirements from the federal centers for disease control and prevention (CDC).

C. Participation in partner services by the source person is voluntary and confidential.

D. Partner services may also be initiated by request of the source person, by request of their health care provider, or through department staff involved in the care or public health investigation of that source person.

E. The identity of exposed persons revealed by a source person shall be confidential and shall not be revealed. Disclosure to any person of a potential exposed person’s identity, except for disclosure for the purpose of prevention or control, including offering partner services, is prohibited unless disclosure is required by law.

F. Any exposed persons contacted by department staff shall not be told the identity of the source person who identified him or her as a contact.

G. For exposed persons contacted in the course of partner services, participation in partner services, further testing, or evaluation is voluntary and confidential.

H. Exposed persons shall be given information on available resources and testing.

[7.4.7.9 NMAC - N, 4/29/2011]

7.4.7.10 REPORTING OF POTENTIAL CRIMINAL SEXUAL ACTS OR ABUSE OR NEGLECT:

In the course of conducting partner services, if a department staff member discovers or has a reasonable suspicion that a criminal act has occurred or that an individual has been abused or neglected, that staff member or the appropriate supervisor of that staff member shall contact department counsel to determine the appropriate course of action and the department shall comply with all mandated reporting requirements.

[7.4.7.10 NMAC - N, 4/29/2011]

PART 8 MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY REVIEW

7.4.8.1 ISSUING AGENCY:

Department of Health, Public Health Division, Family Health Bureau.

[7.4.8.1 NMAC - N, 11/08/2022]

7.4.8.2 SCOPE:

These regulations shall apply to the New Mexico maternal mortality review committee; any department staff or contractors engaged in supporting committee activities; and any public or private entity from whom information may be requested to conduct maternal mortality and morbidity reviews. These regulations supersede any other regulations previously promulgated by the department related to the operations of the New Mexico maternal mortality review committee.

[7.4.8.2 NMAC - N, 11/08/2022]

7.4.8.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated by the secretary of the department of health by the authority of Subsection F of Section 9-7-6 NMSA 1978 and implement the Public Health Act, Section 24-1-3 NMSA 1978, as amended, and the Maternal Mortality and Morbidly Prevention Act Section 24-32-1 to 24-32-5, NMSA 1978.

[7.4.8.3 NMAC - N, 11/08/2022]

7.4.8.4 DURATION:

Permanent.

[7.4.8.4 NMAC - N, 11/08/2022]

7.4.8.5 EFFECTIVE DATE:

November 8, 2022, unless a later date is cited at the end of a section.

[7.4.8.5 NMAC - N, 11/08/2022]

7.4.8.6 OBJECTIVE:

These regulations are promulgated pursuant to statute to define and support the maternal mortality review committee, the purpose of which is to comprehensively review and analyze deaths that occur during pregnancy, childbirth and the year postpartum; to identify remediable problems contributing to maternal mortality; to develop recommended interventions to prevent these deaths; and disseminate findings. The committee shall also review aggregate data related to severe maternal morbidity to look for opportunities for improvement in care that could lead to improved maternal outcomes and fewer deaths. Given the persistent and significant disparities in maternal morbidity and mortality experienced by people of color in New Mexico and the United States overall, the committee will apply lenses of racial justice, diverse representation and health equity across its functions including staffing, committee membership and leadership, case review and analysis.

[7.4.8.6 NMAC - N, 11/08/2022]

7.4.8.7 DEFINITIONS:

As used in these regulations:

A. Definitions beginning with "A":

(1) "Abstractor" means an individual who is trained to comprehensively gather pertinent information from a variety of available sources in order to accurately capture the events of a person's life leading up to and including their death in the form of a case summary for committee review. All abstractors will possess a professional background in maternal health and the requisite training, provided or endorsed by the department, to approach cases with a health equity lens. Given the critical role of the abstractor in identifying the defining details leading to a death, including factors such as racism, bias and discrimination, the department shall undertake deliberate, demonstrable efforts to engage abstractors who possess lived experience as members of communities of color disproportionately impacted by maternal mortality who are able to apply an anti-racist lens to the abstracting process.

(2) "Act" means the Maternal Mortality and Morbidity Prevention Act.

(3) "Administrative co-chair" means the chief medical officer, or another representative of the department and who is appointed by the secretary to serve as co-chair of the committee for administrative matters. The administrative co-chair shall be equipped with the measurable skills, training or lived experience to incorporate the racial, ethnic and linguistic diversity of New Mexico into this leadership role.

(4) "Aggregate data" means health care data that exclude any individually identifiable health information, including patient and health care provider identification.

B. Definitions beginning with "B": "BVRHS" means the department of health bureau of vital records and health statistics.

C. Definitions beginning with "C":

(1) "Case-related material" means any de-identified information that relates to or summarizes an incident of maternal mortality or severe maternal morbidity.

(2) "Case summary" means a de-identified summary of an incident of maternal mortality.

(3) "CDC" means the U.S. centers for disease control and prevention.

(4) "Chief medical officer" means the chief medical officer of the department.

(5) "Clinical co-chair" means a committee member with maternal child health clinical or paraprofessional training nominated and approved by a two-thirds vote of the committee and approved by the department to serve in this position for a term that aligns with the overall duration of their membership on the committee unless the member chooses to step down from the co-chair role prior to the end of their membership term. The clinical co-chair shall be equipped with the measurable skills, training or lived experience to incorporate the racial, ethnic and linguistic diversity of New Mexico into this leadership role.

(6) "Committee" means the maternal mortality review committee.

(7) "Committee member" means a person who has been appointed to sit as a member of the committee and who participates in committee business and votes on committee matters.

(8) "Community co-chair" means a committee member nominated and approved by a two-thirds vote of the committee to a term that aligns with the overall duration of their membership on the committee unless the member chooses to step down from the co-chair role prior to the end of their membership term. The community

co-chair shall possess lived experience as a community member able to represent the regional, racial, linguistic, and ethnic diversity of New Mexico's communities disproportionately impacted by maternal mortality in this leadership role.

(9) "Contributing factors" are the circumstances, events, exposures, procedures, or products identified by the committee as having contributed to an incident or group of incidents resulting in maternal mortality or severe maternal morbidity which may include systemic racism or inequities.

(10) "Coordinator" means the operational staff member designated by the department to manage the day-to-day operations of the committee.

(11) "Critical income" means income lost as a result of uncompensated work time used to attend a committee meeting.

D. Definitions beginning with "D":

(1) "Data set" means a collection of de-identified information collected or created by or under the direction of DOH epidemiologists.

(2) "De-identified data" means information that has been purged of all personally identifying information including, but not limited to, names; any geographic subdivision smaller than a state including street address, city, county, precinct, zip code, and their equivalent geocodes; all elements of dates except the year of an incident, including birth date, admission dates, discharge dates, and dates of death; telephone numbers, fax numbers electronic mail addresses; social security numbers; health plan beneficiary numbers; certificate and license numbers; vehicle identifiers and serial numbers, including license plate numbers; device identifiers and serial numbers; web universal resource locators (URLs); internet protocol address numbers; biometric identifiers, including finger and voice prints; full face photographic images and any comparable images; and any other unique identifying number characteristic, or code.

(3) "Department" or **"DOH"** means the New Mexico department of health.

(4) "DOH epidemiologist" means the operational staff responsible for creating, interpreting, and analyzing data sets and for supporting committee efforts to develop and disseminate data-driven recommendations.

E. Definitions beginning with "E":

(1) "Executive committee" means a subcommittee of the committee consisting of the co-chairs and additional committee members that provides leadership and guidance to the committee and operational staff to effectuate the objective of the committee.

(2) "Expertise" means special skill, knowledge, or judgement that results from training, practice or lived experience.

F. Definitions beginning with "F": [RESERVED]

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H":

(1) "Health care provider" means an individual licensed, certified or otherwise authorized to provide health care services in the ordinary course of business in the state; or a health facility that the department licenses.

(2) "Health equity" means the attainment of the highest level of health for all people through focused and ongoing efforts to address avoidable inequalities, historic and contemporary injustices, and the elimination of health and healthcare disparities.

(3) "HIDD database" means the hospital inpatient discharge database or state inpatient database.

I. Definitions beginning with "I":

(1) "IAD" means: Indian affairs department of the state.

(2) "Identifiable information" means any information that may be used to determine the identity of an individual directly or indirectly involved in an incident of maternal mortality or severe maternal morbidity.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) "Law enforcement agency" means a law enforcement agency of the state, an Indian nation, tribe or pueblo or a political subdivision of the state.

(2) "Lead abstractor" means the clinical co-chair or operational staff member designated to coordinate the activities of any operational staff engaged as abstractors. This person also prepares case summaries for committee review and enters committee decisions into the MMRIA database.

M. Definitions beginning with "M":

(1) "Maternal mortality" means the death of a pregnant person or a birthing person within one year postpartum.

(2) **"Maternal mortality review"** or **"MMR"** means the review of all reported deaths of individuals who die of any cause during pregnancy or within one year of the end of pregnancy.

(3) **"Medical record"** means the written or graphic documentation, sound recording or electronic record relating to medical, behavioral health and health care services that a patient receives from a health care provider or under the direction of a physician or another licensed health care provider. "Medical record" includes diagnostic documentation, including an x-ray, electrocardiogram, and electroencephalogram; other test results; data entered into a prescription drug monitoring program; and an autopsy report.

(4) **"MMRIA"** means the CDC maternal mortality review information application or any successor application.

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O":

(1) **"OAAA"** means the office of African American affairs of the state.

(2) **"OMI"** means the office of the medical investigator.

(3) **"Operational staff"** means staff or contractors of the department assigned or contracted to support the work of the committee or its executive committee.

P. Definitions beginning with "P":

(1) **"PHD"** means the public health division of the department.

(2) **"Pregnancy-associated death"** means a death during or within one year of pregnancy, regardless of the cause. If the definition is updated by the CDC, that definition shall be the applicable definition for these rules.

(3) **"Pregnancy-related death"** means a death during or within one year of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy. If the definition is updated by the CDC, that definition shall be the applicable definition for these rules.

Q. Definitions beginning with "Q": "Qualified invited guest" means a person approved by the co-chairs and invited by the committee to attend a committee meeting to provide technical expertise to the committee, to enhance training in maternal health, to provide insight on maternal mortality or severe maternal morbidity review in other jurisdictions or to provide operational support to the committee.

R. Definitions beginning with "R": [RESERVED]

S. Definitions beginning with "S":

(1) "Secretary" means the secretary of the department of health or designee.

(2) "Severe maternal morbidity" means unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a person's health as identified by hospitalizations using administrative hospital discharge data and the world health organization's international classification of diseases diagnosis and procedure codes.

T. Definitions beginning with "T": "Trauma" means individual and communal trauma, defined as the experiences inflicted upon people and communities impacting their physical, mental and emotional well-being. This unresolved impact leads to a perceived and experienced lack of safety and a recurring experience of stress that impacts the physical and mental bodies of the victim and at times their families and communities intergenerationally. Trauma is linked to acts of violence, including micro-aggressions, systemic inequity and the feeling that oneself, one's family or community are not fully safe or capable of being safe as a result of the traumatic incident(s).

U. Definitions beginning with "U": [RESERVED]

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W": [RESERVED]

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[7.4.8.7 NMAC - N, 11/08/2022]

7.4.8.8 PROGRAM ADMINISTRATION:

The committee's activities shall be administered by the department using a health equity framework across all functions including staffing, committee membership and leadership, and case review and analysis in order to assure that the values of cultural awareness, racial justice, and equity are infused throughout these functions. The department shall designate a committee coordinator in an employed or contracted position and hire contractors and employ operational staff to support the work of the committee. The co-chairs may designate an executive committee to conduct business as outlined herein.

[7.4.8.8 NMAC - N, 11/08/2022]

7.4.8.9 EXECUTIVE COMMITTEE:

If called, the executive committee must include and reflect the ethnic, geographic, and disciplinary make-up of the committee, state and the communities disproportionately impacted by maternal mortality and morbidity.

A. The formation of an executive committee must be endorsed by a vote of a two-thirds majority of the current membership.

B. An executive committee shall consist of co-chairs of the committee and up to three additional committee members nominated and approved by a two-thirds majority of the current membership to effectuate the objectives of the committee. No less than one appointee from either IAD or OAAA will be offered the opportunity to serve on the executive committee. Appointment to the executive committee will be for the duration of the term of membership, or until the member elects to step down from the executive committee, whichever is sooner.

C. Operational staff and qualified invited guests may participate in executive committee deliberations in an advisory capacity as directed by the executive committee, but they are not part of the committee membership.

D. If called, the executive committee shall:

(1) meet at the call of the co-chairs;

(2) monitor and support the activities of the full committee;

(3) establish policy and procedure and provide guidance to operational staff on implementation; and

(4) make final decisions regarding data analysis, data dissemination and evaluation based on findings and recommendations from the full committee.

[7.4.8.9 NMAC - N, 11/08/2022]

7.4.8.10 MEMBERSHIP:

A. Members will be formally appointed by the administrative co-chair. The administrative co-chair may consult with the clinical and community co-chairs, and if called, the executive committee to confirm appointments.

B. The committee shall be composed of no more than 30 members, not including the co-chairs, provided that at least, four of those members shall include:

(1) two members nominated by the secretary of Indian affairs; and

(2) two members nominated by the director of the office of African American affairs.

C. Additional members will be recruited through an open call:

(1) Operational staff will post a call for members along with an application form on the department's website and advertise the call broadly in collaboration with OAAA, IAD, and community-based organizations whose work focuses on health equity within the communities most impacted by maternal mortality and morbidity.

(2) Operational staff will receive applications and conduct an initial analysis using a scoring matrix to evaluate applications that prioritizes applicants who are working in and representing communities that are most impacted per the state maternal mortality ratio so that the composition of the committee reflects:

(a) the racial, ethnic, and linguistic diversity of the state;

(b) the differing geographic regions within the state, including rural and urban areas;

(c) tribal areas and communities; and

(d) communities that are most impacted by pregnancy-related deaths, severe maternal morbidity, or a lack of access to relevant perinatal and intrapartum care services.

(3) Consideration will also be given to assure that core disciplines and organizations representing needed expertise in maternal health and safety, as identified by the committee, are represented.

D. Upon closure of an open call, operational staff will present a completed scoring matrix for all applicants to the co-chairs for consideration.

E. Membership is voluntary.

F. Members may be reimbursed for expenses related to meeting attendance.

(1) Members who must forsake critical income to attend meetings may, with the approval of the department, be reimbursed for loss of that income in an amount not to exceed three hundred dollars ($300.00) per meeting, whether virtual or in person.

(2) Members required to travel in excess of 50 miles for an in-person meeting may, with the approval of the department, receive per diem and mileage for attending that meeting pursuant to the Per Diem and Mileage Act.

(3) Operational staff will advise all members of the opportunity to receive these types of reimbursement, provide forms needed to complete enrollment according to departmental policy, and provide any assistance members need to complete and submit forms.

(4) Members may not initiate a request for critical income or travel reimbursement for meetings that occurred in a previous fiscal year.

G. Members are appointed for a three-year term, with no consecutive terms. Terms served by committee members may be staggered to assure continuity of effort.

H. Each member shall receive training on trauma and the impacts of trauma, including secondary trauma, trauma of racism and trauma of maternal mortality and morbidity presented by a trainer who is a member of communities that are most impacted by pregnancy-related deaths, severe maternal morbidity, or a lack of access to unbiased, affordable and culturally congruent perinatal and intrapartum care services.

[7.4.8.10 NMAC - N, 11/08/2022]

7.4.8.11 CASE IDENTIFICATION:

"Maternal mortality": The coordinator and operational staff shall work with BVRHS to identify any death constituting an incident of maternal mortality within one year from the date of death. Criteria for case identification shall be consistent with standard reporting requirements.

[7.4.8.11 NMAC - N, 11/08/2022]

7.4.8.12 DATA COLLECTION:

A. Duty to report: A health care provider, the office of the state medical investigator, and BVRHS shall notify the operational staff of any incident of maternal mortality within three months of the incident. A report made to BVRHS made within these timelines will be sufficient to satisfy this requirement.

B. Authority to collect information: Except as otherwise restricted or prohibited by state or federal statute or regulation, designated operational staff may access medical records and other information relating to an incident of maternal mortality at any time within five years of the date of the incident.

C. Information gathering: Regarding any incident of maternal mortality involving a New Mexico resident, information including reports, records and data files shall be provided upon request to the designated operational staff from health care providers, law enforcement agencies, BVRHS, and the office of the state medical investigator. The designated operational staff may also request information from other entities with relevant information to a maternal mortality case review. Any committee member

engaged in case review may request that designated operational staff initiate such a request for information from other entities.

D. Information collection process: Information and records requests will be conducted in a confidential manner.

E. Collection of information by interview: Individuals who are operational staff of the department, may, with appropriate training, conduct interviews with a deceased person's family, care providers, and other relevant persons. These interviews shall be conducted according to an established protocol with the consent of the interviewee.

F. Case abstraction process: Information and records obtained through a formal request initiated by operational staff will be provided to an abstractor who is assigned to develop a case summary. An abstractor enters information directly into the MMRIA database. It is the responsibility of the abstractor to employ training, experience, and abstracting tools endorsed or provided by the department or CDC in order to create a comprehensive, accurate summary of the events of a person's life leading up to and including their death. This process must include tools that have been developed to facilitate the identification of racism, discrimination, and interpersonal and structural bias in health care or life course events that may have been contributing factors to the death. An abstractor may consult the co-chairs or other operational staff as needed to confirm interpretations of data and the relevance of details for inclusion in a case summary.

G. Identification of race and ethnicity of the deceased: Race and ethnicity of the deceased, as identified in available records, are noted in otherwise de-identified case summaries in order to allow the committee to consider factors such as the role of systemic racism and inequities related to pregnancy-associated deaths.

[7.4.8.12 NMAC - N, 11/08/2022]

7.4.8.13 COMMITTEE RESPONSIBILITIES:

A. The committee shall meet at the call of the co-chairs.

B. A majority of appointed committee members shall constitute a quorum.

C. The affirmative vote of at least a majority of a quorum present and approval by the co-chairs shall be necessary for any decisions pertaining directly to case review to be taken by the committee. A quorum shall not be achieved without at least one AID appointee and OAAA appointee in attendance. Administrative decisions not pertaining to case review may be voted on electronically outside of the course of a committee meeting to allow all members ample opportunity to cast a vote.

D. Operational staff and qualified guests may participate in committee deliberations in an advisory capacity as directed by the co-chairs of the committee.

E. Operational staff and qualified invited guest presence at a committee meeting shall not convey committee membership.

F. The committee shall be responsible for the following:

(1) review each incident of maternal mortality using a de-identified case summary prepared by operational staff;

(2) review aggregate data related to severe maternal morbidity;

(3) outline trends and patterns and provide recommendations related to maternal mortality and severe maternal morbidity in the state;

(4) serve as a link with maternal mortality and morbidity review teams nationwide and participate in national maternal mortality and morbidity review team activities; and

(5) perform any other functions as resources allow to enhance efforts to reduce and prevent maternal mortality and severe maternal morbidity in the state.

[7.4.8.13 NMAC - N, 11/08/2022]

7.4.8.14 CASE REVIEW PROCESS:

A. The committee reviews prepared case summaries based on the information obtained from reports, records, and data files related to an incident of maternal mortality and entered into the MMRIA database by an abstractor. The committee is responsible for reviewing the summary, identifying contributing factors, making a determination on preventability and pregnancy-relatedness, and articulating recommendations. The lead abstractor shall be responsible for documenting committee decisions regarding case summaries in MMRIA within 30 days of committee review.

B. Any committee member who is concerned that any essential information is being missed by the decisions the abstractor makes in creating summaries may initiate a request to the clinical co-chair or operational staff with the authority to collect information that:

(1) an abstractor's work be reviewed by the clinical co-chair and designated operational staff; or

(2) an alternative abstractor be assigned.

[7.4.8.14 NMAC - N, 11/08/2022]

7.4.8.15 CONFIDENTIALITY OF RECORDS, PROCEEDINGS, AND FINDINGS:

A. Any material obtained pursuant to these rules, any committee proceedings, and findings, including any materials created to facilitate committee proceedings shall be maintained and disposed of in a confidential manner and in any manner as required by law.

B. The following shall be confidential and shall not be subject to the open meetings act or the inspection of public records act or subject to any subpoena, discovery request or introduction into evidence in a civil or criminal proceeding:

(1) any meeting, part of a meeting or activity of the committee or executive committee where data or other information is to be discussed and that may result in disclosure to the public of information protected by law; and

(2) except as may be necessary in furtherance of the duties of the committee or in response to an alleged violation of a confidentiality agreement entered, any information, record, report, notes, memoranda, or other data that the department or committee obtains pursuant to the Maternal Mortality and Morbidity Prevention Act.

C. Only the clinical co-chair and operational staff will have access to medical records, law enforcement reports and vital records data to support the work of the full committee.

(1) The coordinator or DOH epidemiologist may share de-identified, aggregate datasets with the CDC and with state, regional, or tribal entities engaged in reducing incidents of maternal mortality or severe maternal morbidity.

(2) Identifiable information entered into MMRIA shall only be accessible to the clinical co-chair, coordinator, DOH epidemiologists and abstractors.

D. Before participating in their first committee meeting, each member, operational staff, and any qualified invited guest shall be required to review and sign a confidentiality agreement covering the duration of their membership or service to the committee. Signed confidentiality agreements will be collected and retained by the coordinator.

E. A brief reminder of the confidentiality clause and any other relevant process directives will be presented at the beginning of each case review session.

F. For in-person meetings, case-related materials may not be removed from meetings by any member. At the conclusion of any meeting at which case-related material has been distributed, the coordinator shall collect that material and destroy it.

G. For virtual meetings, case summaries and decision forms shall be distributed electronically via a secure encrypted program, and members shall be instructed to delete the summaries from their inbox, hard-drive or cloud-based storage at the conclusion of the meeting.

[7.4.8.15 NMAC - N, 11/08/2022]

7.4.8.16 DISSEMINATION OF INFORMATION; DEVELOPMENT OF RECOMMENDATIONS; ADVANCEMENT OF RECOMMENDATIONS:

A. Data dissemination: The committee shall compile reports using aggregate data and de-identified information on an annual basis in an effort to further study the causes and problems associated with maternal mortality and severe maternal morbidity. These reports shall be distributed to:

(1) the New Mexico legislature;

(2) the Indian affairs department;

(3) office on African American affairs;

(4) health care providers;

(5) community-based organizations working in the interest of maternal and child health;

(6) other government agencies as necessary; and

(7) other entities as necessary to reduce maternal mortality rate in the state.

B. Committee members and operational staff may also deliver presentations using aggregated, de-identified information to support and promote the study of causes and problems associated with maternal mortality and severe maternal morbidity.

[7.4.8.16 NMAC - N, 11/08/2022]

CHAPTER 5: VACCINATIONS AND IMMUNIZATIONS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: IMMUNIZATION REQUIREMENT

7.5.2.1 ISSUING AGENCY:

Public Health Division, Department of Health.

[7.5.2.1 NMAC - Rp, 7.5.2.1 NMAC, 11/27/13]

7.5.2.2 SCOPE:

These regulations govern children presenting satisfactory evidence of age appropriate immunization, or children presenting satisfactory evidence demonstrating that they are in the process of being age appropriately immunized, enrolled in, or who are seeking to be enrolled in**,** all public, private, home, parochial, elementary, childcare, pre-school, and secondary schools, except for those children who have been legally exempted from these immunizations and those children attending school in areas/counties that have not been targeted for a specific immunization requirement. This regulation is incorporated by reference in 6.12.2.8 "Requirements for Immunization of Children Attending Public, Nonpublic, or Home Schools" as promulgated by the New Mexico public education department, and 8.16.2 and 8.17.2 NMAC, "Childcare Centers, Out of School Time Programs, Family Childcare Homes, and Other Early Care and Education Programs and Requirements Governing Registration of Non-Licensed Family Childcare Homes," as promulgated by the children youth and families department (CYFD).

[7.5.2.2 NMAC - Rp, 7.5.2.2 NMAC, 11/27/13]

7.5.2.3 STATUTORY AUTHORITY:

These regulations are promulgated by the secretary of the New Mexico department of health under the authority of Section 9-7-6.3, Section 24-1-3 (N); and Section 24-5-1 NMSA 1978. Enforcement of these regulations is the responsibility of the public health division of the New Mexico department of health.

[7.5.2.3 NMAC - Rp, 7.5.2.3 NMAC, 11/27/13]

7.5.2.4 DURATION:

Permanent.

[7.5.2.4 NMAC - Rp, 7.5.2.4 NMAC, 11/27/13]

7.5.2.5 EFFECTIVE DATE:

November 27, 2013, unless a later date is cited at the end of a section.

[7.5.2.5 NMAC - Rp, 7.5.2.5 NMAC, 11/27/13]

7.5.2.6 OBJECTIVE:

The objective is to provide for the health and safety of students enrolled in New Mexico schools, educational facilities, and daycare centers by requiring immunizations to abate the spread of diseases that are dangerous to the public health.

[7.5.2.6 NMAC - Rp, 7.5.2.6 NMAC, 11/27/13]

7.5.2.7 DEFINITIONS:

A. "Age appropriately immunized" means satisfactory evidence has been provided documenting that the person has completed all required immunizations which someone his or her age is eligible to receive according to the public health division school/daycare entry immunization requirements, which are within the Advisory Committee on Immunization Practice (ACIP) recommendations.

B. "Child" or "Children" are persons who are of the age birth through 18 years.

C. "Department" means the New Mexico department of health.

D. "In the process of being age appropriately immunized" means a child has received all required immunizations he or she is eligible to receive according to the public health division school/daycare entry immunization requirements, but has not completed one or more vaccine series because a sufficient time interval has not elapsed for the subsequent dose or doses of vaccine to be administered according to the recommended intervals between doses published by the ACIP.

E. "Licensed physician" means physician licensed to practice medicine or osteopathic medicine in New Mexico, another state or territory.

F. "Public health authority" means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate. The public health authority is authorized by law to collect or receive protected health information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority.

G. "Public health division" means the public health division of the department.

H. "Public health division regional health officer" means the physician medical director assigned to a public health region in New Mexico as defined by the public health division of the department.

I. "Public health division school/daycare entry immunization requirements" means the immunizations required for entry into all schools and facilities (public, private, home, parochial, elementary, childcare, pre-school, and secondary schools) in New Mexico as set forth by the secretary of the department.

J. "Required immunizations" means those immunizations against diseases deemed to be dangerous to the public health by the public health division, and set forth in its immunization requirements, which are within recommendations of the ACIP.

K. "Satisfactory evidence of commencement of immunization" means satisfactory evidence of a person having begun the process of immunizations, such as a certificate or record signed by a duly licensed physician or other recognized licensed public or private health facility stating that the person has received at least the first in the series of required immunizations and is proceeding with the immunizations according to the prescribed schedule.

L. "Satisfactory evidence of immunization" means a statement, certificate, or record signed by a duly licensed physician or other recognized licensed public or private health facility stating that the required immunizations have been given to the person or record of receipt of immunization in the New Mexico Statewide Immunization Information System (NMSIIS) registry.

[7.5.2.7 NMAC - Rp, 7.5.2.7 NMAC, 11/27/13]

7.5.2.8 IMMUNIZATION REQUIREMENTS:

A. In accordance with Section 9 below required immunizations shall be administered in accordance with guidelines established by the ACIP of the United States department of health and human services and the American academy of pediatrics.

B. A child shall be determined to be non-compliant with these regulations if the child has not been properly exempted from immunization and has not received any of the required immunization doses within the recommended intervals between doses published by the ACIP.

C. Immunization records shall be kept on file at all schools and facilities (public, private, home, parochial, elementary, childcare, pre-school, and secondary schools) or in the NMSIIS under these regulations in accordance with retention periods defined in Subsection D of 1.20.2.101 NMAC and in 1.15.8.101 NMAC.

D. Immunization records shall be kept current and available to the public health division as defined in Section 24-5-4, NMSA 1978.

E. All schools and facilities under these regulations shall be required to participate in an annual immunization records audit at the request of the department.

F. All schools required to comply with these regulations shall notify the local public health division regional health officer if a child about to be enrolled or while enrolled has been held out of school for more than five consecutive school days for non-compliance

with these regulations. Contact information for regional health officers shall be published in the school immunization requirements.

[7.5.2.8 NMAC - Rp, 7.5.2.8 NMAC, 11/27/13]

7.5.2.9 REQUIRED IMMUNIZATIONS LIST:

A. Diphtheria.

B. Pertussis.

C. Tetanus.

D. Poliomyelitis.

E. Measles.

F. Mumps.

G. Rubella.

H. Haemophilus influenza type b (HiB) (for facilities regulated by CYFD as described in 8.16.2 NMAC or other pre-school or school-age populations as determined by the secretary of the department of health).

I. Hepatitis B.

J. Varicella.

K. Hepatitis A (for facilities regulated by CYFD as described in NMAC 8.16.2 or other pre-school populations as determined by the secretary of the department of health).

L. Pneumococcal Disease.

M. Other vaccines for preventable diseases as determined by the secretary of the department of health and within those recommended by the ACIP.

[7.5.2.9 NMAC - Rp, 7.5.2.9 NMAC, 11/27/13]

7.5.2.10 IMMUNIZATION RECORD SHARING:

A. Under the Health Insurance Portability and Accountability Act (HIPAA), immunization data are protected health information; however, HIPAA permits covered entities to disclose, without individual authorization or prior notification, protected health information to public health authorities authorized by law to collect or receive such

information for the purpose of prevention or controlling disease (45 CFR § 164.502). Under federal guidelines, the definition of a "public health authority" requires that an agency's official mandate include the responsibility for public health matters. The mandate can be responsibility for public health matters, generally, or it can be for specific public health matters. An agency's official mandate does not have to be exclusively or primarily for public health. To the extent a public health authority is authorized by law to collect or receive information for the public health purposes specified in the public health provision, covered entities protected health information to such public health authorities without authorization pursuant to the public health provision.

B. Public health authorities include federal public health agencies, tribal health agencies, state public health agencies, local public health agencies, and anyone performing public health functions under a grant of authority from the department.

C. New Mexico schools shall act as a "public health authority" in cooperation with the department when they track immunization status of enrolled students and those in the process of enrolling.

[7.5.2.10 NMAC - Rp, 7.5.2.10 NMAC, 11/27/13]

PART 3: EXEMPTION FROM SCHOOL, CHILDCARE, AND PRE-SCHOOL IMMUNIZATION

7.5.3.1 ISSUING AGENCY:

Public Health Division, Department of Health.

[7.5.3.1 NMAC - Rp, 7 NMAC 5.3.1, 11/27/13]

7.5.3.2 SCOPE:

These regulations govern the procedures for seeking exemptions from any of the immunizations required for public, private, home, parochial, elementary, and secondary schools, as well as early childhood education facilities under the New Mexico public education department and licensed preschool or child care centers.

[7.5.3.2 NMAC - Rp, 7 NMAC 5.3.2, 11/27/13]

7.5.3.3 STATUTORY AUTHORITY:

This regulation has been promulgated by the secretary of the department of health under the authority of Sections 9-7-6, 24-1-3(N), 24-5-1, and Section 24-5-3 NMSA, 1978. Enforcement of this regulation is the responsibility of the public health division of the New Mexico department of health.

[7.5.3.3 NMAC - Rp, 7 NMAC 5.3.3, 11/27/13]

7.5.3.4 DURATION:

Permanent.

[7.5.3.4 NMAC - Rp, 7 NMAC 5.3.4, 11/27/13]

7.5.3.5 EFFECTIVE DATE:

November 27, 2013, unless a later date is cited at the end of a section or paragraph.

[7.5.3.5 NMAC - Rp, 7 NMAC 5.3.5, 11/27/13]

7.5.3.6 OBJECTIVE:

The objective is to establish standards and procedures for obtaining exemptions to required immunizations as allowed by Section 24-5-3 NMSA 1978; specifically for children whose:

A. licensed physician, a physician assistant, or a certified nurse practitioner provides a certificate stating that any of the required immunizations would seriously endanger the life or health of the child; or

B. parent or legal guardian attests via affidavit or written affirmation from an officer of a recognized religious denomination that such child's parents or guardians are bona fide members of a denomination whose religious teaching requires reliance upon prayer or spiritual means alone for healing; or

C. parent or legal guardian attests via affidavit or written affirmation that their religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agent.

[7.5.3.6 NMAC - Rp, 7 NMAC 5.3.6, 11/27/2013; A, 8/29/2023]

7.5.3.7 DEFINITIONS:

A. "ACIP" means advisory committee on immunization practice.

B. "Administrative authority" means the superintendent, principal, or the designee of such person.

C. "Certified nurse practitioner" means a registered nurse licensed by the New Mexico board of nursing for advanced practice as a certified nurse practitioner.

D. "Denial" means a denial of a request for exemption from immunizations.

E. "Department" means the department of health.

F. "Licensed physician" means a physician licensed by the New Mexico board of medicine to practice medicine or osteopathic medicine.

G. "NMSIIS" means the New Mexico Statewide Immunization Information System; a secured, confidential, population-based, computerized registry for recording vaccination information established pursuant to Sections 24-5-7 through 24-5-15 NMSA 1978.

H. "Physician assistant" means a health care practitioner licensed by the New Mexico board of medicine to practice as a physician assistant and to provide services to patients with the supervision of or in collaboration with a licensed physician.

I. "Public health division" means a division of the department of health within which the immunization program is located.

J. "Required immunizations" means those immunizations against diseases deemed to be dangerous to the public health by the public health division, and set forth in its immunization requirements, which are within recommendations of the ACIP.

K. "Satisfactory evidence of commencement of immunization" means satisfactory evidence of a person having begun the process of immunizations, such as a certificate, or record signed by a licensed physician or other recognized public or private health provider stating that the person has received at least the first in the series of required immunizations and is proceeding with the immunizations according to the prescribed schedule.

L. "Satisfactory evidence of immunization" means a statement, certificate, or record signed by a licensed physician or other recognized licensed health provider stating that the required immunizations have been given to the person or record of receipt of immunization in the NMSIIS registry.

M. "Secretary" means the secretary for the department of health.

[7.5.3.7 NMAC - Rp, 7 NMAC 5.3.7, 11/27/2013; A, 8/29/2023]

7.5.3.8 REQUIREMENTS FOR APPROVAL OF EXEMPTIONS FROM IMMUNIZATION:

A. Any minor child through his parent or guardian may file a request for exemption from required immunization with the director of the public health division by providing the following:

(1) certificate or affidavit from a licensed physician, a physician assistant, or a certified nurse practitioner attesting that any of the required immunizations would seriously endanger the life or health of the child; or

(2) an affidavit or written affirmation from an officer of a recognized religious denomination stating that the parents or guardians are bona fide members of the recognized denomination, whose religious teaching requires reliance upon prayer or spiritual means alone for healing; or

(3) an affidavit or written affirmation by a parent or guardian whose religious beliefs, held either individually or jointly with others, do not permit the administration of vaccine or other immunizing agents.

B. The original request for approval of any exemptions from immunization must be mailed to the department of health, public health division, immunization program. The address is P.O. Box 26110, Suite S-1250, Santa Fe, NM, 87502. Request forms can be found at the immunization program offices 1190 St. Francis Drive, Suite South 1250 or on the program's website.

C. Within 60 days of receipt of a request for exemption from immunization, the department of health immunization program staff shall review the request to determine whether the certificate has been duly completed. Incomplete requests shall be returned to the requester with information regarding what elements are missing.

D. The department of health immunization program staff shall determine approval status of all requests for exemption:

(1) exemption requests shall be approved for a one-year period indicated by the public health division director or designee;

(2) in the case of approval of a request for exemption, an approved, signed copy of the request shall be provided to the parents or guardian of the child;

(3) in the case of a denial, the department of health immunization program staff shall state the reasons for denial in a letter of notification to the parents or guardian of the child. The notice to the parents or guardians shall also include information about the review process in 7.5.3.9 NMAC.

[7.5.3.8 NMAC - Rp, 7 NMAC 5.3.8, 11/27/2013; A, 8/29/2023]

7.5.3.9 REVIEW CRITERIA:

A. The department of health immunization program staff will consider the requirements and allowances of the law and the completeness and clarity of the requests for exemption in his or her review. Written criteria for review of exemption from immunization shall be available on the department of health website, included in documents required for submission of immunization exemptions, and provided upon request made to the department.

B. Requests for exemption based on a certificate or affidavit from a licensed physician, a physician assistant, or a certified nurse practitioner will be reviewed for the following:

(1) an original document signed by a licensed physician, a physician assistant, or a certified nurse practitioner, which

(2) contains a statement that immunizations would seriously endanger the health of the child.

C. Requests for religious exemption based on an affidavit or written affirmation from an officer of a religious denomination will be reviewed for the following:

(1) an original document signed by an officer of the denomination, which

(2) contains a statement affirming that the parent or guardian of the child are members of the religious denomination; and

(3) that the religious teachings of the denomination require reliance on prayer or spiritual means alone for healing.

D. Requests for exemption based on an affidavit or written affirmation from a parent will be reviewed for the following:

(1) an original, signed, complete, properly notarized form, which

(2) contains a statement of affirmation from the parent or guardian that their personal religious belief, or jointly-held religious belief does not permit immunization of their child.

[7.5.3.9 NMAC - Rp, 7 NMAC 5.3.9, 11/27/2013; A, 8/29/2023]

7.5.3.10 CHILDREN EXPERIENCING HOMELESSNESS:

Children experiencing homelessness: Pursuant to the McKinney-Vento Homeless Assistance Act (42 USC § 11432(g)(3)(C)), children experiencing homelessness must be able to enroll in school immediately, even if they are unable to produce records normally required for enrollment, such as previous academic records, medical records, proof of residency, or other documentation. If the child needs to obtain immunizations, or medical or immunization records, the enrolling school must immediately refer the parent or guardian of the child or youth to the designated local educational agency liaison, who must assist in obtaining necessary immunizations, or immunization or medical records.

[7.5.3.10 NMAC - Rp, 7 NMAC 5.3.10, 11/27/13]

7.5.3.11 ADMINSTRATIVE REVIEW OF DENIALS:

In the case of a denial, the parent or guardian shall have the right to request an administrative review. Criteria for administrative review shall be available on the department of health website, included in documents required for submission of immunization exemptions, and provided upon request made to the department of health. Any hearing process under 7.5.3.12 NMAC can only be commenced after the administrative review pursuant to 7.5.3.11 NMAC is completed and the parent or guardian receives notification by mail that the administrative review was denied.

A. The parent or guardian may submit a letter requesting administrative review and any supporting documents to the public health division director or designee within 30 days of receipt of notice of the initial denial from the department of health immunization program manager.

B. Within 10 working days of receipt of the request for administrative review, the department of health's public health division director shall review the request for administrative review and any supporting documents and make a determination of approval or denial as to the underlying request for exemption. After the administrative review is complete the department's public health division director shall notify the parent or guardian and the child's school, by certified mail, if the administrative review of the request for exemption was approved or denied.

C. If approved, the child shall be considered exempt from immunizations for a nine-month period.

D. If the appeal is denied, and the parent or guardian desires further review or consideration, the parent or guardian may request a hearing pursuant to 7.5.3.12 NMAC.

[7.5.3.11 NMAC - Rp, 7 NMAC 5.3.11, 11/27/13]

7.5.3.12 RIGHT TO HEARING AFTER ADMINSTRATIVE REVIEW:

A. Right to appeal: A parent or guardian may request a hearing to appeal a decision of the public health division director only after a denial of an administrative review. A hearing may not be requested at the same time as an administrative review is underway pursuant to 7.5.3.11 NMAC.

B. Right to hearing: A parent or guardian may request a hearing before a hearing officer appointed by the secretary to contest a denial of an immunization exemption under this rule, by mailing a certified letter, return receipt requested, to the public health division director within 30 days after the denial resulting from the administrative review. If the parent or guardian fails to request a hearing in the time and manner required by this section, the parent or guardian shall forfeit the right to a hearing, and the denied immunization exemption shall become final and not subject to judicial review.

C. Scheduling the hearing:

(1) Appointment of hearing officer: Upon the public health division director's receipt of a timely request for a hearing, the department shall appoint a hearing officer and schedule a hearing.

(2) Hearing date: The hearing shall be held not more than 60 days and not less than 15 days from the date of service of the notice of the hearing.

(3) Notice of hearing: The department shall notify the parent or guardian of the date, time, and place of the hearing and the identity of the hearing officer, and shall identify the statute(s) and regulation(s) authorizing the department to deny the immunization exemption, within 20 days of the public health division director's timely receipt of the request for hearing.

(4) Hearing venue: The hearing shall be held in Santa Fe, New Mexico.

D. Method of service: Any notice or decision required to be served under this section may be served either personally or by certified mail, return receipt requested directed to the parent or guardian at the last known mailing address (or, if service is made personally, by the last known physical address) shown by the records of the department immunization program. If the notice or decision is served personally, service shall be made in the same manner allowed by the rules of civil procedure for the state district courts of New Mexico. Where the notice or decision is served by certified mail, it shall be deemed to have been served on the date borne by the return receipt showing delivery, or the date of the last attempted delivery of the notice or decision, or the date of the addressee's refusal to accept delivery.

E. Hearing officer duties: The hearing officer shall conduct the hearing, rule on any motions or other matters that arise prior to the hearing, and issue a written report and recommendation(s) to the secretary following the close of the hearing.

F. Official file: Upon appointment, the hearing officer shall establish an official file which shall contain all notices, hearing requests, pleadings, motions, written stipulations, evidence, briefs, and correspondence received in the case. The official file shall also contain proffered items not admitted into evidence, which shall be so identified and shall be separately maintained. Upon conclusion of the proceeding and following issuance of the final decision, the hearing officer shall tender the complete official file to the department for its retention as an official record of the proceedings.

G. Powers of hearing officer: The hearing officer shall have all the powers necessary to conduct a hearing and to take all necessary action to avoid delay, maintain order, and assure development of a clear and complete record, including but not limited to the power to:

(1) administer oaths or affirmations;

(2) schedule continuances;

(3) direct discovery;

(4) examine witnesses and direct witnesses to testify;

(5) subpoena witnesses and relevant books, papers, documents, and other evidence;

(6) limit repetitious and cumulative testimony;

(7) set reasonable limits on the amount of time a witness may testify;

(8) decide objections to the admissibility of evidence or receive the evidence subject to later ruling;

(9) receive offers of proof for the record;

(10) take notice of judicially cognizable facts or take notice of general, technical, or scientific facts within the hearing officer's specialized knowledge (provided that the hearing officer notifies the parties beforehand and offers the parties an opportunity to contest the fact so noticed);

(11) direct parties to appear and confer for the settlement or simplification of issues, and otherwise conduct pre-hearing conferences;

(12) impose appropriate evidentiary sanctions against a party who fails to provide discovery or who fails to comply with a subpoena;

(13) dispose of procedural requests or similar matters;

(14) enter proposed findings of fact and conclusions of law, orders, reports and recommendations; and

(15) utilize his or her experience, technical competence, or specialized knowledge in the evaluation of evidence presented.

H. Minimum discovery; inspection and copying of documents: Upon written request to another party, any party shall have access to documents in the possession of the other party that are relevant to the subject matter of the appeal, except confidential or privileged documents.

I. Minimum discovery; witnesses: The parties shall each disclose to each other and to the hearing officer, either orally or in writing, the names of witnesses to be called, together with a brief summary of the testimony of each witness. In situations where written statements will be offered into evidence in lieu of a witness's oral testimony, the

names of the persons making the statements and a brief summary of the statements shall be disclosed.

J. Additional discovery: At the hearing officer's discretion, upon a written request by a party that explains why additional discovery is needed, further discovery in the form of production and review of documents and other tangible things, interviews, depositions or written interrogatories may be ordered. In exercising his or her authority to determine whether further discovery is necessary or desirable, the hearing officer should consider whether the complexity of fact or law reasonably requires further discovery to ensure a fair opportunity to prepare for the hearing, and whether such request will result in unnecessary hardship, cost, or delay in holding the hearing. Depositions shall not be allowed, except by order of the hearing officer upon a showing that the deposition is necessary to preserve the testimony of persons who are sick or elderly, or who will not be able to attend the hearing.

K. Subpoena limits; service: Geographical limits upon the subpoena power shall be the same as if the hearing officer were a district court sitting at the location at which the hearing or discovery proceeding is to take place. The method of service shall be the same as that under the Rules of Civil Procedure for the district courts, except that rules requiring the tendering of fees shall not apply to the department.

L. Pre-hearing disposition: The subject matter of any hearing may be disposed of by stipulation, settlement, or consent order, unless otherwise precluded by law. Any stipulation, settlement, or consent order reached between the parties shall be written and shall be signed by the hearing officer and the parties or their attorneys.

M. Postponement or continuance: The hearing officer, at his or her discretion, may postpone or continue a hearing upon his or her own motion, or upon the motion of a party, for good cause shown. Notice of any postponement or continuance shall be given in person, by telephone, or by mail to all parties within a reasonable time in advance of the previously scheduled hearing date.

N. Conduct of hearing: These hearings will be closed to prevent the disclosure of confidential information, including but not limited to health information protected by state and federal laws.

O. Telephonic testimony: Upon timely notice to the opposing party and the hearing officer, and with the approval of the hearing officer, the parties may present witnesses by telephone or live video (if available).

P. Legal representation: The department may appear by an officer or employee and parent or guardian may appear pro se or either the department or parent or guardian may be represented by an attorney licensed to practice in New Mexico.

Q. Recording: The hearing officer or a designee shall record the hearing by means of a mechanical sound recording device provided by the department for a record of the

hearing. Such recording need not be transcribed, unless requested by a party who shall arrange and pay for the transcription.

R. Burden of proof: Except as otherwise provided in this rule, the department has the burden of proving by a preponderance of the evidence the basis for the denied immunization exemption.

S. Order of presentation; general rule: Except as provided in this rule, the order of presentation for hearings in all cases shall be:

(1) appearances: Opening of proceeding and taking of appearances by the hearing officer;

(2) pending matters: Disposition by the hearing officer of preliminary and pending matters;

(3) opening statements: The opening statement of the department, and then the opening statement of the party challenging the department's action or proposed action;

(4) cases: The department's case-in-chief, and then the case-in-chief of the party challenging the department's action;

(5) rebuttal: The department's case-in-rebuttal;

(6) closing argument: The department's closing statement, which may include legal argument; and then the closing statement of the party opposing the department's action or proposed action, which may include legal argument;

(7) close: Close of proceedings by the hearing officer.

T. Admissible evidence; rules of evidence not applicable: The hearing officer may admit evidence and may give probative effect to evidence that is of a kind commonly relied on by reasonably prudent persons in the conduct of serious affairs. Rules of evidence, such as the New Mexico Rules of Evidence for the district courts, shall not apply but may be considered in determining the weight to be given any item of evidence. The hearing officer may at his or her discretion, upon his or her motion or the motion of a party or a party's representative, exclude incompetent, irrelevant, immaterial, or unduly repetitious evidence, including testimony, and may exclude confidential or privileged evidence.

U. Objections: A party may timely object to evidentiary offers by stating the objection together with a succinct statement of the grounds for the objection. The hearing officer may rule on the admissibility of evidence at the time an objection is made or may receive the evidence subject to later ruling.

V. Official notice: The hearing officer may take notice of any facts of which judicial notice may be taken, and may take notice of general, technical, or scientific facts within his or her specialized knowledge. When the hearing officer takes notice of a fact, the parties shall be notified either before or during the hearing of the fact so noticed and its source, and the parties shall be afforded an opportunity to contest the fact so noticed.

W. Record content: The record of a hearing shall include all documents contained in the official file maintained by the hearing officer, including all evidence received during the course of the hearing, proposed findings of fact and conclusions of law, the recommendations of the hearing officer, and the final decision of the secretary.

X. Written evidence from witnesses: The hearing officer may admit evidence in the form of a written statement made by a witness, when doing so will serve to expedite the hearing and will not substantially prejudice the interests of the parties.

Y. Failure to appear: If a party who has requested a hearing or a party's representative fails to appear on the date, time, or location announced for a hearing, and if no continuance was previously granted, the hearing officer may proceed to hear the evidence of such witnesses as may have appeared or may accept offers of proof regarding anticipated testimony and other evidence, and the hearing officer may further proceed to consider the matter and issue his report and recommendation(s) based on the evidence presented; and the secretary may subsequently render a final decision. Where a person fails to appear at a hearing because of accident, sickness, or other cause, the person may within a reasonable time apply to the hearing officer to reopen the proceeding, and the hearing officer may, upon finding sufficient cause, fix a time and place for a hearing and give notice to the parties.

Z. Hearing officer written report and recommendation(s): The hearing officer shall submit a written report and recommendation(s) to the secretary that contains a statement of the issues raised at the hearing, proposed findings of fact and conclusions of law, and a recommended determination. Proposed findings of fact shall be based upon the evidence presented at the hearing or known to all parties, including matters officially noticed by the hearing officer. The hearing officer's recommended decision is a recommendation to the secretary of the New Mexico department of health and is not a final order.

AA. Submission for final decision: The hearing officer's report and recommendation(s) shall be submitted together with the complete official file to the secretary of the New Mexico department of health for a final decision no later than 30 days after the hearing.

BB. Secretary's final decision: The secretary shall render a final decision within 45 calendar days of the submission of the hearing officer's written report. A copy of the final decision shall be mailed to the appealing party by certified mail, return receipt requested within 15 days after the final decision is rendered and signed. A copy shall be provided to legal counsel for the public health division.

[7.5.3.12 NMAC - Rp, 7 NMAC 5.3.12, 11/27/13]

PART 4: VACCINE PURCHASING FUND

7.5.4.1 ISSUING AGENCY:

Public Health Division, Department of Health.

[7.5.4.1 NMAC - N, 8/28/15]

7.5.4.2 SCOPE:

These regulations govern the procedures for establishing and administrating a statewide vaccine purchasing program to purchase vaccines for all children in New Mexico (NM), including children eligible for the vaccines for children program and insured children.

[7.5.4.2 NMAC - N, 8/28/15]

7.5.4.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 24-5A-1 through 24-5A-9 of the Vaccine Purchasing Act, NMSA 1978; Section 9-7-6 of the Department of Health Act, NMSA 1978; and Section 24-1-3 of the Public Health Act, NMSA 1978.

[7.5.4.3 NMAC - N, 8/28/15]

7.5.4.4 DURATION:

Permanent.

[7.5.4.4 NMAC - N, 8/28/15]

7.5.4.5 EFFECTIVE DATE:

August 28, 2015, unless a later date is cited at the end of a section.

[7.5.4.5 NMAC - N, 8/28/15]

7.5.4.6 OBJECTIVE:

The objective of this rule is to establish standards and administer a statewide vaccine purchasing program to:

A. expand access to childhood immunizations recommended by the advisory committee on immunization practices;

B. maintain and improve immunization rates;

C. facilitate the acquisition by providers of vaccines for childhood immunizations recommended by the advisory committee on immunization practices; and

D. leverage public and private funding and resources for the purchase, storage, and distribution of vaccines for childhood immunizations recommended by the advisory committee on immunization practices.

[7.5.4.6 NMAC - N, 8/28/15]

7.5.4.7 DEFINITIONS:

A. "Advisory committee on immunization practices" means the group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States, established under Section 222 of the federal Public Health Service Act.

B. "Department" means the department of health.

C. "Fund" means the vaccine purchasing fund.

D. "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care to employees or their dependents under the Employee Retirement Income Security Act of 1974 directly or through insurance, reimbursement or other means.

E. "Health insurance coverage" means benefits consisting of medical care provided directly or through insurance or reimbursement or other means under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

F. "Health insurer" means any entity subject to regulation by the office of the superintendent of insurance that:

(1) provides or is authorized to provide health insurance or health benefit plans;

(2) administers health insurance or health benefit coverage; or

(3) otherwise provides a plan of health insurance or health benefits.

G. "Insured child" means a child under the age of 19 who is eligible to receive health insurance coverage from a health insurer or medical care pursuant to a group health plan.

H. "Office of the superintendent" means the office of the superintendent of insurance.

I. "Policy" means any contract of health insurance between a health insurer and the insured and all clauses, riders, endorsements and parts thereof.

J. "Provider" means an individual or organization licensed, certified, or otherwise authorized or permitted by law to provide vaccinations to insured children.

K. "Vaccines for children program" means the federally funded program that provides vaccines at no cost to eligible children pursuant to Section 1928 of the federal Social Security Act.

[7.5.4.7 NMAC - N, 8/28/15]

7.5.4.8 DUTIES OF THE DEPARTMENT:

The department shall:

A. purchase vaccines for children in New Mexico, including children eligible for the vaccines for children program and insured children;

B. invoice each health insurer and group health plan to reimburse the department for the cost of vaccines provided directly or indirectly by the department to such health insurer's or group health plan's insured children;

C. maintain a list of registered providers who receive vaccines for insured children that are purchased by the state and provide such list to each health insurer and group health plan with every invoice;

D. report the failure of a health insurer to reimburse the department within 30 days of the date of the invoice to the office of the superintendent in order for the office of the superintendent to pursue the proper sanctions or monetary penalties pursuant to their rules and the Vaccine Purchasing Act;

E. report the failure of a health insurer or group health plan to reimburse the department within 30 days of the date of the invoice to the office of the attorney general for collection of the invoice amount, including a civil penalty of five hundred dollars ($500) for each day from the date the payment is due;

F. credit all receipts collected from health insurers and group health plans pursuant to the Vaccine Purchasing Act to the fund;

G. no later than July 1, 2015, and July 1 of each year thereafter, the department shall estimate the amount to be expended annually by the department to purchase, store and distribute vaccines recommended by the advisory committee on immunization

practices to all insured children in the state, including a reserve of 10% of the amount estimated; and

H. no later than September 1, 2015, and each quarter thereafter, the department shall invoice each health insurer and each group health plan for one-fourth of its proportionate share of the estimated annual amount and reserve calculated pursuant to Subsection E of 7.5.4.10 NMAC.

[7.5.4.8 NMAC - N, 8/28/15]

7.5.4.9 PROVIDER PROHIBITIONS:

To avoid duplication of payment, any providers who administer vaccines are prohibited from billing health insurers and group health plans for the cost of any vaccine which was provided to them by the department.

[7.5.4.9 NMAC - N, 8/28/15]

7.5.4.10 PROCESS AND PROCEDURES:

A. No later than July 1, 2015, and July 1 of each year thereafter, the department shall estimate the amount to be expended annually by the department to purchase, store, and distribute vaccines recommended by the advisory committee on immunization practices to all insured children in the state, including a reserve of 10% of the amount estimated.

B. By the due date established by the office of the superintendent, but no later than August 15, 2015, each health insurer and group health plan shall report to the office of the superintendent's director of life and health, P.O. Box 1689, Santa Fe, NM 87504, the number of children it insured who were under the age of 19 as of December 31, 2014, excluding from such reports children who are enrolled in medicaid or in any medical assistance program administered by the department, or the human services department, and children who are American Indian or Alaska Natives. All such reports to the office of the superintendent shall be copied to the department at vpa.fund@state.nm.us.

C. By the due date established by the office of the superintendent, but no later than July 1 of each year subsequent to August 15, 2015, each health insurer and group health plan shall annually report to the office of the superintendent's director of life and health, P.O. Box 1689, Santa Fe, NM 87504, the number of children it insures who will be under the age of 19 as of December 31 of the previous year, excluding from such reports children who are enrolled in medicaid or in any medical assistance program administered by the department, or the human services department, and children who are American Indian or Alaska Natives. All such reports to the office of the superintendent shall be copied to the department at vpa.fund@state.nm.us.

D. Each health insurer and group health plan, when reporting number of children pursuant to this section, shall also provide a designated point of contact to the department and to the office of the superintendent to include: name, title, address, e-mail address, and office phone number no later than August 15, 2015, and by July 1 of each subsequent year. In the event that the point of contact changes prior to the billing cycle referenced in the table below, then an updated point of contact shall be provided to the department and the office of the superintendent as soon as practicable after the change occurs, but no later than 30 days after the change.

E. The annual amount to be reimbursed by each health insurer or group health plan shall be a fraction, the denominator of which is the total number of insured children reported by all health insurers and group health plans and the numerator of which is the number of insured children reported by such health insurer or group health plan, multiplied by the total amount as determined by the department to be expended annually in the corresponding year. Payments shall be remitted to the department's fiscal agent in the manner directed by the department in the invoice with a corresponding notification of remittance to vpa.fund@state.nm.us.

F. No later than September 1, 2015, and each quarter thereafter, the department shall invoice each health insurer and each group health plan for one-fourth of its proportionate share of the estimated amount and reserve calculated pursuant to Subsection E of 7.5.4.10 NMAC. The due dates are as follows:

Billing Cycle:	**Department's Invoice Date:**	**Insurer's and Group Health Plan's Due Date:**
July 1 to September 30	September 1	October 1
October 1 to December 31	December 1	January 1
January 1 to March 31	March 1	April 1
April 1 to June 30	June 1	July 1

[7.5.4.10 NMAC - N, 8/28/15]

7.5.4.11 AUTHORIZED USES OF THE VACCINE PURCHASING FUND:

A. Money in the fund shall be expended only for the purposes specified in the Vaccine Purchasing Act, by warrant issued by the secretary of finance and administration pursuant to vouchers approved by the secretary of health.

B. The fund shall be audited in the same manner as other state funds are audited, and all records of payments made from the fund shall be open to the public.

C. Any balance remaining in the fund shall not revert or be transferred to any other fund at the end of a fiscal year.

D. Money in the fund shall be invested by the state investment officer in accordance with the limitations in Article 12 Section 7 of the constitution of New Mexico. Income from investment of the fund shall be credited to the fund.

E. The fund shall be used for the purchase, storage, and distribution of vaccines, as recommended by the advisory committee on immunization practices, for insured children who are not eligible for the vaccines for children program.

F. The department may update its estimated amount to be expended annually and its reserve to take into account increases or decreases in the cost of vaccines or the costs of additional vaccines that the department determines should be included in the statewide vaccine purchasing program and adjust the amount invoiced to each health insurer and group health plan the following quarter.

G. The department shall credit any balance remaining in the fund at the end of the fiscal year toward the department's purchase of vaccines the following year; provided that the department maintains a reserve of 10% of the amount estimated to be expended in the following year.

[7.5.4.11 NMAC - N, 8/28/15]

7.5.4.12 UNAUTHORIZED USES OF THE VACCINE PURCHASING FUND:

The fund shall not be used:

A. for the purchase, storage, and distribution of vaccines for children who are eligible for the vaccines for children program;

B. for administrative expenses associated with the statewide vaccine purchasing program; or

C. to pass through a federally negotiated discount pursuant to 42 U.S.C. 1396s.

[7.5.4.12 NMAC - N, 8/28/15]

7.5.4.13 INITIAL ADMINISTRATIVE REVIEW OF INVOICE BY THE DEPARTMENT:

A. Each health insurer or group health plan shall have the right to request an initial administrative review of their invoice by the department in the event of a dispute over the invoice amount only. Any other grievances shall be initiated with the office of the superintendent pursuant to their rules. Criteria for the initial administrative review of the invoice shall be available from the department of health immunization program. Any informal hearing or administrative review of the invoice pursuant to the office of the superintendent's rules can only be commenced after the department's initial administrative review of the invoice is completed and the health insurer or group health plan receives notification by mail that the administrative review request has been completed by the department.

B. The health insurer or group health plan may submit a letter requesting an initial administrative review of the invoice and any supporting documents to the immunization program manager or designee within 10 working days of receipt of the department's invoice. Such requests shall be submitted to the immunization program manager at P.O. Box 26110, Santa Fe, NM 87502-6110, and via email at vpa.fund@state.nm.us. The health insurer or group health plan shall send a copy of the request to the office of the superintendent of insurance.

C. Within 10 working days of receipt of the request for an initial administrative review of the invoice, the department of health's immunization program manager or designee shall review the request for an initial administrative review of the invoice and any supporting documents. After the administrative review is complete the department's immunization program manager or designee shall notify the health insurer or group health plan by mail if the invoice amount will remain unchanged or modified.

D. If a modified invoice is issued by the department then payment is due within five days of receipt of the modified invoice or on the due date identified in the original invoice, whichever is later. Payment is due regardless of whether the health insurer or group health plan intends to further pursue an administrative review or informal hearing of the invoice with the office of the superintendent or an appeal to district court. Failure to remit payment will result in the department reporting the failure of a health insurer or group health plan to reimburse the department to the office of the attorney general for collection of the invoice amount, including a civil penalty of five hundred dollars ($500) for each day from the date the payment is due.

E. If the invoice remains unchanged then the invoice amount is due within five days of receipt of the department's decision or on the due date identified in the original invoice, whichever is later. Payment is due regardless of whether the health insurer or group health plan intends to further pursue an administrative review or informal hearing of the invoice with the office of the superintendent or an appeal to district court. Failure to remit payment will result in the department reporting the failure of a health insurer or group health plan to reimburse the department to the office of the attorney general for

collection of the invoice amount, including a civil penalty of five hundred dollars ($500) for each day from the date the payment is due.

F. If the health insurer or group health plan continues to dispute the invoice amount, then it may request an informal hearing or administrative review with the office of the superintendent pursuant to the office of the superintendent's rules as authorized by the Vaccine Purchasing Act. The health insurer or group health plan shall notify the immunization program manager if they are pursuing an informal hearing or administrative review of the invoice with the office of the superintendent via email at vpa.fund@state.nm.us.

[7.5.4.13 NMAC - N, 8/28/15]

7.5.4.14 RIGHT TO AN INFORMAL HEARING OR ADMINISTRATIVE REVIEW WITH THE OFFICE OF THE SUPERINTENDENT AND THE RIGHT TO APPEAL; PENALTIES:

A. A health insurer aggrieved pursuant to the Vaccine Purchasing Act may request an informal hearing or an administrative review with the office of the superintendent pursuant to their rules. The health insurer shall notify the immunization program manager if they are pursuing an informal hearing or administrative review with the office of the superintendent via email at vpa.fund@state.nm.us.

B. A health insurer aggrieved pursuant to the Vaccine Purchasing Act may appeal from an order of the superintendent made after an informal hearing or an administrative hearing pursuant to Section 59A-4-20, NMSA 1978. The appeal from the office of the superintendent's order shall be taken to the district court pursuant to the provisions of Section 39-3-1.1 NMSA 1978.

C. A health insurer or group health plan that fails to file a report pursuant to Subsections B and C of 7.5.4.10 NMAC shall pay a late filing fee of five hundred dollars ($500) per day for each day from the date the report was due.

D. The office of superintendent may require a health insurer or group health plan subject to the Vaccine Purchasing Act to produce records that were used to prepare the report required under Subsections B and C of 7.5.4.10 NMAC. If the office of superintendent determines that there is other than a good faith discrepancy between the number of insured children reported and the number of insured children that should have been reported, the health insurer or group health plan shall pay a civil penalty of five hundred dollars ($500) for each report filed for which the office of superintendent determines there is such a discrepancy.

E. Failure of a health insurer or group health plan to make timely payment of an amount invoiced pursuant to the Vaccine Purchasing Act and this rule shall subject the health insurer or group health plan to a civil penalty of five hundred dollars ($500) for each day from the date the payment is due.

[7.5.4.14 NMAC - N, 8/28/15]

PART 5: NEW MEXICO STATEWIDE IMMUNIZATION REGISTRY

7.5.5.1 ISSUING AGENCY:

Public Health Division, Department of Health.

[7.5.5.1 NMAC - N, 10/30/2018]

7.5.5.2 SCOPE:

These regulations govern the use of the New Mexico statewide immunization registry, a computerized repository of immunization information maintained by the New Mexico department of health.

[7.5.5.2 NMAC - N, 10/30/2018]

7.5.5.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the department of health pursuant to the authority granted under Subsection E of Section 9-7-6 NMSA 1978, Sections 24-5-7 through 24-5-15 NMSA 1978, Subsection R of Section 24-1-3 NMSA 1978, and Section 24-1-21 NMSA.

[7.5.5.3 NMAC - N, 10/30/2018]

7.5.5.4 DURATION:

Permanent.

[7.5.5.4 NMAC - N, 10/30/2018]

7.5.5.5 EFFECTIVE DATE:

October 30, 2018, unless a later date is cited at the end of a section.

[7.5.5.5 NMAC - N, 10/30/2018]

7.5.5.6 OBJECTIVE:

The objective of this rule is to describe implementation and maintenance, submission, reporting, participation, and limits on access to the registry portion of the New Mexico immunization program.

[7.5.5.6 NMAC - N, 10/30/2018]

7.5.5.7 DEFINITIONS:

A. "Authorized user" means a person to whom the division has provided account credentials authorizing that person to access to the registry.

B. "CDC" means centers for disease control and prevention, the federal agency responsible for monitoring and protecting the United States of America from health, safety, and security threats related to diseases.

C. "Data elements" means the information required to be entered into the registry by providers as specified in these regulations or by official division publication.

D. "Department" means the department of health.

E. "Division" means the department of health, public health division.

F. "Government issued identification" means a legible, current credentialing document issued by a local, state or federal government entity that includes a photo.

G. "Health information exchange" means an arrangement that allows the sharing of health care information about individual patients among different health care institutions or unaffiliated providers.

H. "Immunization" means treatment of an individual with either a vaccine licensed by the U.S. food and drug administration for immunization and distribution in the United States, or an immune globulin product licensed by the U.S. food and drug administration and used for the purposes of producing or enhancing an immune response.

I. "NDC" means National Drug Code.

J. "NMDOH" means the New Mexico department of health.

K. "NMSIIS" means the New Mexico statewide immunization information system.

L. "Provider" means an individual or organization required to submit information to the registry pursuant to Section 24-5-8 NMSA 1978 including physicians, nurses, pharmacists, nurse practitioners, physician's assistants and other health care providers authorized by the division.

M. "Patient" means any person offered an immunization.

N. "Registry" means the New Mexico statewide immunization information system (NMSIIS), a computerized repository of immunization information maintained by the New Mexico department of health.

O. "Vaccines for children program" or "VFC" means the program operated by the division that provides federally funded vaccines to children ages 0-18 years who are uninsured, on medicaid, or are Alaska Native/American Indian.

[7.5.5.7 NMAC - N, 10/30/2018]

7.5.5.8 IMPLEMENTATION AND MAINTENANCE OF THE REGISTRY:

The department is responsible for establishing guidelines as necessary regarding the implementation and maintenance of the registry.

[7.5.5.8 NMAC - N, 10/30/2018]

7.5.5.9 REPORTING REQUIREMENTS:

A. Providers shall report all data elements to the registry for all immunizations they administer to a patient unless the patient or the patient's parent or guardian informs the provider that the patient declines to participate in the registry or does not wish to include a particular immunization in the registry.

B. Providers shall report all data elements to the registry within 10 days of administering an immunization. A provider may request an extension of 20 days from the division for large immunization events. Permission for extensions for these events are at the discretion of the division and providers must obtain pre-approval.

C. The following are the minimum data elements that must be reported to the registry:

(1) Vaccination information, including:

(a) name of vaccine;

(b) manufacturer of vaccine;

(c) lot/serial number of vaccine;

(d) funding source of vaccine;

(e) expiration date of vaccine;

(f) NDC number of vaccine;

(g) date of administration of vaccine;

(h) dosage administered to patient;

(i) body site and route of administration.

(2) Patient demographic information, including:

(a) last name;

(b) first name;

(c) middle name, if applicable;

(d) sex;

(e) date of birth;

(f) insurance status;

(g) insurance information;

(h) mailing address;

(i) physical address;

(j) contact information.

D. Providers will be notified through an official memo by the division of any additional required data elements for reporting not already included herein. Any included data elements published through an official memo to providers are incorporated herein by reference as required data elements.

[7.5.5.9 NMAC - N, 10/30/2018]

7.5.5.10 SUBMISSION OF REPORTS OF IMMUNIZATION TO THE REGISTRY:

A. All data elements shall be reported to the registry in a manner and format approved by the division.

B. Direct reporting:

(1) Authorized users may directly review and submit data elements electronically through the registry website interface using individual account credentials assigned by the division.

(2) Each user may only use their individual account credentials assigned to the authorized user.

(3) Authorized user account credentials may not be shared.

C. Data exchange reporting:

(1) Providers with electronic systems that are compatible with the division's data exchange program may request to receive approval to utilize the compatible system for reporting the required data elements.

(2) Providers using data exchange reporting must utilize the file format approved by the division and are responsible for all associated costs.

(3) Providers using data exchange reporting must update their systems to maintain compatibility with the divisions data exchange program as necessary to maintain the integrity of the data transfers.

D. A health information exchange may exchange information with the registry on behalf of a provider. When a health information exchange operates in this manner, the exchange is subject to the same rules as the provider.

E. To decrease duplication of patient records and duplicate vaccines, the division may utilize other information sources to populate the registry and perform data quality activities, such as birth certificates, adoption decrees, paper shot records, or medicaid enrollment information.

[7.5.5.10 NMAC - N, 10/30/2018]

7.5.5.11 PROCEDURES TO DECLINE PARTICIPATION:

A. At the time an immunization is offered or administered, if a patient, or a minor's parent or legal guardian notifies the provider that s/he chooses to decline participation in the registry or does not wish to have a specific immunization recorded in the registry, the provider shall document the patient’s decision to opt-out as follows:

(1) The provider shall document the patient's opt-out decision using a form provided by the division, or the provider's own form provided the same information as the division's form is included.

(2) The provider will store all opt-out documentation in an accessible, orderly system so that in the event of a public health emergency, the department can review the opt-out data to inform emergency responses.

B. Patients must complete the opt-out process with each healthcare provider that offers immunization services to the patient, each time immunization services are provided. If the patient declines participation for certain immunizations only, the patient must complete the opt-out process for each immunization for which the patient opts out.

[7.5.5.11 NMAC - N, 10/30/2018]

7.5.5.12 PROCEDURES FOR REVIEWING AND CORRECTING PATIENT RECORDS:

A. At the time an immunization is offered, the provider shall notify the patient of the procedures to review and correct information contained in the registry.

B. A patient, or a minor patient's parent or guardian, who wishes to review the patient's registry immunization record may request a copy from the patient's provider or from a department public health office, or through a department-approved online portal.

C. If a patient requests to correct any information in the registry, the patient shall submit a written request to the division, the NMDOH Helpdesk, to a department public health office, or to the patient's provider. The request shall identify the patient and the information to be corrected.

D. All requests for corrections must be accompanied by a copy of patient identification. If a patient is a minor, the request must be accompanied by a certified copy of the patient's birth certificate and a copy of identification for the submitter or the parent/guardian of the requesting patient. If the requester is a non-parent legal guardian, the guardian must also submit a copy of the guardian's legal appointment of guardianship.

E. If a patient requests to change the registry's record of the patient's date of birth, the patient must present a birth certificate or other legal documentation to verify the patient's correct date of birth. All such requests must be submitted to division staff via the NMDOH Helpdesk. Information on how to contact the NMDOH Helpdesk can be found on the NMSIIS webpage https://nmsiis.health.state.nm.us/webiznet_nm/Login.aspx.

F. If the department bureau of vital records and health statistics provided the date of birth for a patient, the patient's date of birth may not be changed except through notification by vital records or a court order.

G. Only division staff are permitted to change a patient's name or date of birth on a patient record.

(1) Appropriate documentation as required by this section must be presented to division staff to have the patient's name changed, or spelling corrected or changed.

(2) If a court order for adoption requires a name change, the request for change must be submitted to division staff via the NMDOH helpdesk and must include copies of the patient's legal documentation supporting the request.

H. If a patient requests to change any other information in the registry, supporting materials such as medical records, should be attached to the patient's written request.

I. The division may make a change if the change is supported by appropriate documentation.

J. If the patient cannot be uniquely identified in the registry, or if the request is insufficiently supported, the division will contact the patient to obtain additional information.

K. Upon making a determination, the division will notify the requestor of that decision. If the request is denied, the division will notify the patient of the reason(s) for denial. If the request is approved, the division will record the change in the registry.

[7.5.5.12 NMAC - N, 10/30/2018]

7.5.5.13 PROCEDURES TO WITHDRAW CONSENT AND REMOVE INFORMATION FROM REGISTRY:

A. To remove a record from NMSIIS, a patient must submit by mail or hand delivery to the department a completed decision to remove NMSIIS record form. The decision to remove form can be obtained from a provider or printed from the department website at https://nmhealth.org/about/phd/idb/imp/siis/.

B. The patient's request to remove information must be accompanied by a copy of patient identification. If the patient is a minor, the request must be accompanied by a copy of the patient's birth certificate and a copy of identification for the submitter or parent/guardian of the patient. If the requester is a guardian, a copy of the legal appointment of guardianship will be required.

C. Upon receipt of the request, or upon receipt of any requested additional information, the division shall delete the patient's record from the registry. The division shall notify the patient when the record is deleted.

[7.5.5.12 NMAC - N, 10/30/2018]

7.5.5.14 LIMITS ON ACCESS TO THE REGISTRY:

A. Access to the information in the registry shall be limited to primary care physicians, nurses, pharmacists, managed care organizations, school nurses, and other appropriate health care providers including nurse practitioners and physician assistants, or public health entities as designated by the secretary of health. A managed care organization may only access information for its enrollees.

B. Requests for access to the registry shall be made by a provider in writing to the division and access shall be determined by the division.

C. No person or automated system may access or attempt to access the registry without approval from the division.

D. At the division's discretion, access may be modified.

E. A patient, or a patient's parent or guardian if the patient is under the age of 18, may access the patient's records.

[7.5.5.13 NMAC - N, 10/30/2018]

7.5.5.15 COMPLAINT INVESTIGATIONS:

A. If the division receives a complaint or otherwise learns of noncompliance of a provider relating to these rules, an investigation will be initiated.

B. Upon completion of the investigation, the division will issue an investigative report substantiating or not substantiating the alleged noncompliance.

[7.5.5.14 NMAC - N, 10/30/2018]

7.5.5.16 SANCTIONS AND NONCOMPLIANCE:

A. A provider is in noncompliance if they fail to follow any of these regulations.

B. If noncompliance is substantiated, the department will issue the provider a written report of deficiencies which shall include a plan of correction.

(1) The provider must correct any deficiencies identified in the department's plan of correction within a fixed period of time.

(2) The period of time for a provider to correct deficiencies will be reasonably determined by the division and be based on the circumstances of the noncompliance. The time period will be specified in the plan of correction.

C. Upon expiration of the correction date as stated in the plan of correction, pursuant to Section 24-1-21 NMSA the division may impose a separate civil monetary penalty of one hundred dollars ($100) for each repeated instance of noncompliance, including, but not limited to each invalid or improper entry. The division shall issue a written report detailing the repeated non-compliance and the civil monetary penalty. The civil monetary penalty shall not exceed five thousand dollars ($5,000) per report.

[7.5.5.15 NMAC - N, 10/30/2018]

7.5.5.17 ADMINISTRATIVE REVIEW:

A. If a provider wishes to appeal the issuance of a civil monetary penalty, the provider must submit a written request for an administrative review within 10 working days from the date of issuance of the civil monetary penalty.

B. An administrative review will be conducted by an assigned division bureau chief or designee within 30 days of the request for review. Additional time to conduct the administrative review may be granted if requested by the provider and good cause is shown.

(1) The provider may request a paper administrative review, limited to records and a written appeal, or may appear in person or through an advocate of the provider's choice and present evidence to refute the results of the investigation and the reason for the issuance of the civil monetary penalty during an administrative review.

(2) The assigned bureau chief or designee will complete their review and either overturn, modify, or uphold the civil monetary penalty in a written decision within 10 days of the completion of the administrative review.

[7.5.5.16 NMAC - N, 10/30/2018]

7.5.5.18 ADMINISTRATIVE HEARING:

A. If the provider wishes to appeal the result of the administrative review, the provider must submit a written request to the division within 10 working days from the date of issuance of the assigned bureau chief or designee's written decision.

B. Hearing process:

(1) Hearing will be conducted by a hearing officer appointed by the secretary.

(2) Hearings shall be conducted in Santa Fe, New Mexico, unless the appellant can show significant hardship sufficient to require the case be held in a different location.

(3) Due to federal and state laws regarding the confidentiality of protected health information, all hearings held pursuant to this section shall be closed to the public.

(4) The hearing shall be recorded on audio recording equipment. The hearing officer shall maintain the recording. No other recordings may be made except with the permission of the hearing officer.

(5) Any hearing provided for in this rule may be held telephonically, with the consent of the parties.

(6) A request for a telephonic hearing must be made no later than 10 business days prior to the date of the hearing; notice of the telephonic hearing shall be given to all parties and shall include all necessary telephone numbers;

(6) The department shall schedule and hold the hearing no later than 60 calendar days from the date the department receives the appellant's request for hearing. The hearing officer may extend the 60-day time period for good cause shown, or the parties may extend that period by mutual agreement.

(7) The department shall issue notice of the hearing at least fifteen days prior to the scheduled date of the hearing. The notice shall include a statement of the time, place, and nature of the hearing.

(9) An appellant's failure to appear at the hearing at the date and time noticed shall constitute a default unless good cause for the failure to appear is shown.

(10) All parties shall be given the opportunity to respond and present evidence and argument on relevant issues.

(11) A party may be represented by a person licensed to practice law in New Mexico or a non-lawyer representative or may represent himself or herself.

(12) The hearing officer shall create a record of the proceedings which shall include the following:

(a) all pleadings, motions, and rulings;

(b) evidence and briefs received or considered;

(c) a statement of any matters officially noticed;

(d) offers of proof, objections, and rulings thereon;

(e) proposed findings and conclusions; and

(f) any action recommended by the hearing officer.

(13) Unless the hearing officer determines a different procedure is appropriate, the hearing officer shall conduct the hearing as follows:

(a) opening statements by the appellant and the department;

(b) upon conclusion of the opening statements, the department shall present its case;

(c) upon conclusion of the departments case, the appellant may present his or her case;

(d) upon conclusion of either party's case, the opposing party may present rebuttal evidence; and

(e) after presentation of the evidence by the parties, the parties may present closing arguments.

(14) The rules of evidence as applied in courts do not apply in the proceedings; any relevant evidence shall be admitted; irrelevant, immaterial, or unduly repetitious evidence may be excluded.

(15) The department shall be required to prove its case by a preponderance of the evidence.

(16) The parties may submit briefs including findings of fact and conclusions of law for consideration by the hearing officer. All briefs must be submitted 15 days after the conclusion of the hearing.

(17) No later than 30 calendar days after the last submission by a party, the hearing officer shall prepare and submit to the secretary a written recommendation of action to be taken by the secretary; the recommendation shall propose sustaining, reversing, or modifying the proposed action of the department.

(18) The secretary shall issue a final written decision accepting or rejecting the hearing officer's recommendation in whole or in part no later than 30 calendar days after receipt of the hearing examiner's recommendation; the final decision shall identify final action taken. Service of the secretary's final decision shall be made upon the appellant by registered or certified mail.

[7.5.5.18 NMAC - N, 10/30/2018]

CHAPTER 6: FOOD HANDLING

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: FOOD SERVICE AND FOOD PROCESSING

7.6.2.1 ISSUING AGENCY:

New Mexico Environmental Improvement Board.

[7.6.2.1 NMAC - Rp, 7.6.2.1 NMAC, 12/1/2018]

7.6.2.2 SCOPE:

All food establishments and food processing plants.

[7.6.2.2 NMAC - Rp, 7.6.2.2 NMAC, 12/1/2018]

7.6.2.3 STATUTORY AUTHORITY:

Section 74-1-8 NMSA 1978 directs the environmental improvement board to promulgate regulations and standards for food protection. Section 74-1-9 NMSA 1978 directs the procedures for adoption. Section 25-1-4 delineates requirements of food service establishments to prepare and serve food in a manner safe for human consumption, free from adulteration, spoilage, contamination and unwholesomeness. Section 25-1-7 NMSA 1978 authorizes the department of environment to execute any provisions of the Food Service Sanitation Act (Chapter 25, Article 1 NMSA 1978).

[7.6.2.3 NMAC - Rp, 7.6.2.3 NMAC, 12/1/2018]

7.6.2.4 DURATION:

Permanent.

[7.6.2.4 NMAC - Rp, 7.6.2.4 NMAC, 12/1/2018]

7.6.2.5 EFFECTIVE DATE:

December 1, 2018, unless a later date is cited at the end of a section.

[7.6.2.5 NMAC - Rp, 7.6.2.5 NMAC, 12/1/2018]

7.6.2.6 OBJECTIVE:

The objective of these regulations is to protect the public health by establishing standards and provisions for the safe operation of food establishments and food processing plants to assure that consumers are not exposed to adverse environmental health conditions.

[7.6.2.6 NMAC - Rp, 7.6.2.6 NMAC, 12/1/2018]

7.6.2.7 DEFINITIONS:

A. Adoption of food code definitions. Except as otherwise provided below, Part 1-2 (Definitions) of the 2017 United States food and drug administration model food code is hereby adopted and incorporated in its entirety.

B. Modifications to food code definitions. The following terms defined in food code Part 1-2 have the meanings set forth herein, in lieu of the meanings set forth in food code, Part 1-2.

(1) "Adulterated" has the meaning state in the New Mexico Food Act, Section 25-2-10 NMSA 1978.

(2) "Critical control point" means a point, step, or procedure in a food process at which a control measure can be applied and at which control is essential to prevent, reduce to an acceptable level, or eliminate an identified food hazard.

(3) "Critical limit" means the maximum or minimum value to which a physical, biological, or chemical parameter must be controlled at a critical control point to prevent, eliminate, or reduce to an acceptable level the occurrence of the identified food hazard.

(4) "Drinking water" means water that meets criteria as specified in 20.7.10 NMAC. Drinking Water is traditionally known as "potable water", and includes the term "water" except where the term used connotes that the water is not potable, such as "boiler water," "mop water," "rainwater," "wastewater," and "non-drinking" water.

(5) "Food establishment" means an operation that stores, prepares, packages, serves, or vends food directly to the consumer, or otherwise provides food for human consumption such as a restaurant; satellite or catered feeding location; catering operation if the operation provides food directly to a consumer or to a conveyance used to transport people; market; vending location; conveyance used to transport people; an institution; or food bank; and relinquishes possession of food to a consumer directly, or indirectly through a delivery service such as home delivery of grocery orders or restaurant takeout orders, or delivery service that is provided by common carriers.

(a) Food establishment includes:

(i) an element of the operation such as a transportation vehicle or a central preparation facility that supplies a vending location or satellite feeding location unless the vending or feeding location is permitted by the regulatory authority; or

(ii) an operation that is conducted in a mobile, stationary, temporary, or permanent facility or location; where consumption is on or off the premises; and regardless of whether there is a charge for the food.

(b) Food establishment does not include:

(i) an establishment that offers only prepackaged foods that are not time/temperature control for safety (TCS) foods;

(ii) a produce stand that only offers whole, uncut fresh fruits and vegetables;

(iii) a food processing plant; including those that are located on the premises of a food establishment;

(iv) a kitchen in a private home if only baked goods (e.g., cookies, brownies, cakes, fruit pies) that are not TCS food, are prepared for sale or service at a

fundraising function (e.g., a religious or charitable organization's bake sale) if the consumer is informed by a clearly visible placard at the sales or service location that the food is prepared in a kitchen that is not subject to regulation and inspection by the regulatory authority;

(v) an area where food that is prepared as specified in Item (iv) of Subparagraph (b) of Paragraph (5) of Subsection B of 7.6.2.7 NMAC is sold or offered for human consumption;

(vi) a kitchen in a private home, such as a facility licensed by or registered with the department of health (DOH), or the children, youth and families department (CYFD), or a bed-and-breakfast operation that prepares and offers food to guests if the home is owner occupied, the number of available guest bedrooms does not exceed six, breakfast is the only meal offered, the number of guests served does not exceed 18, and the consumer is informed by statements contained in published advertisements, mailed brochures, and placards posted at the registration area that the food is prepared in a kitchen that is not regulated and inspected by the regulatory authority;

(vii) a private home that receives catered or home-delivered food that is served to non-paying guests;

(viii) non-paying guests in private homes;

(ix) a private home or home environment where residents take part in preparing and serving their own meals;

(x) a pot-luck dinner or similar event in which the food is prepared or contributed by the participants and for which no fee is charged;

(xi) a custom exempt meat processing facility where animals are processed for personal use by the animal owner as food and not for sale or service in a food establishment;

(xii) a dairy establishment as defined in the New Mexico Food Act;

(xiii) an animal slaughter facility;

(xiv) an aquaculture facility that raises fish;

(xv) a "pure honey" processing facility; "pure honey" refers to natural liquid or solid honey extracted from the combs or in the comb taken from beehives with no processing or adding of additional ingredients; or

(xvi) an operation that offers to consumers whole raw agricultural products.

(6) "Hazard analysis critical control point (HACCP) plan" means a document prepared in accordance with the principles of HACCP to ensure control of hazards which are significant for food safety.

(7) "Hermetically sealed container" means an airtight container that is designed and intended to be secure against the entry of microorganisms and to maintain the commercial sterility of its contents after processing, or to maintain the controls which prevent potential growth of microorganisms or the elaboration of toxins through acidity (pH) or water activity (a_w).

(8) "Public water system" has the meaning stated in 20.7.10 NMAC.

(9) "Regulatory authority" means the New Mexico environment department.

(10) "Temporary food establishment" (TFE) means a food establishment that operates at a fixed location in conjunction with a single event or celebration for a period not exceeding the length of the event or celebration, and does not exceed 30 days.

C. Additions to food code definitions. The following terms not defined in food code Part 1-2 have the meanings set forth herein when the terms are used in this part.

(1) "Acid food" means food that has a natural pH of 4.6 or below.

(2) "Acidified food" means low-acid food to which acid(s) or acid food(s) are added and have a water activity (a_w) greater than 0.85 and have a finished equilibrium pH of 4.6 or below. Carbonated beverages and food that are stored, distributed, and retailed under refrigeration are not classified as acidified food.

(3) "Control point" means a step at which biological, chemical, or physical factors can be controlled.

(4) "Corrective action" means an action to be taken when the results of monitoring at the critical control point indicate a loss of control.

(5) "Deviation" means failure to meet a critical limit.

(6) "Food code" means the 2017 United States food and drug administration model food code.

(7) "Food handler card" means a card issued to an individual after successful completion of a food handler training program to function as a food employee.

(8) "Food handler training program" means an ANSI/ASTM E2659-09 accredited food handler training certificate program.

(9) "Good manufacturing practices" (GMPs) means the minimum sanitary and processing requirements related to production methods, equipment, facilities, and other controls that a food processing plant must meet to assure that food is safe and wholesome.

(10) "Hazard analysis and critical control point" (HACCP) means a food safety management system that focuses on the identification, evaluation, and control of food safety hazards.

(11) "Hazard analysis" means the process of collecting and evaluating information on hazards associated with the food under consideration to decide which are significant and must be addressed in the HACCP plan.

(12) "Home-based food processing operation" means any business in which a residential kitchen is permitted to process approved food that is not classified as a TCS food and is packaged and is offered directly to the consumer.

(13) "Jerky" means a dried, finished meat, poultry, fish, or game animal product having a water activity (a_w) less than 0.85.

(14) "Low acid food" means any food, other than alcoholic beverages, with a finished equilibrium pH greater than 4.6 and a water activity (a_w) greater than 0.85. Tomatoes and tomato products having a finished equilibrium pH less than 4.7 are not classified as low acid food.

(15) "Misbranded" has the meaning stated in the New Mexico Food Act, Section 25-2-11 NMSA 1978.

(16) "Mobile food establishment" means a food establishment that is designed to be readily movable; completely retains its mobility; and is equipped to serve food. Mobile food establishment includes self-contained mobile units, non-self-contained mobile units, pushcarts, and mobile support units.

(17) "Mobile support unit" means an enclosed motor vehicle department-licensed driven or towed wheeled vehicle used in conjunction with a New Mexico based servicing area that travels to, and services, other mobile food establishments as needed to replenish supplies, including food and potable water, clean the interior of the unit, or dispose of liquid or solid wastes.

(18) "Monitoring" means to conduct a planned sequence of observations or measurements to assess whether a process, point, or procedure is under control and to produce an accurate record for future use in verification.

(19) "Non self-contained mobile unit" means an enclosed motor vehicle department-licensed driven or towed wheeled vehicle that is required to operate from a New Mexico based servicing area.

(20) "Operational plan" means a written plan outlining the product formulation, production steps, safety requirements, distribution, labeling, and recall procedures of a food product that will be implemented by a food establishment or food processing plant when processing packaged food.

(21) "Process authority" means an expert in the processes for controlling pathogenic microorganisms in food, and as such, is qualified by education, training and experience to evaluate all of the aspects of pathogen control measures-and determine if such control measures, when properly implemented, will control pathogens effectively.

(22) "Pushcart" means a human propelled unit, equipped to serve food, that is required to operate from a New Mexico based servicing area.

(23) "Recall" means a return of food products that are either known or suspected to be adulterated, misbranded, or otherwise unsafe for human consumption, to the manufacturer or distributor, or that are disposed of by approved methods.

(24) "Sanitation standard operating procedures" (SSOPs) means written procedures specific to a single food processing plant to be followed routinely for the performance of designated operations to ensure sanitary conditions and to prevent product adulteration in a food processing plant.

(25) "Self-contained mobile unit" means an enclosed motor vehicle department-licensed driven or towed wheeled vehicle that is not required to operate from a New Mexico based servicing area.

(26) "Shelf-stable product" means a product that is hermetically sealed and, when stored at room temperature, should not demonstrate any microbial growth.

(27) "Standard operating procedures" (SOPs) means written procedures to be followed routinely for the performance of designated operations in a food processing plant.

(28) "Standards of identity" means legal standards, defined by the food and drug administration (FDA), for foods regarding minimum quality specifications, including permitted ingredients and processing requirements, to be marketed under a certain name.

(29) "Sub-ingredient" means an ingredient within another ingredient that has been added to a food and is declared parenthetically following the name of the ingredient or by dispersing each ingredient in its order of predominance in the ingredient statement without naming the original ingredient.

(30) "Validation" means that element of verification focused on collecting and evaluating scientific and technical information to determine whether the HACCP system, when properly implemented, will control effectively the identified food hazards.

(31) "Verification" means those activities, other than monitoring, that establish the validity of the HACCP plan and that the system is operating according to the plan. It includes validation procedures.

[7.6.2.7 NMAC - Rp, 7.6.2.7 NMAC, 12/1/2018]

7.6.2.8 FOOD ESTABLISHMENT REQUIREMENTS:

A. Adoption of food code. Except as otherwise provided, the 2017 United States food and drug administration model food code and the supplement to the 2017 food code are hereby adopted and incorporated in their entirety.

B. Modifications to food code. Except as otherwise provided, the following modifications are made to the incorporated food code.

(1) 2-102.12 Certified food protection manager.

(a) At least one employee per food establishment that has supervisory and management responsibility and the authority to direct and control food preparation and service shall be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program.

(b) This section applies to food establishments, temporary food establishments, and mobile food establishments.

(c) This section does not apply to certain types of food establishments deemed by the regulatory authority to pose minimal risk of causing, or contributing to, foodborne illness based on the nature of the operation and extent of food preparation.

(d) A single certified food protection manager may be responsible for more than a single food establishment, provided that a variance is approved by the regulatory authority as specified in Paragraph (12) of Subsection B of 7.6.2.8 NMAC and Section 8-103.11 of the food code.

(e) The effective date of Paragraph (1) of Subsection B of 7.6.2.8 NMAC shall be three months from the effective date of 7.6.2.8 NMAC.

(2) 2-102.20 Food protection manager certification

(a) A person in charge who demonstrates knowledge by being a food protection manager that is certified by a food protection manager certification program that is evaluated and listed by a Conference for Food Protection-recognized accrediting agency as conforming to the conference for food protection standards for accreditation of food protection manager certification programs is deemed to comply with Paragraph 2-102.11(B).

(b) A food establishment that has an employee that is certified by a food protection manager certification program that is evaluated and listed by a Conference for Food Protection-recognized accrediting agency as conforming to the Conference for Food Protection Standards for Accreditation of Food Protection Manager Certification Programs is deemed to comply with Section 2102.12.

(3) 3-201.15 Molluscan shellfish.

(a) Molluscan shellfish shall be obtained from sources according to law and the requirements specified in the United States (U.S.) DOH and human services, public health service, FDA, national shellfish sanitation program guide for the control of molluscan shellfish.

(b) Molluscan shellfish shall be from sources that are listed in the interstate certified shellfish shippers list.

(4) 3-202.18 Shellstock identification.

(a) Shellstock shall be obtained in containers bearing legible source identification tags or labels that are affixed by the harvester or dealer that depurates, ships, or reships the shellstock, as specified in the national shellfish sanitation program guide for the control of molluscan shellfish, and that list:

(i) except as specified under Subparagraph (c) of Paragraph 3 of Subsection B of 7.6.2.8 NMAC, on the harvester's tag or label, the following information in the following order: the harvester's identification number that is assigned by the shellstock control authority, the date of harvesting, the most precise identification of the harvest location or aquaculture site that is practicable based on the system of harvest area designations that is in use by the shellstock control authority and including the abbreviation of the name of the state or country in which the shellfish are harvested, the type and quantity of shellfish, the following statement in bold, capitalized type: "this tag is required to be attached until container is empty or retagged and thereafter kept on file for 90 days";

(ii) except as specified in Subparagraph (d) of Paragraph (3) of Subsection B of 7.6.2.8 NMAC, on each dealer's tag or label, the following information in the following order: the dealer's name and address, the certification number assigned by the shellstock control authority, the original shipper's certification number including the abbreviation of the name of the state or country in which the shellfish are harvested, the same information as specified for a harvester's tag under Item (i) of Subparagraph (a) of Paragraph (3) of Subsection B of 7.6.2.8 NMAC, and the following statement in bold, capitalized type: "this tag is required to be attached until container is empty and thereafter kept on file for 90 days."

(b) A container of shellstock that does not bear a tag or label or that bears a tag or label that does not contain all the information as specified under Subparagraph

(a) of Paragraph (3) of Subsection B of 7.6.2.8 NMAC shall be subject to a hold order or seizure and destruction in accordance with Section 25-2-6 NMSA 1978.

(c) If a place is provided on the harvester's tag or label for a dealer's name, address, and certification number, the dealer's information shall be listed first.

(d) If the harvester's tag or label is designed to accommodate each dealer's identification as specified under Item (ii) of Subparagraph (a) of Paragraph (3) of Subsection B of 7.6.2.8 NMAC, individual dealer tags or labels need not be provided.

(5) 3-502.11 Variance requirement. A food establishment shall obtain a variance from the regulatory authority as specified in Sections 8-103.10 and 8-103.11 of the food code before:

(a) smoking food as a method of food preservation rather than as a method of flavor enhancement;

(b) curing food;

(c) using food additives or adding components such as vinegar:

(i) as a method of food preservation rather than as a method of flavor enhancement; or

(ii) to render a food so that it is not TCS food;

(d) packaging TCS food using a reduced oxygen packaging method except where the growth of and toxin formation by clostridium botulinum and the growth of listeria monocytogenes are controlled as specified under Section 3-502.12 of the food code;

(e) operating a molluscan shellfish life-support system display tank used to store or display shellfish that are offered for human consumption;

(f) preparing food by another method that is determined by the regulatory authority to require a variance; or

(g) sprouting seeds or beans.

(6) 4-205.10 Food equipment, certification and classification.

(a) Food equipment, including new and replacement equipment, shall be certified or classified for sanitation by an American national standards institute (ANSI) - accredited certification program. Such accredited programs include, but are not limited to, the national sanitation foundation (NSF), underwriters laboratories (UL), intertek ETL, or the Canadian standards administration (CSA).

(b) Food equipment that is certified or classified for sanitation by an ANSI - accredited certification program is deemed to comply with Parts 4-1 and 4-2 of the Food Code.

(7) 4-301.11 Cooling, heating, holding capacities and use.

(a) Equipment for cooling and heating food, and holding cold and hot food, shall be sufficient in number and capacity to provide food temperatures as specified under Chapter 3 of the food code.

(b) Steam tables, slow cookers, and other hot holding devices shall not be used in cooking, heating or reheating food as specified under Sections 3-401 and 3-403 of the food code.

(8) 5-102.11 Standards. Except as specified under Section 5-102.12 of the food code:

(a) Water from a public water system shall meet the construction and drinking water quality standards specified in 20.7.10 NMAC; and

(b) Water from a non-public water system shall meet:

(i) the construction requirements and drinking water quality standards of a non-community water system as specified in 20.7.10 NMAC; and

(ii) the drinking water source setback requirements as specified in 20.7.3 NMAC.

(9) 5-102.13 Sampling. Except when used as specified under Section 5-102.12 of the Food Code, water from a non-public water system shall meet the sampling requirements of a non-community water system as specified in 20.7.10 NMAC.

(10) 5-203.13 Service sink.

(a) Except as specified in Paragraph (C) of Section 5-203.13 of the food code, at least one service sink or one curbed cleaning facility equipped with a floor drain shall be provided and conveniently located for the cleaning of mops or similar wet floor cleaning tools and for the disposal of mop water and similar liquid waste.

(b) Toilets and urinals may not be used as a service sink for the disposal of mop water and similar liquid waste.

(c) When no health hazard will exist, the regulatory authority may approve an alternative method.

(11) 6-501.115 Prohibiting animals.

(a) Except as specified in Subparagraphs (b) and (c) of Paragraph (10) of Subsection B of 7.6.2.8 NMAC, live animals may not be allowed on the premises of a food establishment.

(b) Live animals may be allowed in the following situations if the contamination of food, clean equipment, utensils, and linens, and unwrapped single-service and single-use articles cannot result:

(i) edible fish or decorative fish in aquariums, shellfish or crustaceans on ice or under refrigeration, and shellfish and crustaceans in display tank systems;

(ii) patrol dogs accompanying police or security officers in offices and dining, sales, and storage areas, and sentry dogs running loose in outside fenced areas;

(iii) in areas that are not used for food preparation and that are usually open for customers, such as dining and sales areas, service animals that are controlled by the disabled employee or person, if a health or safety hazard will not result from the presence or activities of the service animal;

(iv) pets in the common dining areas of institutional care facilities such as nursing homes, assisted living facilities, group homes, or residential care facilities at times other than during meals if effective partitioning and self-closing doors separate the common dining areas from food storage or food preparation areas, condiments, equipment, and utensils are stored in enclosed cabinets or removed from the common dining areas when pets are present, and dining areas including tables, countertops, and similar surfaces are effectively cleaned before the next meal service;

(v) in areas that are not used for food preparation, storage, sales, display, or dining, in which there are caged animals or animals that are similarly confined, such as in a variety store that sells pets or a tourist park that displays animals; and

(vi) pet dogs in outdoor dining areas, if allowed by the food establishment, and pet dogs are excluded from any area where food is prepared, pet dogs are kept on a leash and under reasonable control at all times, pet dogs are not allowed on chairs, consumer's laps, tables, or other furnishings, consumers shall not feed pet dogs on food establishment tableware, and a sign approved by the regulatory authority is posted at each entrance to the designated outdoor dining area stating the conditions under which pet dogs are allowed and alerting patrons that pet dogs are allowed and may be present.

(c) Live or dead fish bait may be stored if contamination of food, clean equipment, utensils, and linens, and unwrapped single-service and single-use articles cannot result.

(12) 8-103.10 Modifications and waivers.

(a) The regulatory authority may grant a variance by modifying or waiving the requirements of the food code if in the opinion of the regulatory authority a health hazard or nuisance will not result from the variance. If a variance is granted, the regulatory authority shall retain the information specified under Section 8-103.11 of the food code in its records for the food establishment.

(b) The regulatory authority shall grant the variance, grant the variance subject to conditions, or deny the variance within 15 working days following the receipt of the variance request.

(13) 8-201.11 When plans are required. Except for temporary food establishments, a permit applicant or permit holder shall submit to the regulatory authority properly prepared plans and specifications for review and approval at least 30 calendar days before:

(a) the construction of a food establishment;

(b) the conversion of an existing structure for use as a food establishment;

(c) the remodeling of a food establishment or a change of type of food establishment or food operation as specified under Subparagraph (c) of Paragraph (17) of Subsection B of 7.6.2 NMAC if the regulatory authority determines that plans and specifications are necessary to ensure compliance with the food code; or

(d) opening or changing ownership of an existing food establishment, if current plans and specifications are not on file with the regulatory authority.

(14) 8-301.11 Prerequisite for operation.

(a) A person may not operate a food establishment or servicing area without a valid permit to operate issued by the regulatory authority.

(b) Except as specified in Subparagraphs (c) and (d) of Paragraph (13) of Subsection B of 7.6.2 NMAC, when more than a single food establishment is operated on the premises, each one shall be separately permitted.

(c) Bars operating in conjunction with a food establishment do not require a separate permit.

(d) A food establishment used as a servicing area does not require a separate permit.

(e) Prior to the issuance of a permit or the renewal of a permit, the regulatory authority shall make inspections of the food establishment or food processing plant as it deems necessary.

(15) 8-302.11 Submission 30 calendar days before proposed opening. An applicant shall submit an application for a permit at least 30 calendar days before the date planned for opening a food establishment, mobile food establishment, food processing plant, or home-based food processing operation.

(16) 8-302.13 Qualifications and responsibilities of applicants. To qualify for a permit, an applicant shall:

(a) be an owner of the food establishment or an officer of the legal ownership;

(b) comply with the requirements of 7.6.2 NMAC;

(c) as specified under Paragraph (21) of Subparagraph B of 7.6.2.8 NMAC, agree to allow access to the food establishment and to provide required information; and

(d) pay the applicable permit fees when approval to open is granted by the regulatory authority.

(17) 8-302.14 Contents of the application. The application shall include:

(a) the name, mailing address, telephone number, and signature of the person applying for the permit and the name, mailing address, and location of the food establishment;

(b) information specifying whether the food establishment is owned by an association, corporation, individual, partnership, or other legal entity;

(c) a statement specifying whether the food establishment:

(i) is mobile or stationary and temporary or permanent;

(ii) prepares, offers for sale, or serves time/temperature control for safety food only to order upon a consumer's request, or in advance in quantities based on projected consumer demand and discards food that is not sold or served at an approved frequency, or using time as the public health control as specified under Section 3-501.19 of the food code;

(iii) prepares time/temperature control for safety food in advance using a food preparation method that involves two or more steps which may include combining time/temperature control for safety food ingredients, cooking, cooling, reheating, hot or cold holding, freezing or thawing;

(iv) prepares food as specified under Item (ii) of Subparagraph (c) of Paragraph (16) of Subparagraph B of 7.6.2.8 NMAC for delivery to and consumption at a location off the premises of the food establishment where it is prepared;

(v) prepares food as specified under Item (ii) of Subparagraph (c) of Paragraph (16) of Subparagraph B of 7.6.2.8 NMAC for service to a highly susceptible population;

(vi) prepares only food that is not time/temperature control for safety food;

(vii) does not prepare, but offers for sale only prepackaged food that is not time/temperature control for safety food;

(d) the name, title, address, and telephone number of the person directly responsible for the food establishment;

(e) the name, title, address, and telephone number of the person who functions as the immediate supervisor of the person specified under Subparagraph (d) of Paragraph (16) of Subsection B of 7.6.2.8 NMAC, such as the zone, district, or regional supervisor;

(f) the names, titles, and addresses of the persons comprising the legal ownership as specified under Subparagraph (b) of Paragraph (16) of Subsection B of 7.6.2.8 NMAC, including the owners and officers, and the local resident agent if one is required based on the type of legal ownership;

(g) a statement signed by the applicant that attests to the accuracy of the information provided in the application and affirms that the applicant will comply with the food code, and allow the regulatory authority access to the food establishment as specified under Subparagraph (a) of Paragraph (20) of Subsection B of 7.6.2.8 NMAC and to the records specified under Sections 3-203.12 and 5-205.13 of the food code and Subparagraph (6) of Paragraph (D) of Section 8-201.14 of the food code; and

(h) other information required by the regulatory authority.

(18) 8-303.20 Existing establishments, permit renewal, and change of ownership.

(a) The regulatory authority may renew a permit for an existing food establishment upon submission of a renewal form provided by the regulatory authority and the required fee(s) as specified in Roman numerals (i) and (ii) of Subparagraph (a) of Paragraph (3) of Subsection D of 7.6.2.8 prior to the expiration date of the permit. Permit renewals that are not submitted before the expiration date shall be assessed a late fee as specified in Subparagraph (c) of Paragraph (3) of Subsection D of 7.6.2.8, regardless of whether a permit fee is required.

(b) The regulatory authority may issue a permit to a new owner of an existing food establishment, mobile food establishment, servicing area, or food processing plant upon completion of requirements as specified in Paragraph (13) of Subsection B of

7.6.2.8 and Paragraph (15) of Subsection B of 7.6.2.8, and an inspection shows it is in compliance with 7.6.2 NMAC.

(19) 8-401.10 Establishing inspection interval.

(a) Except as specified in Subparagraph (b) of Paragraph (18) of Subsection B of 7.6.2.8 NMAC, the regulatory authority shall inspect a food establishment, mobile food establishment, food processing plant, or home-based food processing operation at least annually to determine compliance with the Food Service Sanitation Act, the New Mexico Food Act, and 7.6.2 NMAC.

(b) The regulatory authority may periodically inspect throughout its permit period a temporary food establishment that prepares, sells, or serves unpackaged time/temperature control for safety food and that:

(i) has improvised rather than permanent facilities or equipment for accomplishing functions such as handwashing, food preparation and protection, food temperature control, warewashing, providing drinking water, waste retention and disposal, and insect and rodent control; or

(ii) has inexperienced food employees.

(c) When an inspection conducted by the regulatory authority reveals a violation, or repeat violation of priority items of 7.6.2 NMAC and a re-inspection is scheduled by the regulatory authority, a re-inspection penalty fee shall be assessed by the regulatory authority and paid by the operator as specified in Subparagraph (d) of Paragraph (3) of Subsection D of 7.6.2.8 NMAC.

(20) 8-401.20 Performance- and risk-based. The regulatory authority shall prioritize, and conduct more frequent inspections based upon its assessment of a food establishment’s history of compliance with the food code and the establishment’s potential as a vector of foodborne illness by evaluating:

(a) past performance, for nonconformance with code or HACCP plan requirements that are priority items or priority foundation items;

(b) past performance, for numerous or repeat violations of Food Code or HACCP plan requirements that are core items;

(c) past performance, for complaints investigated and found to be valid;

(d) the hazards associated with the particular foods that are prepared, stored, or served;

(e) the type of operation including the methods and extent of food storage, preparation, and service;

(f) the number of people served; and

(g) whether the population served is a highly susceptible population.

(21) 8-402.11 Allowed at reasonable times after due notice.

(a) After the regulatory authority presents official credentials and provides notice of the purpose of, and an intent to conduct, an inspection, the person in charge shall allow the regulatory authority to determine if the food establishment, mobile food establishment, food processing plant, or home-based food processing operation is in compliance with the food code by allowing access to the establishment, allowing inspection, and providing information and records specified in the food code and to which the regulatory authority is entitled according to law, during the food establishment's hours of operation and other reasonable times.

(b) The regulatory authority shall be allowed to copy any records pertaining to the manufacture, processing, packing, distribution, receipt, holding, or importation of food maintained by or on behalf of a food establishment, mobile food establishment, food processing plant, or home-based food processing operation in any format, including paper and electronic formats, and at any location. Proprietary documents shall be protected by the regulatory authority as specified in Section 8-202.10 of the food code.

(22) 8-402.20 Refusal, notification of right to access, and final request for access. If a person denies access to the regulatory authority, the regulatory authority shall:

(a) inform the person that:

(i) the permit holder is required to allow access to the regulatory authority as specified under Section 8-402.11 of the food code;

(ii) access is a condition of the acceptance and retention of a food establishment permit to operate as specified under Section 8-304.11 of the food code;

(iii) if access is denied, an order issued by the appropriate authority allowing access, hereinafter referred to as an inspection order, may be obtained according to law; and

(iv) refusal to allow access is grounds for immediate permit suspension or revocation;

(b) make a final request for access.

(23) 8-403.30 Issuing report and obtaining acknowledgement of receipt. The regulatory authority shall provide a copy of the completed inspection report and the

notice to correct violations, as soon as possible after the inspection, to the permit holder or to the person in charge, and request a signed acknowledgment of receipt.

(24) 8-801.10 Proper methods. A notice issued in accordance with the food code shall be considered to be properly served if it is served by one of the following methods:

(a) the notice is personally served by the regulatory authority, a law enforcement officer, or a person authorized to serve a civil process to the permit holder, the person in charge, or person operating a food establishment without a permit; or

(b) the notice is sent by the regulatory authority to the last known address of the permit holder or the person operating a food establishment without a permit, by registered or certified mail or by other public means so that a written acknowledgment of receipt may be acquired.

(25) 8-801.20 Restriction or exclusion order, hold order or immediate suspension. An employee restriction or exclusion order, an order to hold and not distribute food, such as a hold, detention, embargo, or seizure order which is hereinafter referred to as a hold order, or an immediate suspension order shall be:

(a) served as specified in Paragraph (24) of Subsection B of 7.6.2.8 NMAC; or

(b) clearly posted by the regulatory authority at a public entrance to the food establishment and a copy of the notice sent by first class mail to the permit holder or to the owner or custodian of the food, as appropriate.

(26) 8-901.10 Conditions warranting remedy. The regulatory authority may seek an administrative or judicial remedy to achieve compliance with the provisions of the food code if a person operating a food establishment or employee:

(a) fails to have a valid permit to operate a food establishment as specified under Section 8-301.11 of the food code;

(b) violates any term of condition of a permit as specified under Section 8-304.11 of the food code;

(c) allows repeated violations of the Food Service Sanitation Act, Chapter 25, Article 1 NMSA 1978; the New Mexico Food Act, Chapter 25, Article 2 NMSA 1978; or serious or repeated food code violations to reoccur or remain uncorrected beyond time frames for correction approved, directed, or ordered by the regulatory authority;

(d) fails to comply with a regulatory authority order issued as specified in Section 8-501.20 of the food code concerning an employee or conditional employee suspected of having a disease transmissible through food by infected persons;

(e) fails to comply with a hold order as specified in Paragraph (27) of Subsection B of 7.6.2.8 NMAC;

(f) fails to comply with an order issued as a result of a hearing for an administrative remedy as specified in Section 8-906.40 of the food code; or

(g) Fails to comply with an immediate suspension order issued by the regulatory authority as specified in Paragraph (24) of Subsection B of 7.6.2.8 NMAC and Paragraph (30) of Subsection B of 7.6.2.8 NMAC.

(27) 8-903.10 Hold order, justifying conditions and removal of food.

(a) The regulatory authority may place a hold order on a food that:

(i) originated from an un-approved source;

(ii) may be unsafe, adulterated, or not honestly presented;

(iii) is not labeled according to law, or, if raw molluscan shellfish, is not tagged or labeled according to law; or

(iv) is otherwise not in compliance with the food code.

(b) If the regulatory authority has reasonable cause to believe that the hold order will be violated, of finds that the order is violated, the regulatory authority may remove the food that is subject to the order to a place of safekeeping.

(28) 8-903.20 Hold order, warning or hearing not required.

(a) The regulatory authority may issue a hold order to a permit holder or to a person who owns or controls the food, as specified in Paragraph (26) of Subsection B of 7.6.2.8 NMAC, without prior warning, notice of a hearing, or a hearing on the hold order.

(b) If the suspected food has been distributed, the permit holder shall be given the opportunity to recall the food voluntarily at the permit holder’s expense.

(c) If the permit holder refuses to recall the suspected food, the regulatory authority may order a mandatory recall of the suspected food at the permit holder’s expense.

(29) 8-903.60 Examining, sampling, and testing food. The regulatory authority may examine, sample, and test food in order to determine its compliance with the Food Service Sanitation Act, Chapter 25, Article 1 NMSA 1978; the New Mexico Food Act, Chapter 25, Article 2 NMSA 1978; and 7.6.2 NMAC.

(30) 8-903.80 Destroying or denaturing food. When any food is found, by examination or laboratory analysis, to be in violation of safe health standards, the regulatory authority may order condemnation and disposal of the product lot, at the expense of the permit holder.

(31) 8-904.10 Conditions warranting action. The regulatory authority may immediately suspend a permit if it determines through inspection, or examination of employees, food records, or other means as specified in the food code, that an imminent health hazard exists.

(32) 8-904.20 Immediate suspension, warning or hearing not required. The regulatory authority may immediately suspend a person's permit as specified in Paragraph (31) of Subsection B of 7.6.2.8 NMAC by providing written notice as specified in Section Paragraph (25) of Subsection B of 7.6.2.8 NMAC of the immediate suspension to the permit holder or person in charge, without prior warning, notice of a hearing, or a hearing.

(33) 8-904.30 Contents of the notice. An immediate suspension notice shall state:

(a) that the food establishment permit is immediately suspended and that all food operations shall immediately cease;

(b) the reasons for the immediate suspension with reference to the provisions of the food code that are in violation;

(c) the name and address of the regulatory authority representative to whom a written request for re-inspection may be made and who may certify that reasons for the suspension are eliminated; and

(d) that the permit holder may request an appeal hearing by submitting a timely request as specified in Paragraph (35) of Subsection B of 7.6.2.8 NMAC and Paragraph (36) of Subsection B of 7.6.2.8 NMAC.

(34) 8-904.50 Term of suspension, reinstatement of permit.

(a) An immediate suspension shall remain in effect until the conditions cited in the notice of suspension no longer exist and their elimination has been confirmed by the regulatory authority through re-inspection and other means as appropriate.

(b) The suspended permit shall be reinstated immediately if the regulatory authority determines that the public health hazard or nuisance no longer exists. A notice of the reinstatement shall be provided to the permit holder or person in charge.

(35) 8-905.10 Response to notice of hearing or request for hearing, basis and time frame.

(a) A permit applicant may request a hearing regarding the disposition of an application for a new or revised permit if the regulatory authority does not issue or deny the permit within the time frame specified in the Food Code.

(b) A permit holder may request a hearing to address concerns about the regulatory authority's denial of application for a permit or request for a variance, or compliance actions, except that a hearing request does not stay the regulatory authority's restriction or exclusion of employees specified in Section Paragraph (31) of Subsection B of 7.6.2.8 NMAC.

(c) A person desiring a hearing in response to a denial of an application for permit or an adverse administrative determination shall submit a hearing request to the regulatory authority within 10 calendar days of the date of the denial, inspection, or compliance action.

(36) 8-905.20 Request for hearing, required form and contents. A request for hearing as specified in Section 8-905.10 of the food code shall be in written form and contain the following information.

(a) If a request for hearing:

(i) a statement of the issue of fact specified in Paragraph (B) of Section 8-905.30 of the food code for which the hearing is requested; and

(ii) a statement of defense, mitigation, denial, or explanation concerning each allegation of fact.

(b) If either a response to notice of hearing or a request for a hearing:

(i) a statement indicating whether the presence of witnesses for the regulatory authority is required; and

(ii) the name and address of the respondent's or requestor's legal counsel, if any.

(37) 8-905.60 Notice, contents. A notice of hearing shall contain the following information:

(a) time, date and place of the hearing;

(b) purpose of the hearing;

(c) the rights of the respondent, including the right to be represented by counsel and to present witnesses and evidence on the respondent's behalf as specified in Paragraph (39) of Subsection B of 7.6.2.8 NMAC; and

(d) the consequences of failing to appear at the hearing.

(38) 8-905.100 Record of proceeding. A complete digital recording of a hearing shall be made and maintained as part of the regulatory authority's records.

(39) 8-907.10 Rights of parties.

(a) The rules of civil procedure and the rules of evidence shall not apply, but a hearing shall be conducted so that all relevant views, arguments, and testimony are amply and fairly presented.

(b) Parties to a hearing may be represented by counsel, examine and cross examine witnesses, and present evidence in support of their position.

(40) 8-907.30 Evidence to be excluded. Evidence shall be excluded that is irrelevant, immaterial, unduly repetitious, or excludable on constitutional or statutory grounds, or on the basis of evidentiary privilege.

(41) 8-909.10 Gaining access to premises and records. The regulatory authority may seek access for one or more of the following purposes, according to law for gaining access:

(a) if admission to the premises of a food establishment, mobile food establishment, temporary food establishment, food processing plant, or home-based food processing operation is denied or other circumstances exist that would justify an inspection order under law, to make an inspection including taking photographs;

(b) to examine and sample the food or other substances found on the premises; and

(c) to examine and copy the records on the premises relating to food as specified in Section 8-402.11 of the food code.

C. Omissions. The following provisions are omitted from the incorporated food code:

(1) 5-203.11(C) Handwashing sinks.

(2) 8-7 Authority.

(3) 8-902.20 Content of inspection order.

(4) 8-905.30 Provided upon request.

(5) 8-905.40 Provided in accordance with law.

(6) 8-905.50 Timeliness, appeal proceeding within five business days, other proceeding within 30 calendar days.

(7) 8-905.70 Proceeding commences upon notification.

(8) 8-905.80 Procedure, expeditious and impartial.

(9) 8-905.90 Confidential.

(10) 8-906.10 Appointment by regulatory authority and purpose.

(11) 8-906.20 Qualifications.

(12) 8-906.30 Powers, administration of hearings.

(13) 8-906.40 Powers, administrative remedies.

(14) 8-909.20 Contents of court petition.

(15) 8-909.30 Sworn statement of denied access.

(16) 8-909[-].40 Contents of an order.

(17) 8-909.50 Optional contents of an order.

(18) 8-910.10 Institution of proceedings.

(19) 8-911.10 Authorities, methods, fines, and sentences.

(20) 8-912.10 Petitions of injunction.

(21) 8-913.10 Petitions, penalties, and continuing violations.

D. Additional requirements. Except as otherwise provided, the following additions are made to the incorporated food code:

(1) 2-104.11 Food handler cards.

(a) Except as specified in Subparagraphs (b) and (g) of Paragraph (1) of Subsection D of 7.6.2.8 NMAC, food employees shall demonstrate their knowledge of safe food handling practices through passing a test from a food handler training program and possess a valid food handler card.

(b) Except as specified in Subparagraph (g) of Paragraph (1) of Subsection D of 7.6.2.8 NMAC, individuals who do not possess a valid food handler card prior to

employment as a food employee shall obtain such card within 30 calendar days from the beginning of employment.

(c) Food handler cards shall be kept by the food employee on his or her person while working at a food establishment or a copy kept on file by the current employer and be made available for inspection by the regulatory authority.

(d) The regulatory authority may approve an entity's training program to be used in lieu of requiring a food handler card of its food employees. A food employee must complete the entity's approved training program at least every three years. This exemption is only valid during the food employees' time of employment with the entity that administered the training.

(e) An employee or person in charge at any food establishment, food processing plant, temporary food establishment, or mobile food establishment must provide training regarding pertinent safe food handling practices to food employees prior to beginning food handling duties, if the food employee does not hold a valid food handler card. Record of the training, including name of instructor, date of training, and name(s) of food employees shall be maintained on file and made available to the regulatory authority upon request. The record of training shall be maintained for the duration of the food employee's employment.

(f) Food handler cards shall be valid for three years from the date of issuance.

(g) This paragraph does not apply to:

(i) food employees who comply with Paragraph (1) of Subsection B of Section 7.6.2.8 NMAC;

(ii) food employees who comply with Subparagraph (b) of Paragraph (1) of Subsection D of 7.6.2.8 NMAC;

(iii) food employees who do not prepare or handle Time/Temperature Control for Safety Food, provided that at a minimum the permit holder assures the employee complies with Subparagraph (e) of Paragraph (1) of Subsection D of 7.6.2.8 NMAC;

(iv) employees or volunteers who occasionally function as a food employee, provided that at a minimum the permit holder assures the employee complies with Subparagraph (e) of Paragraph (1) of Subsection D of 7.6.2.8 NMAC;

(v) food employees or volunteers working as food employees of temporary food establishments, provided that at a minimum the person in charge during hours of operation complies with Paragraph (1) of Subsection B of Section 7.6.2.8 NMAC or has a valid food handler card, either of which shall be obtained prior to

issuance of a temporary food establishment permit, and the permit holder assures the food employee or volunteer complies with Subparagraph (e) of Paragraph (1) of Subsection D of 7.6.2.8 NMAC;

(vi) food employees or volunteers working as food employees for charitable organizations serving the needy, provided that at a minimum the person in charge during hours of operation complies with Paragraph (1) of Subsection B of Section 7.6.2.8 NMAC; or

(vii) employees who do not function as food employees.

(h) The food handler card requirements of Paragraph (1) of Subsection D of Section 7.6.2.8 NMAC shall become effective three months after the effective date of 7.6.2.8 NMAC.

(2) 8-301.12 Responsibility for operation.

(a) Except as specified in Subparagraphs (b) and (c) of Paragraph (2) of Subsection D of 7.6.2.8 NMAC, the permit holder shall be responsible for all food operations conducted on the premises for which a permit is issued.

(b) Permit holders shall not be responsible for food operations on the premises when another permit holder is operating with a permit.

(c) Each permit holder shall be responsible for shared facilities or equipment on the premises.

(3) 8-303.15 Permit fees, late fees, penalty fees, and expiration dates.

(a) Except as specified in Subparagraph (b) of Paragraph (3) of Subsection D of 7.6.2.8 NMAC, permit fees shall be:

(i) $200.00 for food establishments, mobile food establishments, servicing areas, and food processing plants;

(ii) $100.00 for home-based food processing operations; and

(iii) $25.00 for temporary food establishments for each single event or celebration.

(b) Permit fees shall be waived for food establishments, mobile food establishments, and temporary food establishments that provide food to consumers at no charge, as well as temporary food establishments that serve only non-TCS food or operate no more than two days in a calendar month.

(c) In addition to the permit fees specified above, a $25 late fee shall be added to the permit fee if the permit is not renewed on or before the expiration date of the permit.

(d) A re-inspection penalty fee of $100 shall be assessed by the regulatory authority and paid by the operator when a re-inspection is scheduled by the regulatory authority as specified in Subparagraph (c) of Paragraph (18) of Subsection B of 7.6.2.8 NMAC.

(e) If a permit is not renewed as specified in Section 8-303.20 of the food code, and applicable re-inspection penalty fees are not paid within 30 days after the expiration of the permit, a new permit shall not be issued except upon completion of requirements specified in Section 8-303.10 of the food code.

(f) Permits issued by the regulatory authority shall include an expiration date, which shall be:

(i) The last day of the anniversary month of the date of original issue for food establishments, mobile food establishments, servicing areas, and food processing plants.

(ii) The last day of the single event or celebration for temporary food establishments.

(g) No discount or refund shall be made for partial years or for permit suspension or revocation.

(4) 8-407.11 Posting of compliance emblems.

(a) Except as specified in Subparagraph (e) of Paragraph (4) of Subsection D of 7.6.2.8 NMAC, an emblem indicating the compliance status of a food establishment shall be posted in a conspicuous place at each entrance to the food establishment where it can be easily seen by consumers and shall be posted or removed only by the regulatory authority.

(b) An "approved" emblem shall be posted at a food establishment that is operated in compliance with the food code.

(c) An "unsatisfactory" emblem may be posted at a food establishment when any priority items are out of compliance during an inspection; or any priority item, priority foundation item, or core item is out of compliance on a repeated basis within the last 25 months.

(d) Removal, defacing, or obstruction of an emblem by any person other than the regulatory authority shall result in immediate permit suspension or revocation.

(e) Food processing plants and temporary food establishments are exempt from the posting of compliance emblems.

(5) 8-901.201 Permit suspension and revocation.

(a) The regulatory authority may suspend or revoke a permit for reasons specified in Section 8-901.10 of the food code.

(b) The regulatory authority shall conduct a hearing as specified in Section 8-905 of the food code, as amended in 7.6.2 NMAC, prior to suspending or revoking a permit.

(c) The permit holder shall be notified of the hearing at least seven days prior to the hearing as specified in Paragraph (37) of Subsection B of 7.6.2.8 NMAC.

(d) Failure by the permit holder to appear shall result in immediate suspension or revocation of the permit.

(e) The suspension of a permit shall remain in effect until the conditions leading to the suspension no longer exist and their elimination has been confirmed by the regulatory authority through re-inspection and other means as appropriate.

(f) A permit shall only be revoked if a permit has previously been suspended.

(g) A permit that has been revoked shall not be considered for reapplication until the permit holder has demonstrated to the satisfaction of the regulatory authority that the food establishment will comply with the food code.

[7.6.2.8 NMAC - Rp, 7.6.2.8 NMAC, 12/1/2018]

7.6.2.9 MOBILE FOOD ESTABLISHMENT REQUIREMENTS:

A. In addition to meeting the applicable requirements of 7.2.6.8 NMAC, with the exception of Section 5-203.12 of the food code, mobile food establishments shall comply with the requirements specified in this section.

B. The regulatory authority may impose additional requirements for mobile food establishments as specified in Section 8-102.10 of the food code. Additional requirements may include, but are not limited to:

(1) limiting or restricting the number and type of food items to be prepared and served;

(2) limiting or restricting preparation steps;

(3) limiting or restricting hours of operation, or hours of operation before returning to a servicing area; or

(4) requiring a servicing area or mobile support unit.

C. The regulatory authority may modify or waive requirements for mobile food establishments as specified in Paragraph (12) of Subsection B of 7.6.2.8 NMAC and Section 8-103.11 of the food code.

D. Mobile food establishments shall provide the following required information as specified in Paragraph (F) of Section 8-201.12 of the food code:

(1) the location of the potable water source;

(2) the location and method of solid and liquid waste disposal; and

(3) the identifying system used to distinguish the permitted unit from others.

E. Mobile food establishments shall have adequate electrical and fuel capacity, as determined by the regulatory authority, to allow proper operation of equipment. The electrical and fuel sources shall be adequately supplied at all times when food temperature control is required.

F. Mobile food establishments shall be operated within 200 feet of toilet facilities as specified in Sections 5-203.11 and 5-203.12 of the food code whenever the unit is stopped to operate for more than a two hour period.

G. The operation of mobile food establishments shall be conducted within the enclosure of the permitted unit. During a single event or celebration, certain operations (e.g., additional covered storage, additional food preparation area, outdoor serving counter) may be conducted outside of the enclosure, when approved. If approved, an additional temporary food establishment permit shall be required.

H. Mobile food establishments shall provide only single-service articles for use by consumers.

I. Self-contained mobile food establishment requirements. Self-contained mobile food establishments shall:

(1) meet all of the equipment requirements of the food code;

(2) include adequate storage facilities on the unit for all food, equipment, utensils, supplies, potable water, and waste water used in the operation of the unit;

(3) be capable of accomplishing all steps of the operation, including required food preparation and warewashing, within the enclosure of the unit;

(4) provide, as specified in Paragraph (F) of Section 8-201.12 of the food code, how and where the unit will be cleaned and serviced and where it will be stored during non-operating hours; and

(5) notify the regulatory authority office of jurisdiction at least 24 hours in advance before operating in a jurisdictional area outside of the permitting office.

J. Non-self-contained mobile unit and pushcart requirements.

(1) Non-self-contained mobile units and pushcarts shall provide, as specified in Paragraph (F) of Section 8-201.12 of the food code, an agreement between the operator and the servicing area that includes:

(a) the days and hours the servicing area will be used;

(b) the extent of support services to be provided; and

(c) a copy of the current servicing area permit.

(2) Prior to discontinuing use of a servicing area, the operator shall provide a revised agreement as specified in Paragraph (1) of Subsection J of 7.6.2.9 NMAC for a new servicing area. Mobile food establishments shall not operate prior to the approval of a new servicing area.

(3) Non-self-contained mobile units and pushcarts shall operate within a reasonable distance, and report at least daily, to the servicing area for support services.

(4) Non-self-contained mobile units and pushcarts shall notify the regulatory authority in writing and receive prior approval to operate outside of a reasonable distance of the servicing area.

K. Additional pushcart requirements.

(1) Pushcarts are limited to:

(a) serving non-TCS foods or drinks;

(b) serving individually commercially packaged TCS foods in the original packaging and maintained at proper temperatures; and

(c) assembling and serving of pre-cooked sausage (e.g., hot dog, bratwurst, frankfurter) with commercially prepared toppings (e.g., chili, sauerkraut, relish).

(2) Pre-preparation, such as washing, slicing, peeling, cutting of food intended for use on a pushcart, shall occur at the servicing area.

(3) Food handling shall be conducted under an overhead protective cover.

(4) Grills shall include a protective lid that can be readily closed.

(5) Operators of pushcarts shall ensure the following are contained on, or within, the cart in sufficient supply for daily operation:

(a) food, utensils, single service articles, and cleaning supplies;

(b) handwashing sink as specified in Section 5-202.12 of the food code with a minimum of five gallons of potable water; and

(c) wastewater holding tank meeting the requirements of Section 5-401.11 of the food code.

(6) TCS food served on pushcarts shall not be subsequently cooled and reheated.

(7) Ice chests may be utilized for packaged food provided that they are continuously drained in an approved manner and the food is maintained at temperatures as specified in Section 3-202.11 of the food code.

[7.6.2.9 NMAC - Rp, 7.6.2.9 NMAC, 12/1/2018]

7.6.2.10 TEMPORARY FOOD ESTABLISHMENT REQUIREMENTS:

A. In addition to meeting the applicable requirements of 7.6.2.8 NMAC, with the exception of Section 5-203.12 of the food code, temporary food establishments shall comply with the requirements specified in this section.

B. The regulatory authority may impose additional requirements for temporary food establishments as specified in Section 8-102.10 of the food code. Requirements may include, but are not limited to:

(1) require food safety training for employees prior to issuing a permit;

(2) restrict the number and type of food items to be prepared and served;

(3) restrict preparation steps;

(4) restrict hours of operation; or

(5) require a servicing area for advanced preparation of food.

C. The regulatory authority may modify or waive requirements for temporary food establishments as specified in Paragraph (12) of Subsection B of 7.6.2.8 NMAC and Section 8-103.11 of the food code.

D. Temporary food establishment requirements.

(1) Temporary food establishments shall serve only food that has been approved.

(2) Except as specified in this subparagraph, temporary food establishments shall conduct all food operations within the approved enclosure. Temporary food establishments may, after approval, store or prepare food at an offsite food establishment prior to operation when:

(a) the food establishment has adequate equipment for the type and volume of food and preparation steps required; and

(b) the temporary food establishment operator provides to the regulatory authority a letter of agreement between the operator and the food establishment that includes:

(i) the days and hours the food establishments will be used;

(ii) a list of tasks that will be performed at the food establishments; and

(iii) a copy of the current food establishment permit.

(3) Temporary food establishments shall provide, in writing, to the regulatory authority for approval the:

(a) location of the approved potable water source;

(b) location and method of solid waste disposal; and

(c) location and method of liquid waste disposal.

(4) Temporary food establishments shall supply a handwashing sink, located as specified in Section 5-204.11 of the food code, for employee hand washing. At a minimum, a handwashing sink shall consist of a container with a faucet-type spigot filled with warm water and a catch bucket for the wastewater. The water shall be maintained at a minimum of 100 degrees fahrenheit as specified in Section 5-202.12 of the food code.

(5) Temporary food establishments shall maintain an adequate supply of liquid soap and single use paper towels at the handwashing sink at all times.

(6) Temporary food establishments shall provide a warewashing station as specified in Section 4-301.12 of the food code. Extra utensils may be approved in lieu of a warewashing station as specified in Table 10-1, below.

(7) Temporary food establishments shall maintain an adequate supply of potable water at all times during operation for tasks such as: handwashing; food preparation; and washing, rinsing, and sanitizing of surfaces, utensils, and equipment. Except as specified in Table 10-1, below, auxiliary heating units capable of producing an adequate supply of hot water for such purposes shall be provided.

(8) Temporary food establishments shall provide an adequate supply of ice, as necessary, to maintain TCS food at temperatures as specified in Section 3-501.16 of the food code.

(9) Temporary food establishments shall not store packaged food in undrained ice or iced water, except for pressurized containers of non-TCS beverages. The water or ice shall contain at least 10 parts per million of available chlorine and shall be changed as necessary to keep the water and container clean. Ice used to store food shall not be used as food.

(10) Temporary food establishments shall not store raw meat, poultry, fish, or eggs in the same ice chests as ready-to-eat food when ice chests are approved for use to store food as specified in Table 10-1, below.

(11) Temporary food establishments shall transport food at temperatures as specified in Section 3-501.16 of the Food Code and protect food from contamination as specified in Part 3-3 of the food code.

(12) Temporary food establishments shall not carry over previously heated or cooked food from one day to the next. This requirement may be waived for Type 3 temporary food establishments (as identified in Table 10-1, below) or for food prepared in advance at an offsite food establishment.

(13) Temporary food establishments shall operate on a surface that is smooth, easily cleanable, and non-absorbent (e.g., concrete, machine laid asphalt). Grass may be approved as specified in Table 10-1, below.

(14) Temporary food establishments shall operate under a weather-resistant covering that is smooth, easily cleanable and nonabsorbent to protect the operation from overhead contamination.

(15) Temporary food establishments shall be constructed in a manner that prevents the entrance of insects or other vermin and adequately protects food from consumers and environmental contamination.

(16) Temporary food establishments shall provide separation (e.g. table) to keep consumers from entering the food operation.

(17) Temporary food establishments shall provide walls that are smooth, easily cleanable, and non-absorbent. This requirement may be waived when flying insects and other pests are absent due to location, weather, or other limiting conditions. Except as specified in Table 10-1, below, walls shall meet the following requirements:

(a) cover tightly from ceiling to floor;

(b) use an approved counter-serving opening with tight fitting screened doors or air curtain; counter-serving openings shall be kept closed, except when in use; and

(c) when approved for use, screening shall be 16 mesh to 1 inch.

(18) In conjunction with the requirements specified in this section, a temporary food establishment shall, based upon risk, be classified as a Type 1, 2 or 3 temporary food establishment and meet the corresponding requirements specified in Table 10-1, below.

Table 10-1

	Type 1	**Type 2**	**Type 3**
Menu	unpackaged non-TCS commercially processed packaged TCS in original package (receive-store-hold)	no cook (receive-store-minimum prep*-hold-serve) same day prep (receive-store-minimum prep*-cook-hold-serve) reheat commercially processed (receive-store-reheat-hold-serve)	complex food prep (receive-store-prep-cook-cool-reheat-hot hold-serve) serving highly susceptible population
Handwashing	gravity fed <= 4 hrs - insulated container or auxiliary heating source > 4 hrs - auxiliary heating source	same as Type 1	hot & cold running water under pressure

	Type 1	**Type 2**	**Type 3**
3-compartment sink	unpackaged non-TCS <= 4 hrs - 3-comp or extra utensils > 4 hrs - 3-comp required packaged TCS: not required	same as Type 1 unpackaged non-TCS	3-comp required w/hot & cold running water under pressure
Refrigeration	unpackaged non-TCS: not required packaged TCS: <= 1 day - insulated ice chest w/drained ice 2-3 days - mechanical equipment > 3 days - mechanical ANSI equipment only	same as Type 1 packaged TCS	mechanical ANSI equipment only
Cold holding (e.g., prep table, display case)	unpackaged non-TCS: not required packaged TCS: ice bath 2-3 days - mechanical equipment recommended > 3 days - mechanical ANSI equipment recommended	same as Type 1 packaged TCS	same as Type 1 packaged TCS
Hot holding	not allowed	covered non-ANSI equipment allowed**	covered ANSI equipment only

	Type 1	Type 2	Type 3
Cooking/ reheating	not allowed	covered non-ANSI equipment allowed**	covered ANSI equipment only
Flooring	grass; smooth, durable, easily cleanable such as: concrete, machine-laid asphalt, sealed wood, tile, impermeable tarp	<= 2 days - same as Type 1 > 2 days - same as Type 1, no grass	<= 3 days - same as Type 1, no grass > 3 days - constructed flooring
Walls	unpackaged non-TCS <= 3 days - no sides, ability to cover solid > 3 days - 3.5 side screening, ability to cover solid packaged TCS: not required	<= 1 day - no sides, ability to cover solid 1 to 3 days - 3.5 side screening, ability to cover solid > 3 days - complete enclosure w/approved opening	complete enclosure w/approved opening
Training	as required by regulatory authority	as required by regulatory authority	certified food protection manager required

*Minimum preparation includes activities such as: slicing/cutting fruits and vegetables, opening commercially packaged TCS foods, and seasoning TCS foods. Minimum preparation does not include activities such as: cutting, slicing, or forming raw meat, poultry, or fish; assembly of complex menu items.

**Chafing dishes may be allowed for events of four hours or less. Insulated ice chests and slow cookers are not allowed for hot holding. Slow cookers are not allowed for heating, cooking, or reheating.

[7.6.2.10 NMAC - Rp, 7.6.2.10 NMAC, 12/1/2018]

7.6.2.11 GENERAL FOOD PROCESSING REQUIREMENTS:

A. Food processing plant permit requirements.

(1) All food processing plants shall comply with all applicable provisions of 7.6.2.8 NMAC.

(2) No person shall operate a food processing plant without a permit issued by the regulatory authority.

(3) When a food establishment has an adjunct/additional food processing plant, each such business may be permitted separately.

B. Sale of adulterated or misbranded food.

(1) No person shall sell or offer, or expose for sale, or have in possession with intent to sell, any processed and packaged food product that is adulterated or misbranded.

(2) The term "adulterated" includes products that are defective, unsafe, filthy, or produced under unsanitary conditions (Section 25-2-10, NMSA 1978).

(3) "Misbranding" includes statements, designs, or pictures in labeling that are false or misleading, or failure to provide required information outlined in Paragraph (2) of Subsection D of 7.6.2.11 NMAC.

(4) Adulterated or misbranded food products shall be reconditioned, condemned or destroyed in accordance with Section 25-2-6, NMSA 1978.

C. Labeling requirements.

(1) All packaged food shall be labeled in accordance with the applicable requirements of the Federal Food, Drug and Cosmetic Act as amended, the Fair Packaging and Labeling Act, regulations developed thereunder, and the New Mexico Food Act. Details concerning type, size and location of required labels are contained in FDA regulations covering the requirements of the federal acts (Code of Federal Regulation, Title 21, Part 101.)

(2) At least the following information shall appear on the label of any packaged food:

(a) the name, street address, city, state and zip code of either the manufacturer, packer, or distributor;

(b) an accurate statement of the net amount of food in the package, in terms of weight measure, volume measure (listed in both "English" and metric units) or numerical count;

(c) the common or usual name of the food contained in the package; and

(d) ingredients of the food, listed by their common names, in order of their predominance by weight.

(3) If the label of a food bears representation in a foreign language, the label must bear all the required statements in the foreign language, as well as in English. This requirement does not apply to Spanish names that are commonly used in New Mexico.

(4) Any food product that does not comply with all applicable labeling requirements shall be deemed to be misbranded.

D. Standards if identity.

(1) Standards of identity define what a given food product is, its name and the ingredients that must be used, or are allowed to be used, and the ones that must be declared on the label. FDA food standards govern both labeling and composition of such foods, and must be consulted for detailed specifications. The standards are published in the annual editions of the Code of Federal Regulations (CFR), Title 21, Parts 103 through 169.

(2) Any food product that is represented as, or purports to be, a food for which a standard of identity has been promulgated, must comply with the specifications of the standard in every respect. A food product that does not comply fully with the applicable standard is misbranded, unless its label bears the word "imitation" or meets the descriptive label requirements in the CFR, Title 21, Part 101.

E. Low acid canned foods and acidified foods.

(1) All processors of low acid canned foods or foods that have been acidified must comply with specific federal regulations contained in the CFR, Title 21, Parts 108, 113, and 114.

(2) All processors of low acid canned foods and acidified foods are required by federal regulation to register their food processing plants and file processing information for all products with the FDA using appropriate forms. Registration and processing information forms are obtainable on request from: FDA, LACF Registration Coordinator (HFF-233), 200-C Street, SW, Washington, D.C. 20204.

(3) Any low acid canned food product that does not comply with the federal requirements will be considered adulterated.

F. Operational plans.

(1) Food processing plants shall, at the time of application for a permit for review and acceptance by the regulatory authority, provide the following information for the product(s) to be manufactured and distributed:

(a) names of the ingredient(s);

(b) the final product pH if appropriate;

(c) the final product water activity (a_w) if appropriate;

(d) names of preservative(s);

(e) the type of packaging to be used and whether the packaging is integral to product stability (e.g. the vacuum packing of fresh meat); and

(f) the complete operational procedure for product formulation, using a flow chart to show at what stage(s) each ingredient is added.

(2) Food processing plants shall, at the time of application for a permit for review and acceptance by the regulatory authority, provide the following information about product distribution:

(a) the intended distribution and use condition of the product;

(b) if the product is to be distributed at ambient, refrigerated or frozen temperature;

(c) the expected shelf life during distribution, retail storage, and in the hands of the ultimate consumer;

(d) how the product should be prepared for consumption; and

(e) what mishandling of the product might occur in the merchandising channels or in the hands of the consumer.

(3) Food processing plants shall, at the time of application for a permit for review and acceptance by the regulatory authority, state the intended process (cooking time and temperatures). This information may be included in the flow chart required in Subparagraph (f) of Paragraph (1) of Subsection F of 7.6.2.11 NMAC. Consideration must be given to those steps that lead to the destruction or inhibition of disease causing or spoilage organisms if done properly, or the growth of such organisms if done improperly.

(4) Food processing plants shall, at the time of application for a permit for review and acceptance by the regulatory authority, submit product labels that comply with all requirements of Subsection C of 7.6.2.11 NMAC.

(5) Prior to adding any new product to the product line, or changing the manufacturing process or product distribution for any existing product in the product line, the food processor shall provide to the regulatory authority:

(a) for each new product, the same information as specified for the initial application in Paragraphs (1), (2), (3) and (4) of Subsection F of 7.6.2.11 NMAC; and

(b) for each existing product for which a change will be made in the manufacturing process or product distribution, the applicable changes to the information previously submitted pursuant to Paragraphs (1), (2), (3) and (4) of Subsection F of 7.6.2.11 NMAC.

(6) All food processing plants shall design, maintain and use a coding system that will identify the date and place of manufacture of each product on the product label, or securely affixed to the body of the container. A description of the proposed coding system shall be included in the application.

(7) The regulatory authority may require that the food processing plant's processes be reviewed by a competent process authority to approve all critical factors of public health significance as defined in the CFR, Title 21, Sections 114.83 and 114.89.

(8) In lieu of a process authority, the regulatory authority may accept those processes which comply with Paragraphs (1) and (2) of Subsection E of 7.6.2.11 NMAC.

(9) Recall procedures shall be prepared and must be on file at the food processing plant. Procedures shall include plans for recalling products which may be injurious to human health; for identifying products which may be injurious to human health; for identifying, collecting, warehousing, and controlling products; for determining the effectiveness of recalls; for notifying the regulatory authority, FDA, and United States department of agriculture (USDA) of any recalls; and for implementing recall programs.

(10) Whenever the regulatory authority finds or has probable cause to believe that any food processing plant's product fails to meet standards or is adulterated with any substance that may be injurious to human health, the suspected lot of product shall be embargoed or detained at the food processing plant, if not yet distributed to consumers or retail outlets, until a determination of ultimate disposition is made.

(11) If the suspected lot has been distributed, the food processing plant shall be given the opportunity to recall the product voluntarily at the processor's expense.

(12) If a food processing plant refuses to conduct a voluntary recall, the secretary of the New Mexico environment department may order a mandatory recall of the suspected product lot at the processor's expense.

(13) When any food product is found, by examination or laboratory analysis, to be in violation of the standards of Subsections B, D or E, of 7.6.2.11 NMAC, the secretary of the New Mexico environment department may order condemnation and disposal of the product lot at the food processing plant's expense.

G. Compliance with accepted operational procedures.

(1) A copy of the accepted process and procedures shall be on file at the food processing plant. It shall be available for review by the regulatory authority at all times. A food processing plant shall not deviate from the accepted process and operational procedures without written consent of the regulatory authority.

(2) Samples of ingredients, materials obtained from selected points during the course of processing or handling, and final products shall be examined for pathogenic microorganisms as often as necessary for quality assurance. Food products may also be tested for organisms that are indicative of the possible presence of pathogens or for specific spoilage organisms. The secretary of the New Mexico environment department may request that certain foods be examined for specific pathogenic microorganisms or their toxins.

(3) Routine inspections of facilities, equipment and operations will be conducted as specified in this section. In addition, HACCP evaluations will be conducted by the regulatory authority of the food processing plant as needed to identify hazards, critical control points, and daily monitoring requirements.

[7.6.2.11 NMAC - Rp, 7.6.2.11 NMAC, 12/1/2018]

7.6.2.12 JERKY MANUFACTURED FOOD REQUIREMENTS:

A. In addition to complying with the requirements specified in 7.6.2.11 NMAC, food processing plants that produce jerky shall comply with the requirements specified in this section.

B. Food processing plants that produce jerky shall have the appropriate approved equipment to measure and monitor food safety factors related to the production of jerky.

C. Cooking. The following parameters shall be achieved in a sealed oven, for a minimum of one hour, and no less than fifty percent of the cooking time, during the jerky cooking process:

(1) a minimum internal temperature of 145 degrees fahrenheit for four minutes for meat and 165 degrees fahrenheit instantaneous for poultry; and

(2) maintain a steady or increasing relative humidity level throughout the cooking process.

D. In lieu of complying with the cooking parameters specified in Subsection C of 7.6.2.12 NMAC the regulatory authority may approve alternative methods for treating product provided that the proposed method is scientifically-based and adequately documented by data developed according to an experimental protocol.

E. Food establishments that produce jerky shall:

(1) meet the requirements of Subsections B and C of 7.6.2.12 NMAC;

(2) have an approved operational plan for each product produced;

(3) keep the operational plan on file at the food establishment;

(4) follow the approved operational plan and not deviate from it without approval from the regulatory authority; and

(5) monitor and record food safety factors, including but not limited to, time, temperature, and humidity and make the records available to the regulatory authority.

[7.6.2.12 NMAC - Rp, 7.6.2.12 NMAC, 12/1/2018]

7.6.2.13 BOTTLED DRINKING WATER MANUFACTURED FOOD REQUIREMENTS:

A. In addition to meeting the requirements specified in 7.6.2.11 NMAC, food processing plants that produce bottled drinking water shall comply with the requirements specified in this section.

B. Bottled drinking water processing operational requirements and standards.

(1) The bottled drinking water plant shall follow generally accepted good manufacturing practice such as contained in 21 CFR Part 129 or the international bottled water association bottled water code of practice.

(2) Bottled drinking water which is bottled through lines or equipment used for food or milk products shall demonstrate (assure) that the cleaning process prevents adulteration of the bottled water. Bottled drinking water shall not be transported or stored in bulk tanks used for any non-food product, nor processed or bottled through equipment or lines used for any non-food product.

C. Bottled drinking water labeling requirements. All bottled drinking water labels shall meet the requirements specified in Subsection C of 7.6.2.11 NMAC.

D. Analytical requirements. Unless otherwise provided, samples shall be collected, prepared, and examined using the most current methods for the examination of drinking water listed in 40 CFR Part 141 or by other methods for the examination of drinking water approved by the United States environmental protection agency. Examination of samples shall be performed by an approved laboratory.

E. Monitoring requirements.

(1) Bottled drinking water plants shall be required to submit one microbiological sample per finished product per week. A copy of the microbiological

analysis report shall be submitted within 10 working days of analysis to the regulatory authority. Any coliform or fecal coliform positive result shall require the plant owner or operator to notify the regulatory authority within 24 hours and to submit to resampling guidelines specified in 20.7.10 NMAC.

(2) Bottled drinking water plants that know that a maximum contaminant level, as specified in 20.7.10 NMAC, has been exceeded or who have reason to believe circumstances exist that may adversely affect the safety of bottled drinking water, including but not limited to source contamination, spills, accidents, natural disasters, or breakdowns in treatment, shall notify the regulatory authority within 24 hours.

[7.6.2.13 NMAC - Rp, 7.6.2.13 NMAC, 12/1/2018]

7.6.2.14 SHELLFISH REQUIREMENTS:

Adoption of national shellfish sanitation program (NSSP) guide for control of molluscan shellfish. Except as otherwise provided, the 2017 NSSP guide for control of molluscan shellfish is hereby adopted and incorporated in its entirety.

[7.6.2.14 NMAC - Rp, 7.6.2.14 NMAC, 12/1/2018]

7.6.2.15 HOME-BASED FOOD PROCESSING:

A. Plan review, permitting, inspection, and training requirements.

(1) No person shall operate a home-based food processing operation without a permit.

(2) In addition to meeting the applicable requirements of 7.6.2.8 NMAC and 7.6.2.11 NMAC, home-based food processing operations shall comply with the requirements specified in this section.

(3) Home-based food processing operations shall meet the requirements of Paragraph (1) of Subsection D of 7.6.2.8 NMAC and Part 2-1 of the food code.

(4) The permit issued shall be displayed at the home-based food processing operation. A copy of the permit shall be displayed at places at which the operator sells food at times when the operator is selling the home-based processed foods.

B. Food protection requirements.

(1) Home-based processed food products and components shall be stored separate and apart from residential foods and protected from contamination, insects, rodents, pests, water leaks, dust, dirt and other contaminants.

(2) Home-based food processing operations must keep a sample of each processed food batch for 14 days. The samples shall be labeled with the production date and time.

(3) Vehicles used in transporting home-based processed food products shall be maintained in a safe and sanitary manner. Vehicle compartments used to transport animals shall not be used for transporting home-based processed foods.

C. Exceptions and limitations.

(1) The following provisions from the food code, as amended in 7.6.2 NMAC, shall not apply to home-based food processing operations:

(a) 8-407.11;

(b) 5-501.11;

(c) 4-803.11;

(d) 6-202.112;

(e) 4-803.13(A);

(f) 4-402.11;

(g) 4-402.12;

(h) 4-205.10;

(i) 8-101.10(B);

(j) 6-202.14;

(k) 6-201.14;

(l) 6-201.13;

(m) 4-701.10;

(n) 5-204.11;

(o) self-closing doors as required in 6-202.15(A)(3); and

(p) 5-501.10.

(2) Food products processed by home-based food processing operations shall not be time/temperature control for safety foods and shall be approved by the regulatory authority.

(3) Home-based food processing operations shall only sell their products at farmer's markets, roadside stands, festivals, or other venues in which the producer sells directly to the consumer.

(4) Products processed by a home-based food processing operation shall not be sold, used, or offered for consumption in food establishments including, but not limited to, restaurants, grocery stores and convenience stores, by internet sales, or sold in interstate commerce.

(5) Pets shall not be permitted in the kitchen and shall be kept out of food preparation areas during home-based food processing related activities.

(6) Non-employees shall not be allowed entry into the kitchen during home-based food processing related activities. Home-based food processing operations shall not wash out or clean pet cages, pans or similar items in the kitchen.

(7) Household cooking may not occur in the kitchen during home-based food processing-related activities.

(8) The following provisions from the food code, as amended in 7.6.2 NMAC, are applicable to home-based food processing operations only during home-based food processing related activities:

(a) 2-103.11;

(b) 2-401.11;

(c) 3-304.11;

(d) 4-701.10;

(e) 5-204.11;

(f) 5-205.11;

(g) 5-501.13;

(h) 6-301.12; and

(i) 6-501.115.

(9) Home-based food processing operations shall submit a detailed procedure to be used to clean and sanitize the kitchen sink before and during home-based food processing related activities.

(10) Home-based food processing operations shall comply with Section 5-402.11 of the food code unless an alternative method is approved.

D. Home-based food labeling. A home-based food processing operation shall properly label all foods in accordance with Subsection C of 7.6.2.11 NMAC and include the words "home produced" in bold conspicuous 12 point type on the principal display panel.

[7.6.2.15 NMAC - Rp, 7.6.2.15 NMAC, 12/1/2018]

7.6.2.16 CATERING FOOD ESTABLISHMENTS:

A. In addition to complying with the requirements specified in 7.6.2.8 NMAC food establishments that cater shall comply with the requirements specified in the section.

B. Catering food establishments shall:

(1) operate from a permitted food establishment or servicing area,

(2) be permitted and operated separately from other permitted food establishments or servicing areas,

(3) upon request by the regulatory authority, provide a schedule of events to be catered, and

(4) supply a handwashing sink and adequate supply of liquid soap and single use paper towels as specified in Paragraph (4) and (5) of Subsection D of 7.6.2.10 NMAC when the catering activity includes preparation, delivery, and/or display, service, and restocking of food that is not packaged.

[7.6.2.16 NMAC, N, 12/1/2018]

CHAPTER 7: HOSPITALS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR ACUTE CARE, LIMITED SERVICES AND SPECIAL HOSPITALS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.12 NMAC.]

PART 3: REQUIREMENTS FOR RURAL EMERGENCY HOSPITALS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.13 NMAC.]

PART 4: BOARD OF TRUSTEES OF MINERS' COLFAX MEDICAL CENTER

7.7.4.1 ISSUING AGENCY:

Miners' Colfax Medical Center.

[Recompiled 10/31/01]

7.7.4.2 SCOPE:

[RESERVED]

[Recompiled 10/31/01]

7.7.4.3 STATUTORY AUTHORITY:

Miners' Colfax medical center (hereinafter medical center") is the miners' hospital for the state of New Mexico, deriving its legal status and authority from the Enabling Act for New Mexico SS 7 and 12, the Constitution of the state of New Mexico, art. XIV, SS 1, 2 and 3, and 23-3-1, et seq. NMSA 1978.

[Recompiled 10/31/01]

7.7.4.4 DURATION:

[RESERVED]

[Recompiled 10/31/01]

7.7.4.5 EFFECTIVE DATE:

[RESERVED]

[Recompiled 10/31/01]

7.7.4.6 OBJECTIVE: PURPOSE OF THE MINER'S HOSPITAL:

The miners' hospital is a general hospital and is intended and meant to be for the free treatment and care of resident miners of the state of New Mexico who may become sick or injured in the line of their occupation. The board of trustees may make provision for

charges to miners with sufficient means to pay for their care. The medical center also provides health care services for non-miners and miners who do not meet the statutory requirements for free treatment in a manner consistent with trust requirements.

[Recompiled 10/31/01]

7.7.4.7 DEFINITIONS:

[RESERVED]

[Recompiled 10/31/01]

7.7.4.8 GOVERNING BOARD:

A. The governing board is a board of trustees, the members of which are appointed by the governor of the state of New Mexico with the advice and consent of the senate. One member of the board shall be a licensed physician, two members shall be miners or their representatives and two members shall be representatives of the general public. Members of the board shall be appointed for staggered terms of five years each.

B. The board of trustees is a body corporate under the name of the "board of trustees of miners' hospital of New Mexico" and has the power to sue and be sued, to contract, to acquire land by purchase or donation, and to do all other things in furtherance of its duties to provide for the operation of a medical center and to determine, set, and execute medical center policy. The board of trustees shall supervise and control all functions of the operation and management of the medical center. The board of trustees has absolute discretion to take whatever action may be necessary in the best interest of the medical center, including but not limited to: full power and authority with regard to the medical staff; authority to approve all medical staff by-laws, rules and regulations, to suggest amendments of these to the medical staff and to amend them with due consideration to medical staff recommendations; authority to oversee all aspects of the medical staff operations to ensure compliance with applicable federal and state laws and with standards proposed by the joint commission on accreditation of healthcare organizations.

C. By duly-adopted medical staff by-laws governing appointments to the medical staff of the hospital, the board shall provide a system of continual review and evaluation of the quality of health care being rendered at the hospital. The medical staff by-laws shall assure the board of trustees that any patient treated by the medical center shall receive quality care.

D. Members of the board of trustees owe a fiduciary duty of care and loyalty to the bedical center. A trustee shall avoid active participation in a transaction in which they or a corporation with which they are associated has a significant interest. Members of the board of trustees shall adhere to the Conflict of Interest Act, 10-16-1, et seq., NMSA 1978. Disclosures of financial interests shall be made to the secretary of state during the month of January of each year pursuant to 10-16-10, supra. In addition, the conflict

of interest statements required by 10-16-10, NMSA 1978 shall be submitted to the chairperson of the board and to the medical center's chief executive officer.

E. Trust eligibility requirements shall be established by the board with due regard to the statutes and trust requirements governing the medical center and its responsibilities as the miners' hospital.

[Recompiled 10/31/01]

7.7.4.9 REGULAR AND SPECIAL MEETINGS OF THE BOARD OF TRUSTEES:

The board of trustees shall hold regular meetings at such times and places as set by the board of trustees, with such meetings to occur not less than 8 times per year. Special meetings of the board of trustees may be called by the chair or upon the request of any two members of the board. A quorum shall consist of three members. Meetings shall be open to the public in accordance with the Open Meetings Act, 10-15-1, et seq. NMSA 1978, as amended. The board shall resolve annually, at the first regularly-scheduled meeting of each new year, the procedure for providing reasonable notice of meetings pursuant to 10-15-1(C), supra. The resolution shall state the number of days in advance that notice shall precede a regular, special or emergency meeting and how such notice will be given. Meetings of the board of trustees shall be regularly attended.

[Recompiled 10/31/01]

7.7.4.10 OFFICERS OF THE BOARD OF TRUSTEES:

A. The officers of the board of trustees shall be a chair, a vice-chair and a secretary-treasurer, all of whom shall be elected by a majority vote at a regular board meeting. Elections shall be conducted at an annual meeting to the held during the month of July, unless necessitated by vacancies on the board. Should the term of appointment for a member-officer expire and a new member be appointed; should a member-officer resign his position as board member by tendering his resignation; or should a member-officer be removed from office on the board, the board shall conduct an election to fill the office of such member-officer for the remaining term of his or her office.

B. The chair shall call and preside at all meetings. The chair may approve the meeting agenda in consultation with the chief executive officer of the medical center and shall be available for consultation with the chief executive officer on request. The vice-chair shall act as chair in the absence of the chair and, when so acting, shall have all the powers and authority of such office. The secretary-treasurer shall act as chair in the absence of both the chair and vice-chair and, when so acting, shall have all the powers and authority of such office. The chair shall have such additional powers and duties as may be prescribed elsewhere in the by-laws or established by resolution or policy of the board. The secretary-treasurer shall act as custodian of all records and reports of the

board of trustees and shall be responsible for the keeping and reporting of adequate records of all transactions and the minutes of all meetings of the board of trustees.

[Recompiled 10/31/01]

7.7.4.11 ADMINISTRATION OF THE MEDICAL CENTER:

A. The board of trustees may provide for the management and administration of the medical center by contracting with a corporation engaged in providing management services in conformity with standards for an accredited hospital. The board of trustees may employ directly a competent, experienced, professional hospital administrator. In either case, a medical center administrator shall be secured and shall be the chief executive officer responsible for the management of the medical center.

B. The chief executive officer of the medical center shall have all authority and responsibility necessary to operate the medical center in all its activities and departments, subject only to policies issued by the board of trustees and to applicable federal and state laws and regulations. He or she shall act as the duly authorized representative to the board in all matters in which the board has not formally designated some other person to act. He or she shall report as directed to the chair between board meetings and to the board at each meeting.

C. The authority and duties of the chief executive officer shall include, but not be limited to: to sign, together with such other authorized board member, any deeds, mortgages, bonds, contracts or other instruments which the board has authority to execute except in cases where the execution shall have been expressly delegated by the board or by the by-laws or by statute; to carry out all policies established by the board of trustees; to conduct all activities of the medical center in compliance with federal and state laws and regulations; to prepare an annual budget showing the expected receipts and expenditures as required by the board and by departments of state government; as head of the medical center, to select, employ, control, and discharge all employees, consistent with the regulations of the state personnel board, and to develop and maintain additional personnel policies and practices approved by the board of trustees; to see that all physical properties are accounted for, safeguarded, and kept in a good state of repair and operating condition; to supervise all business affairs and to ensure that all funds are collected and expended to the best possible advantage; to assist the chief of staff, the medical staff, and all those concerned with the rendering of professional services to the end that the best possible care may be rendered to all patients; to submit regularly to the board of trustees, or its authorized committees, periodic reports of medical center services, statistics, and financial activities and to prepare and submit such special reports as may be required by the board of trustees; to attend all meetings of the board of trustees, of the committees on which he or she serves and other committees as necessary or required, and the medical staff executive committee; to perform any other duty that may be necessary or in the best interest of the medical center; to serve as the liaison officer and channel of

communications for all official communications between the board of trustees and the medical staff.

[Recompiled 10/31/01]

7.7.4.12 COMMITTEES OF THE BOARD OF TRUSTEES:

There shall be two types of committees of the board of trustees--permanent and special.

A. Permanent committees:

(1) Committee of the whole: The general conduct of the board of trustees' business shall be through the five-member body acting as a whole on matters pertaining to the operation of the medical center, unless otherwise specified in these by-laws or voted by the board of trustees. In acting as a whole, the board should provide for effective means of liaison between the governing body, the medical staff and the administration, and shall evaluate annually the administrator's performance.

(2) Joint conference committee: The joint conference committee shall serve as a liaison between the board of trustees, the medical staff, and the administration. The committee shall provide a forum for effective communication regarding medical center policy and operation; institutional/program planning and goal setting; accrediting and licensing requirements and inspections; requests and recommendations from the medical staff; quality assurance; matters related to the medical staff by-laws, rules and regulations and other matters of mutual concern to the medical staff, the administration, and the board, which may be referred to this committee by the board of trustees. The committee shall consist of the chair and secretary-treasurer of the board of trustees, the chief and vice-chief of the medical staff, and the hospital administrator. The chair of the board of trustees shall serve as chair of the joint conference committee. The committee shall meet at least quarterly, and shall maintain a written record of its attendance, proceedings, recommendations, and actions, which shall be forwarded to the board and to the medical staff.

(3) Credentials committee: The credentials committee shall be composed of three licensed physicians appointed by the board of trustees. The chief of the medical staff shall submit recommendations of qualified individuals to the board of trustees for their review and consideration. The committee shall review the professional credentials of all physicians and health care professionals, except those allied health professionals employed by the medical center, who apply to join or to continue as medical center staff for the purpose of rendering patient care. The committee shall, to the best of its ability, determine the competence of the applicant, the need for the services which the applicant would offer, and the availability of related support services which may be required for quality patient care. After consideration of these factors, the committee shall make a recommendation to the board of trustees regarding the granting, suspension, or revocation of privileges and the appropriate scope of privileges. The board of trustees

will act to grant, suspend, or rescind privileges, with consideration of the committee's recommendations.

B. Special committees: The chair of the board of trustees, with the concurrence of the board, shall create and make appointments of such standing and special committees as may be considered necessary or desirable. Such committees may be for, but are not limited to, the purposes of budget and finance, long-range planning, building and equipment, preliminary credentials review, etc. Appointments shall be made during a regular or special business meeting of the board of trustees; such appointments become effective immediately. Reappointment to a committee, including reappointment as chair, is authorized if the individual is otherwise eligible. Each committee so created shall consist of at least two trustees and may include persons who are not trustees. The chair of any such committee shall be a member of the board of trustees. Members of committees who are not members of the board of trustees are accorded full voting participation in the committees of which they are members. Minutes shall be kept of all committee meetings and reports of committee activities and recommendations shall be sent to the board.

C. Committee meetings shall be held on the call of the committee chair: Meetings will be held at a time and place to conserve travel and time of the members. Committees shall have the power of making recommendations to the board of trustees.

[Recompiled 10/31/01]

7.7.4.13 MEDICAL STAFF:

A. Appointment: Ultimate responsibility for medical staff appointments rests with the board of trustees. Medical staff membership shall be limited, unless otherwise provided by law, to individuals who are currently licensed to practice medicine, osteopathy, and dentistry. These individuals may be appointed to the medical staff in accordance with the by-laws of the medical staff, and pursuant to the following criteria:

(1) Appointment to the medical staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these By-laws and in the policies adopted by the board. All individuals practicing medicine and oral surgery in the medical center, unless by specific provisions of these by-laws, must first have been appointed to the medical staff.

(2) Only physicians and oral surgeons who:

(a) are currently licensed to practice in this state;

(b) are located close enough to provide timely care for their patients;

(c) possess current, valid professional liability insurance coverage in amounts specified in Subsection B [now Subsection B or 7.7.4.13 NMAC] of this Article;

(d) are certified by the appropriate specialty board, unless such requirement is waived by the board after considering the special competence and experience of the applicant, and

(e) can document their background, experience, training and demonstrated competence, their adherence to the ethics of their profession, their good reputation and character and their ability to work harmoniously with others sufficiently so that all patients treated by them shall receive quality care and that the hospital and the medical staff will be able to operate in an orderly manner, shall be qualified for appointment to the medical staff. The word "character" is intended to include the applicant's mental and emotional stability.

(3) No individual shall be entitled to appointment to the medical staff or to the exercise of particular clinical privileges in the Medical Center merely by virtue of the fact that:

(a) he or she is licensed to practice any profession in this or any other state;

(b) he or she is a member of any particular professional organization; or

(c) he or she had in the past, or currently has, medical staff appointment or privileges in another hospital.

(4) No individual shall be denied appointment on the basis of age, sex, race, creed, color or national origin.

B. Malpractice insurance: Good management of the assets of the hospital and legitimate protection of the patients of the hospital require that all appointees to the medical staff and all applicants for appointment have and maintain malpractice insurance in adequate amounts to cover claims or suits arising from alleged malpractice. Qualification under the Medical Malpractice Act of New Mexico 41-5-1 et. seq., NMSA 1978, or coverage under the Tort Claims Act of New Mexico, 41-4-1 et. seq., NMSA 1978, in cases of physicians who are "public employees" is sufficient. In all other cases, the adequacy of insurance protection required may depend upon the scope of staff privileges to be exercised and other considerations. Accordingly, the minimum policy limits in each instance shall not be less than those approved by the board after it has considered a recommendation in this regard from the medical staff executive committee. Compliance with this policy by medical staff appointees shall be evidenced by filing with the chief executive officer of the medical center a certificate of insurance from the carrier, showing at least the minimum amount required as aforesaid. Any lapse in insurance coverage or cancellation of insurance coverage will result in suspension of privileges until insurance is obtained.

C. By-laws, rules and regulations: The medical staff will develop, adopt, and periodically review medical staff by-laws, rules and regulations which are consistent with medical center policy and legal or other requirements. Such medical staff by-laws, rules and regulations shall become effective only upon approval by the board of trustees and when so approved, shall become a part of the board's by-laws. The medical staff by-laws, rules and regulations shall include at least the following principles and procedures by which the medical staff shall govern itself; formal means for medical staff participation in the development of medical center policy relative to both management and patient care; procedure for processing and evaluating applications for appointment or reappointment to the medical staff and for the granting of clinical privileges; a requirement that no qualified applicant shall be denied appointment and/or clinical privileges on the bases of sex, race, creed, or national origin; a requirement that all applicants must sign a statement to the effect that they have read and agree to be bound by the medical staff by-laws, rules and regulations and by the current medical center policies that apply to their activities; mechanisms designed to assure the achievement and maintenance of quality medical practice and patient care to include board policy, the quality assurance program, and other quality measures; a grievance procedure, triggered by adverse recommendations for appointment, reappointment, addition or modification of clinical privileges, that entitles the affected party to notice, hearing, and appellate review.

D. Delegated authority:

(1) The board delegates to the medical staff the authority and responsibility to: provide appropriate medical care; to evaluate the quality of medical care; to organize itself by adopting by-laws, rules and regulations for review and approval by the board of trustees; and, to accept and process applications for initial appointment and reappointment to the medical staff and delineation of privileges.

(2) In the exercise of its overall responsibility the board shall assign to the medical staff executive committee reasonable authority

(a) to ensure appropriate professional care to patients so that all patients with the same health problems shall receive the same level of care;

(b) to ensure the ongoing review and appraisal of the quality of professional care rendered, and to report results and findings to the board; and

(c) to ensure that:

(i) only medical staff appointees with admitting privileges admit patients;

(ii) each medical staff appointee practices only within the scope of privileges granted by the board;

(iii) all individuals who provide patient care services but who are not subject to the medical staff delineation process, are competent to provide such services and that their competency is monitored;

(iv) each patient's general medical condition is the responsibility of a qualified medical staff appointee. The committee shall also report to the board the mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care.

(3) The medical staff executive committee shall make recommendations directly to the board concerning:

(a) the structure of the medical staff;

(b) all matters relating to professional competency including the conduct, evaluation, and revision of quality assurance mechanisms;

(c) disciplinary actions and the mechanism for fair hearing procedures;

(d) such specific matters as the board may refer to it.

E. Board-medical staff liaison: The official method of communication and liaison between the board of trustees and the medical staff shall take place with the chief of staff or his designee attending regular meetings of the board of trustees.

[Recompiled 10/31/01]

7.7.4.14 VOLUNTEER AUXILIARY:

The board may authorize an auxiliary comprised of community-minded volunteers who are interested in serving patients and furthering the purpose of the medical center. Such auxiliary shall be organized in responsible administrative units with elected officers and shall adopt by-laws and/or rules and regulations for the governance of their conduct and service within the medical center, subject to prior approval by the board of trustees.

[Recompiled 10/31/01]

7.7.4.15 AMENDMENTS:

The board acting through the committee-of-the-whole shall review these by-laws on a continuing basis and at least once per year prior to the annual meeting and may amend them by an affirmative vote of a majority of the members of the board of trustees, provided that all members shall possess a full statement of such proposed amendments prior to the meeting where amendment of the by-laws is discussed or effected.

[Recompiled 10/31/01]

CHAPTER 8: RESIDENTIAL HEALTH FACILITIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: ASSISTED LIVING FACILITIES FOR ADULTS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.14 NMAC.]

PART 3: REGULATIONS GOVERNING RESIDENTIAL SHELTER CARE FACILITIES FOR CHILDREN

7.8.3.1 ISSUING AGENCY:

Children, Youth and Families Department.

[7.8.3.1 NMAC – N, 05/15/01]

7.8.3.2 SCOPE:

All Children's Crisis Shelters, Multi Service Homes, Community Homes, and New or Innovative programs that provide children's services as specified in these regulations. Community Homes licensed under these regulations are subject only to Sections 7.8.3.1 through 7.8.3.5; Sections 7.8.3.7 through 7.8.3.9; Sections 7.8.3.11 through 7.8.3.24; and Sections 7.8.3.82 through 7.8.3.127 of these regulations. Community Homes are exempt from all references to the word 'welfare' in these regulations.

A. These regulations apply to the following:

(1) Public or private, profit or nonprofit residential facilities providing services as outlined by these regulations.

(2) Any facility providing services as outlined by these regulations which by State or federal law or regulation must be licensed by the State of New Mexico.

B. These regulations do not apply to the following:

(1) Offices and treatment room of licensed private practitioners.

(2) Agencies providing Treatment Foster Care Services which are licensed by the Protective Services Division of the Department.

(3) Room and board facilities in public or private schools accredited or supervised by the New Mexico State Department of Education and inspected for fire and safety by the New Mexico State Fire Marshal's office.

(4) Residential Treatment Services and Day Treatment Services that provide Children and Adolescent Mental Health Services, which are licensed by Children, Youth and Families Department, Certification Unit.

[7.8.3.2 NMAC – N, 05/15/01]

7.8.3.3 STATUTORY AUTHORITY:

Sections 24-1-3, 24-1-5 and 9-7-6 NMSA 1978.

[7.8.3.3 NMAC – N, 05/15/01]

7.8.3.4 DURATION:

Permanent.

[7.8.3.4 NMAC – N, 05/15/01]

7.8.3.5 EFFECTIVE DATE MAY 15, 2001:

[7.8.3.5 NMAC – N, 05/15/01]

7.8.3.6 OBJECTIVE:

A. Establish minimum standards for licensing of residential facilities that provide services in order to promote the health, safety and welfare of children in need of such services.

B. Provide for monitoring of facility compliance with these regulations through surveys to identify any factors that could affect the health, safety, and welfare of the clients or the staff.

C. Assure that the agency/facility establishes and follows written policies and procedures which specify how this is met.

D. To assure that adequate supervision must be provided at all times. Failure to provide a child with the care, supervision and services outlined in these regulations is a violation of these regulations which could result in suspension, revocation or denial of license.

[7.8.3.6 NMAC – N, 05/15/01]

7.8.3.7 DEFINITIONS:

For the purpose of these regulations, the following apply:

A. ABUSE means any act or failure to act, performed intentionally, knowingly or negligently that causes or is likely to cause harm to a client as defined in 32A-4-2 NMSA 1978.

B. ACTION PLAN means a written document submitted to the Licensing Authority which states those actions that the facility will be implementing, with specific time frames and responsible parties for each, to correct the deficiencies identified in the previous on-site visit or review of documents.

C. ADMINISTRATOR means the person in charge of the day-to-day operation of a facility. The administrator, director, or operator may be the licensee or an authorized representative of the licensee. The administrator may also be referred to as the director or operator.

D. AMBULATORY means the ability of the child to walk without assistance.

E. APPLICANT means the individual, or organization which, applies for a license.

F. BED means the total assembly on which a child sleeps, including frame, springs, mattress, mattress cover/pad, sheets, pillow, blankets and bedspread.

G. CAPACITY means the maximum number of children who can be accommodated in rooms designated specifically for them in a facility pursuant to these regulations.

H. CHILD/ADOLESCENT means a person under the chronological age of 18 years. Those persons who, while a resident or client of a facility licensed pursuant to these regulations reach the age of 18 will, for the purposes of these regulations, be considered a child until they complete their course of treatment in the facility.

I. CHILDREN'S CRISIS SHELTER means a facility which provides short term (usually less than 90 days) emergency living accommodations to children in a crisis situation such as abandonment, abuse, neglect or runaway.

J. CLEARED STAFF MEMBER means an individual who has received a State and federal criminal background clearance as documented by the Department clearance letter.

K. CLIENT means any person who receives treatment from a Children's Crisis Shelter, Multi Service Home, or Community Home.

L. COMMUNITY HOME means a facility which operates twenty-four (24) hours a day providing full time care, supervision and support needed to not more than sixteen (16) resident children in a single residential building and which meets the definition incorporated in 9-8-13 NMSA 1978. The facility provides parenting, activities and experiences needed by a child to develop and realize their full potential.

M. CORPORAL PUNISHMENT means touching a child's body with the intent of inducing pain and includes, but is not limited to, shaking, spanking, hitting, hair pulling, ear pulling or forced exercise.

N. CRIMINAL RECORDS CHECK means the process of fingerprinting on State and FBI approved cards and submission of the fingerprint cards for the purpose of obtaining the State and federal conviction records of an individual. The services of an agency contracted by the Department of Public Safety (DPS) who can access the DPS database in order to obtain State criminal background checks for those applicants who have resided in the State of New Mexico for five years or more may be utilized as a means of obtaining State criminal records checks prior to employment. Federal fingerprinting is still required. The use of an alternate method to obtain State criminal background checks do not replace the federal fingerprinting requirement.

O. CRUELTY (MENTAL/ PHYSICAL) AND INDIFFERENCE TO THE WELFARE OF CHILDREN means a failure to provide a child with the care, supervision, and services to which the child is entitled. Examples of physical and mental cruelty include physical device/chemical restraints, striking, slapping or hitting, withholding food or bathroom privileges as punishment, swearing at or threatening a child, and indifference to the basic needs of the child.

P. DEFICIENCY means a violation of or failure to comply with a provision(s) of these regulations.

Q. DEPARTMENT means the New Mexico Children, Youth and Families Department.

R. DIRECT SERVICES STAFF means supervisors, therapists, child care workers, coordinators or other employees who work directly with children in their daily living activities in a facility.

S. DIRECTED ACTION PLAN means an Action Plan that the Licensing Authority writes and specifies that the facility must enforce within a specific time frame because of the serious nature of the deficiency.

T. DISCIPLINE means training that enables a child to develop self control and orderly conduct in relationship to peers and adults.

U. EMERGENCY SANCTION means an immediate measure that is imposed on a facility for violations of applicable licensing laws and regulations, other than revocation, suspension, or denial of renewal of license when a health and/or safety violation warrants prompt action.

V. EMERGENCY SUSPENSION means an immediate and temporary canceling of a license pending an appeal hearing and/or correction of deficiencies.

W. EMPLOYMENT HISTORY means a written summary for the most recent three-year period of all periods of employment with names, addresses and telephone numbers of the employers and the individual's immediate supervisor, specifying all periods of non-employment, stating the reason for leaving employment and explanation of periods of non-employment, with documented verifying references.

X. FACILITY means a publicly or privately owned or operated residence licensed pursuant to these regulations which provides living accommodations, meals, supervision, care, and in some instances, programmatic services to children.

Y. GOVERNING BODY means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a facility licensed pursuant to these regulations.

Z. LICENSE means the authority granted by the Licensing Authority pursuant to these regulations to operate for a specified period of time.

AA. LICENSEE means the person(s) who, or organization which, has ownership, leasehold, or similar interest in the facility and in whose name a license for a facility has been issued and who is legally responsible for compliance with these regulations.

BB. LICENSING AUTHORITY means the New Mexico Children, Youth and Families Department.

CC. MAINTENANCE means keeping the building(s) in a repaired and safe condition and the grounds in a safe, sanitary and presentable condition.

DD. MOBILE NON-AMBULATORY means unable to walk without assistance but able to move from place to place with the use of devices such as walkers, crutches, wheelchairs, etc.

EE. MORAL TURPITUDE means conduct contrary to justice, honesty, modesty or good morals including such acts as domestic abuse, drunk driving or other similar convictions.

FF.MULTI SERVICE HOME means a facility that provides residential care to children who have been referred by other agencies or parents because of abuse, neglect, delinquency, substance abuse, or other problems.

GG. NON-MOBILE means unable to move without human assistance from place to place.

HH. PREMISES means all parts of buildings, grounds, vehicles and equipment of a facility.

II. PROGRAMMATIC SERVICES means services provided to children to meet special needs above and beyond living accommodations, meals, care, and routine supervision.

JJ. PUNISHMENT means a penalty imposed on a child for wrongdoing.

KK. RESTRAINT means a mechanical device used to involuntarily physically restrict a client's freedom of movement, performance of physical activity, or have normal access to his or her body. It is limited to those situations with adequate, appropriate justification and requires policies and procedures with clear criteria. This standard does not apply to therapeutic holding or comforting of children or to a timeout when the individual to whom it is applied is physically prevented from leaving a room for 15 minutes or less and when its use is consistent with protocol.

LL. REVOCATION means making a license null and void through its cancellation.

MM. SANCTION means a measure imposed on a facility by the Licensing Authority for violations of these standards.

NN. SECLUSION means the involuntary confinement of a client alone in a room where the individual is physically prevented from leaving and is limited to those situations with adequate, appropriate justification, requiring policies and procedures with clear criteria.

OO. SECLUSION ROOM means a room designed and utilized to isolate and contain a child who poses an imminent threat of physical harm to self or others or serious disruption to the environment.

PP. SELF-ADMINISTRATION OF MEDICATIONS means assistance and supervision of the child in the self-administration of a drug, provided that the medication is in the original container, with a proper label and directions. A staff member may hold the container for the child, assist with opening of the container, and assist the child in self-administering the medication.

QQ. SUBSTANTIATED COMPLAINT means a complaint determined to be factually substantiated, based on an investigation of events.

RR. SUPERVISION means the monitoring of the children's whereabouts and activities by the facility staff in order to ensure health, safety, and welfare.

SS. SURVEY means an entry, by the Licensing Authority, into a facility licensed, or required to be licensed, pursuant to these regulations, for examination of the premises and records, and interviewing of staff and children.

TT.SUSPENSION means a temporary cancellation of a license pending an appeal hearing and/or correction of deficiencies. During a period of suspension, the Medicaid provider agreement is not in effect.

UU. U/L APPROVED means approved for safety by the National Underwriters Laboratory.

VV. UNSUBSTANTIATED COMPLAINT means a complaint not determined to be factually substantiated, based on an investigation of events.

WW. VARIANCE means an act taken, at the sole discretion of the Licensing Authority, to refrain from enforcing compliance with a portion(s) of these regulations for an unspecified period of time for facilities which were in existence at the time these regulations were promulgated, new facilities in existing construction, or for new services when the granting of a variance will not create a danger to the health and safety of children and staff of a facility.

XX. WAIVE/WAIVER means to refrain from pressing or enforcing compliance with a portion(s) of these regulations for a limited period of time provided the health, safety, or welfare of the clients and staff are not in danger. Waivers are issued at the sole discretion of the Licensing Authority.

[7.8.3.7 NMAC – N, 05/15/01]

7.8.3.8 RELATED REGULATIONS, LAWS AND CODES:

These regulations supplement the following regulations, laws, codes and any future amendments to such regulations or superseding regulations.

A. New Mexico Department of Health Regulation 7 NMAC 4.3, Control of Disease and Conditions of Public Health Significance, effective October 31, 1996.

B. New Mexico Department of Health Regulation 7 NMAC 4.4, Control of Communicable Disease in Health Facility Personnel, effective October 31, 1996.

C. New Mexico Department of Health Regulation 7 NMAC 1.3, Health Records, effective October 31, 1996.

D. New Mexico Department of Health Regulation 7 NMAC 20.2, Comprehensive Behavioral Health Standards, effective January 1, 2000.

E. New Mexico Department of Health Regulation 7 NMAC 1.7, Health Facility Licensure Fees and Procedures, effective October 31, 1996.

F. New Mexico Department of Health Regulation 7 NMAC 1.2, Adjudicatory Hearings, effective February 1, 1996.

G. New Mexico Health Department Regulations HED 85-6 (HSD) Governing Criminal Records Check and employment History of Licensees and Staff of Child Care Facilities, effective August 30, 1985, will be repealed and repromulgated as 8.8.3 NMAC, Regulations Governing Criminal Records Checks and Employment History Verification.

H. Environmental Improvement Board Regulation 7.6.2 NMAC, Food Service and Food Processing, effective August 12, 2000.

I. New Mexico State Fire Board Life Safety Code Handbook 101, effective June 9, 1997.

J. Construction Industries Division Regulation 14 NMAC 7.3, 1977 Uniform Building Code, effective December 31, 1998.

K. New Mexico Department of Health Regulation 7.5.2 NMAC, Immunization Requirement, effective September 1, 2000.

L. New Mexico Department of Health Regulation 7 NMAC 1.7, Health Facility License Fees and Procedures, effective October 31, 1996.

M. New Mexico Department of Health Regulation 7 NMAC 1.8, Health Facility Sanctions and Civil Monetary Penalties, effective October 31, 1996.

N. New Mexico Children's Code NMSA 32A-1-1 et. seq. (1997).

[7.8.3.8 NMAC – N, 05/15/01]

7.8.3.9 STANDARD OF COMPLIANCE:

The degree of compliance required throughout these regulations is designated by the use of the words "shall", "must", "may", or "should" "Shall" or "must" means mandatory. "May" means permissive. "Should" means recommended, strongly advised or desirable.

[7.8.3.9 NMAC – N, 05/15/01]

7.8.3.10 LICENSING CATEGORIES:

A. Children's Crisis Shelter: Any facility which provides short term (usually less than 90 days) emergency living accommodations to children in a crisis situation such as abandonment, abuse, neglect or runaway. A Children's Crisis Shelter provides services on a twenty-four hour a day basis and is not limited as to total capacity. Children's records required for a Children's Crisis Shelter:

(1) Personal Information: Full name; Date of birth; Name address and telephone number of parents or legal guardian.

(2) Circumstances concerning the admission.

(3) Any condition which may require medical attention noticed at time of admission.

(4) Documentation as to efforts to obtain information not available at time of admission of the child.

(5) Admission Agreement.

B. Multi Service Home: Any facility that provides residential care to children who have been referred by other agencies or parents because of abuse, neglect, delinquency, substance abuse, or other problems. The facility provides supervision and direction in daily activities, and other services such as but not limited to individual and family counseling, case management, parenting, and volunteer services. Children's records required for a Multi Service Home:

(1) Personal Information:

(a) Full Name.

(b) Social Security Number.

(c) Name, address and telephone number of parents or guardian.

(d) Documentation of the current legal status of the child.

(2) Medical Information:

(a) Any condition requiring medical attention.

(b) Physical.

(c) Immunization Records.

(3) Treatment plan.

(4) Educational information.

(5) Admission Agreement.

C. New or Innovative Programs: Professional organizations which have demonstrated a need for new or innovative services for residential shelter care for not more than sixteen (16) children on a twenty-four hour basis which does not fit into one of the above categories may be licensed at the sole discretion of the Licensing Authority, if all requirements are met.

(1) Children's records required for New Or Innovative Programs:

(a) Personal information:

(i) Full name.

(ii) Date of birth.

(iii) Social Security Number.

(iv) Name, address, and phone number of parents or legal guardian

(b) Medical information:

(i) Any condition requiring medical attention.

(ii) Any required medications.

(iii) Physical evaluation.

(iv) Immunization Record.

(c) Educational Information.

(d) Admission Agreement.

(e) Other records may be necessary based on the services needed by the children to be cared for in the facility requesting license under the category of New or Innovative Programs. These will be determined by the Licensing Authority prior to issuance of initial license.

D. Location of Children's Records: When an agency has multiple Residential Shelter Care Facilities for Children located within the same city or town the primary record may be kept in a central office location, however, each facility must have the following information on file for each child in care.

(1) Full name.

(2) Age.

(3) Name address and phone number of person to contact in case of emergency.

(4) Name address and phone number of physician or medical facility to contact in case of emergency.

(5) Any special problems or medical condition that the child may have.

(6) Medications and dosage if applicable.

[7.8.3.10 NMAC – N, 05/15/01]

7.8.3.11 INITIAL LICENSURE PROCEDURES:

To apply for a license for a facility pursuant to these regulations the following procedures must be followed by the applicant.

A. These regulations must be used as a reference for design of a new building, renovation or addition to an existing building.

B. The applicant of the proposed facility must advise the Licensing Authority of its intent to open a facility pursuant to these regulations.

C. Floor and Site Plans: All applications for initial licensure must be accompanied by a set of floor plans for the facility:

(1) Floor and site plans are of professional quality, on substantial paper of at least 18" x 24", and are drawn to an accurate scale of 1/4 to 1’.

(2) Floor plans include:

(a) Proposed use of each room, e.g., staff’s bedroom, staff’s toilet, children’s bedrooms (include number of children intended to sleep in each room), living room, kitchen, laundry, etc.

(b) Interior dimensions of all rooms.

(i) One building or wall section showing exterior and interior wall construction. Section includes floor, wall, ceiling, and the finishes, e.g., carpet, tile, gypsum board with paint, wood paneling.

(ii) Door types, swing, and sizes of all doors, e.g., solid core, hollow core, 3’0" x 6’8" x 1 3/4" thick.

(iii) Air conditioning, if applicable.

(iv) All sinks, tubs, showers and toilets.

(v) Windows including size, type, sill height, and openable area.

(vi) Any level changes within the building, e.g., sunken living room, ramps, steps.

(vii) A site/plot plan must be provided to indicate surrounding conditions including all steps, ramps, parking, walks and any permanent structures.

(viii) Indicate if the building is new construction, remodeled or alteration addition. If remodeled or an addition, the plans indicate existing and new construction plans.

D. Floor and site plans are reviewed by the Licensing Authority for compliance, and comments may be sent to the applicant specifying any needed changes or requests for any additional information.

E. Licensing Phase: Prior to renovation or addition to an existing building the applicant must submit to the Licensing Authority the following:

(1) The application form, obtained from Licensing Authority, must be completed by typing or printing all the information requested, signed and notarized by the applicant.

(2) Fees: All applications for licensure are accompanied by the required fee.

(a) Current fee schedules are available from the Licensing Authority.

(b) Fee payments must be in the form of a certified check, money order, personal, or business check and made payable to the State of New Mexico.

(c) Fee payments are non-refundable.

(3) Zoning And Building Approval:

(a) The agency provides an initial application accompanied with the written approval from the appropriate authority, such as city, county, or municipality.

(b) The agency provides an initial application accompanied with original written building approval (Certificate of Occupancy), from the appropriate authority, city, county, or municipality.

(4) Fire Authority Approval: All initial applications are accompanied with written approval from the fire authority having jurisdiction. Written documentation from the State Fire Marshal's office or Fire Authority having jurisdiction evidencing a facility's compliance with applicable fire prevention codes is submitted to the Licensing Authority prior to issuance of an initial license.

(5) New Mexico Environment Department Approval:

(a) For private water supply, if applicable.

(b) For private waste or sewage disposal, if applicable.

(c) For kitchen ,if meals are prepared, if applicable

(6) Copy Of Appropriate Drug Permit: Issued by the State Board of Pharmacy, if applicable.

F. Initial Survey: Upon receipt of a properly completed application including all supporting documentation as outlined above, an initial survey of the proposed facility must be scheduled by the Licensing Authority.

G. Issuance of License: Upon completion of the initial survey and determination that the facility is in substantial or partial compliance with these regulations, the Licensing Authority may issue a license.

[7.8.3.11 NMAC – N, 05/15/01]

7.8.3.12 LICENSES:

A. Annual License: The Licensing Authority may, at its sole discretion, issue a license for up to one year to a facility which is determined to be in substantial compliance with these regulations.

B. Temporary License: The Licensing Authority at its sole discretion may issue a Temporary License, after an on-site survey, if it determines the facility to be in partial compliance with these regulations.

(1) A Temporary License shall cover a period of time not to exceed 120 days, during which time the facility must correct all specified deficiencies. In order to be issued a Temporary License, deficiencies may not be violations of health and safety standards.

(a) The facility must submit an Action Plan within ten days. The Licensing Authority approves the Action Plan. The facility is then either inspected on-site again, or is required to submit proof of correction through submission of appropriate and relevant documentation within ten days.

(b) If the facility does not meet licensing requirements at the end of the Temporary Licensure period, a second Temporary License may be granted. Another application must be submitted before a second Temporary License may be issued. Only two consecutive Temporary Licenses may be granted.

(2) When a Temporary License is issued, the previous license and its expiration date become null and void, and the Temporary License effective dates are in effect.

C. Amended License: A licensee applies to the Licensing Authority for an amended license when there is a change of a licensee; a change of the facility name; change of capacity; or change of owner.

(1) An application for an amended license is submitted in writing to the Licensing Authority.

(2) The application is accompanied by the required fee for the amended license.

(3) The application is submitted within ten business days of the change.

(4) Upon receipt of the completed application and fee, an on-site survey is performed by the Licensing Authority prior to the issuance of the amended license.

(5) Application for increase of capacity will not be approved nor an amended license issued until an on site survey has been made by the Licensing Authority to determine if the facility has the required space for the increase in capacity. A facility shall not accept additional children until the Licensing Authority has approved and issued an amended license.

[7.8.3.12 NMAC – N, 05/15/01]

7.8.3.13 LICENSE RENEWAL:

A. The Licensee submits a renewal application on the forms obtained from the Licensing Authority, along with the required fee, at least 30 days prior to the expiration of the current license.

B. Upon receipt of the renewal application and required fee, and prior to the expiration of the current license, the Licensing Authority conducts an on-site survey and issues a new license effective the day following the date of expiration of the current license if the facility is in substantial compliance with these regulations.

C. If a licensee fails to submit a renewal application with the required fee and the current license lapses, the facility ceases operations until it obtains a new license through the initial license procedures.

[7.8.3.13 NMAC – N, 05/15/01]

7.8.3.14 POSTING OF LICENSE:

The facility's license is posted on the licensed premises in an area visible to the public.

[7.8.3.14 NMAC – N, 05/15/01]

7.8.3.15 NON-TRANSFERABLE RESTRICTIONS ON A LICENSE:

A. A license is nontransferable to other persons or locations.

B. The license is null and void and is returned to the Licensing Authority when any one of the following situations occur:

(1) Ownership of the facility changes.

(2) The facility changes location.

(3) The licensee of the facility changes.

(4) The facility discontinues or suspends operations.

C. A facility wishing to continue operation as a licensed facility under the above-mentioned circumstances submits an application for an amended license in accordance with these regulations at least 30 calendar days prior to the anticipated change.

[7.8.3.15 NMAC – N, 05/15/01]

7.8.3.16 AUTOMATIC EXPIRATIONS OF A LICENSE:

A license automatically expires at midnight on:

A. The day indicated on the license as the expiration date, unless renewed, suspended, or revoked; or:

B. The day a facility discontinues or suspends operation; or

C. The day a facility is sold, leased, or otherwise changes ownership and/or licensee; or

D. The day a facility changes location.

[7.8.3.16 NMAC – N, 05/15/01]

7.8.3.17 SUSPENSION OR REVOCATION OF A LICENSE OR IMPOSITION OF EMERGENCY SANCTIONS WITHOUT PRIOR HEARING:

In accordance with Section 24-1.5 (H) NMSA 1978, if immediate action is required to protect human health and safety, the Licensing Authority may immediately suspend or revoke a license or impose emergency sanctions pending a hearing, provided such hearing is held within five working days of such action, unless waived by the licensee.

[7.8.3.17 NMAC – N, 05/15/01]

7.8.3.18 GROUNDS FOR REVOCATION, SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF SANCTIONS:

A license may be revoked or suspended, an initial or renewal application for license may be denied, or sanctions may be imposed after notice and opportunity for a hearing, for any of the following:

A. Failure to comply with any provision(s) of these regulations.

B. Failure to allow surveys by authorized representatives of the Licensing Authority.

C. Employment of any person convicted of a felony or misdemeanor including a misdemeanor involving moral turpitude or presence at a facility of a staff member under the influence of alcohol or mood-altering drugs. If after employment, a staff member is charged and/or convicted of a felony or misdemeanor involving moral turpitude and it is known to the agency, it is immediately reported to the Licensing Authority.

D. Purposeful or intentional misrepresentation(s) or falsification(s) of any information on application forms or other documents provided to the Licensing Authority.

E. Discovery of repeat violations of these regulations or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous licensure periods.

F. Presence of and or a history of licensure revocation, suspension, denial, other similar disciplinary actions taken by regulatory bodies within this state, or other states regardless of whether any of these actions resulted in a settlement.

G. Failure to provide the required care and services as outlined by these regulations for the clients receiving care at the facility.

H. Exceeding licensed capacity.

[7.8.3.18 NMAC – N, 05/15/01]

7.8.3.19 HEARINGS AND APPEALS:

A. Appeals of any sanction except "Revocation or Suspension of a License or Imposition of Emergency Sanction(s) Without Prior Hearing" as outlined above, are made in writing to the Licensing Authority within 10 business days of receipt of the official notice of revocation, suspension, denial of licensure.

B. When an appeal is filed the sanction is stayed until a hearing is held and final determination issued or an informal resolution reached, unless it is an emergency revocation or suspension of license. A hearing will beheld within 30 calendar days.

C. The entity filing the appeal may also request an informal resolution conference at that time. The purpose of the informal resolution conference is to allow the entity receiving the sanction an opportunity to present information on plans to remedy deficiencies and discuss possible pre-hearing dispositions. This does not apply to the emergency revocation or suspension of a license or to the imposition of emergency sanctions.

D. The Licensing Authority and the licensee may informally resolve any filed or potential appeal arising from the imposition of sanctions. However, in the case of an emergency revocation or suspension of licensure and/or the imposition of an emergency sanction, there is no stay available.

[7.8.3.19 NMAC – N, 05/15/01]

7.8.3.20 CURRENTLY LICENSED FACILITIES:

Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but which fails to meet all building requirements, may, at the discretion of the Licensing Authority, continue to be licensed as a children's crisis shelter, community home, multi service home, or new or innovative programs. Variances may be granted for those building requirements the facility cannot meet, provided:

A. The variances granted will not create a hazard to the health, safety and welfare of the clients and staff or otherwise deny access to any disabled person who is otherwise qualified to receive services from the facility; and

B. The building requirements for which variances are granted cannot be corrected without an unreasonable expense to the facility; and

C. Variances are not in conflict with existing building and fire codes; and

D. Variances granted are recorded and made a permanent part of the facility file; and

E. Variances granted continue to be in effect as long as the facility continues to provide services pursuant to these regulations and meet the criteria of 7.8.3.20A NMAC. These variances are not transferable to a different facility or transferred/assigned upon the sale of the facility.

[7.8.3.20 NMAC – N, 05/15/01]

7.8.3.21 NEW FACILITY:

A. If a facility is opened in an existing building, a variance may be granted for those building requirements the facility cannot meet under the same criteria outlined in these

regulations and if not in conflict with existing building and fire codes. Such a variance is granted at the sole discretion of the Licensing Authority.

B. A new facility opened in a newly constructed building must meet all requirements of these regulations.

[7.8.3.21 NMAC – N, 05/15/01]

7.8.3.22 FACILITY SURVEYS:

A. A survey by the Licensing Authority is conducted at a minimum once per year in each facility licensed pursuant to these regulations. Additional surveys or on-site visits may be made to provide the facility with technical assistance, and/or to assess and monitor progress with correction of violations found on previous surveys or to investigate complaints of allegations of abuse, neglect or exploitation.

B. The facility is provided with a written report of the findings within 10 business days of completion of the survey.

C. The facility may be required to submit an Action Plan, approved by the Licensing Authority, within 10 business days of receipt of the findings. The Action Plan may be a Directed Action Plan due to the serious nature of the deficiencies and the Licensing Authority will expect health and safety deficiencies to be corrected immediately.

D. The Licensing Authority, at its sole discretion, may accept the Action Plan as written or require modifications of the Action Plan by the licensee.

E. Application for licensure, whether initial or renewal, constitutes permission for entry into, and surveys of, a facility by the authorized Licensing Authority representatives at reasonable times while the application is pending, and if licensed, during the licensure period.

F. Licensing Authority surveyors have the right to enter upon and into the premises of any facility which is licensed or required to be licensed, whether or not an application for licensure has been made, at any reasonable time for the purpose of determining the state of compliance with these regulations.

G. On-site surveys are announced or unannounced at the sole discretion of the Licensing Authority.

[7.8.3.22 NMAC – N, 05/15/01]

7.8.3.23 COMPLAINT AND INVESTIGATION PROCEDURES:

A. Submission of complaints: Complaints regarding any facility licensed pursuant to these regulations are submitted to the Licensing Authority.

B. The Licensing Authority will process any complaint regarding any facility licensed or required to be licensed under these regulations.

C. A Licensing Authority representative receiving complaints will ask complainants to identify themselves and provide all information necessary to document the complaint.

D. The Licensing Authority will investigate any complaint in which the health, safety, or welfare of a child could be in danger.

E. Initiation of investigation: The Department screens, and if it deems appropriate, will initiate an investigation within 30 business days from receipt of a complaint. If it is probable that the health, safety, or welfare of a child is in jeopardy, the complaint is investigated as soon as possible after the complaint is made.

F. Results of investigation: The licensee of the facility is notified of the results of the investigation in writing.

G. Anonymity may be requested by the complainant, but cannot be guaranteed.

H. Action by the Licensing Authority in response to a complaint:

(1) Unsubstantiated complaint: A complaint which is unsubstantiated by the Licensing Authority is not made part of the facility file and the Licensing Authority takes no further action.

(2) Substantiated complaint: The Licensing Authority may take the following actions if a complaint is substantiated:

(a) Require the facility to submit a written Action Plan to the Licensing Authority.

(b) Impose other sanctions that may include, but not be limited to, the denial, suspension or revocation of a license, or the filing of criminal charges, or a civil action which may be initiated by the Licensing Authority.

(c) The complaint will be made part of the Licensing Authority's file on the facility.

[7.8.3.23 NMAC – N, 05/15/01]

7.8.3.24 CAPACITY OF A FACILITY:

The capacity of a facility licensed pursuant to these regulations is determined by the following:

A. All facilities, except Children's Crisis Shelters, are limited to a total capacity of 16 children in a single residential building.

B. By square footage of children's sleeping rooms as specified by these regulations.

C. The capacity as reflected on the license issued to a facility licensed pursuant to these regulations must not be exceeded at any time. EXCEPTION: The facility may exceed its licensed capacity for a period not to exceed 72 hours due to emergency placements by families, Juvenile Probation and Parole Officers, sheriff, police, court or Protective Services. The facility notifies the Licensing Authority within one business day of the event.

[7.8.3.24 NMAC – N, 05/15/01]

7.8.3.25 REPORTING OF INCIDENTS:

All facilities licensed pursuant to these regulations must report immediately by phone and follow-up in writing to the Licensing Authority within 24 hours, any serious incident or unusual occurrence which has, or could threaten the health, safety, or welfare of the clients or staff of the facility. Such incidents may include, but are not limited to:

A. Fire, flood, or other natural disaster which creates structural damages to the facility or poses health hazards;

B. Any outbreak of contagious disease dangerous to the public health;

C. Any human act(s) by staff member(s) or client(s) of the facility which presents or poses possible physical and/or psychological health hazards;

D. Any human act(s) by staff member(s) or client(s) of the facility which results in the serious illness, injury, or physical and/or psychological impairment;

E. Any death of a client;

F. Any suspected client abuse, neglect or exploitation of a client, as defined in these regulations.

G. Incidents that include acts of physical harm to a client by staff or other clients.

H. Absence of clients without permission, including not returning from a pass, for longer than 24 hours past the designated return time.

I. Any non-informational call made to poison control involving potential harm to a client or resulting in treatment of a client.

[7.8.3.25 NMAC – N, 05/15/01]

7.8.3.26 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE FACILITY:

A. Each facility licensed pursuant to these regulations maintains the following reports and records on file and makes them available for review upon request by the Licensing Authority:

(1) A copy of the current Residential Shelter Care Regulations;

(2) A copy of the latest fire inspection report by the fire authority having jurisdiction;

(3) A copy of the last survey conducted by the Licensing Authority including any variances granted;

(4) Records of monthly fire and emergency evacuation drills conducted by the facility;

(5) Health certificates of staff;

(6) Agreements or contracts with other health care providers to provide services that are not available in the facility, if applicable;

(7) Latest inspection of drug room by State Board of Pharmacy, if applicable; and

(8) New Mexico Environment Department approval of private waste, sewage disposal, or kitchen, if applicable.

B. New Mexico Environment Department approval of kitchen and food management and, if applicable, survey reports of private water supply, private waste and/or sewage disposal. EXCEPTION: Those facilities which have been exempted by the Environmental Improvement Division or recognized local authority from meeting the requirements for kitchens and food service and have the exemption on file.

C. One month of menus of meals served in the facility.

D. Documentation of staff Criminal Record Checks and verification of employment history as required by these regulations.

E. A valid drug permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations who as a regular part of their program supervise the administration and/or client’s self-administration of medication and safeguard medications for the children in care.

F. A copy of the current American Red Cross and Cardio Pulmonary Resuscitation certification, or other recognized organization's, Standard First Aid Certificate, for all direct care staff within 90 days of employment.

[7.8.3.26 NMAC – N, 05/15/01]

7.8.3.27 FACILITY RULES:

A. Each facility has written rules which are age appropriate and clear and understandable to the children in care. The rules include but are not limited to the following:

(1) The use of tobacco or alcohol;

(2) The use of the telephone;

(3) Visitors and visiting hours;

(4) Daily routine of the facility such as bed times, free time, study hours, use of personal possessions, playing of radios and watching television; and

(5) Leaving the premises of the facility;

B. Facility rules are posted in an area of the facility readily available to the children.

C. Prior to placement in, or admission to a facility, the rules are explained to the child, parents, or legal guardian in a language they can understand.

D. A facility will prohibit the use of firearms, weapons, tobacco, illegal substances, such as street drugs, and alcoholic beverages on the premises of the facility, including in vehicles.

[7.8.3.27 NMAC – N, 05/15/01]

7.8.3.28 CHILDREN'S RIGHTS:

All facilities licensed pursuant to these regulations must support, protect, and enhance the rights of children.

A. A facility must not make discriminatory distinction or refuse admission and services to any child based solely on consideration of race, religion, color, national origin, ancestry, sex, physical or mental handicap.

B. At time of admission to a facility licensed pursuant to these regulations the child's parent or legal guardian will be given a copy of children's rights as listed below. These rights will also be posted in the facility:

(1) The right to confidentiality of records.

(2) The right to use his/her own personal possessions.

(3) The right to preparation and maintenance of accurate and complete records during any stay in the facility.

(4) The right to privacy.

(5) The right to humane care and environment.

(6) The right of religious worship.

(7) The right to receive visitors in private at reasonable times.

(8) The right to written and telephone access which includes the right to send and receive correspondence unopened by others and the right of private telephone conversations.

C. Any time a child's rights are restricted because of a treatment or program plan, or to protect the health, safety and welfare of the child, the reasons for the restriction of rights must be clearly documented in the child's record.

[7.8.3.28 NMAC – N, 05/15/01]

7.8.3.29 ADMISSION AGREEMENT:

Prior to admission to a facility, the licensee or authorized representative and the child's parent/s or guardian, shall sign a written admission agreement. The facility shall keep the original agreement in the child's records and a copy must be provided to the child's parents or guardian. A standard form may be developed and used. The admission agreement must meet the criteria stated below:

A. The services that will be provided by the facility and the charges for such services must be explained in full.

B. The method of payment for the services must be clearly stated.

C. Terms for termination of the admission agreement either on part of the facility or the parents or guardian must be clearly outlined.

D. A new admission agreement must be made whenever any term of the agreement is changed by either the facility or the parents or guardian.

[7.8.3.29 NMAC – N, 05/15/01]

7.8.3.30 PERSONNEL AND STAFFING REQUIREMENTS:

A. Governing Body: Each facility licensed pursuant to these regulations shall have a governing body. The governing body shall:

(1) Have ultimate authority for the overall operation of the facility program and is responsible for ensuring a facility's continual compliance and conformity with the program goals of the facility;

(2) Adopt and periodically review and revise written by-laws and policies. These must define the program goals, describe and define the major lines of authority and areas of responsibility within the facility;

(3) Appoint a director to implement its policies.

B. Director: The director of a facility licensed pursuant to these regulations must have the following minimum qualifications:

(1) Be at least twenty-one (21) years of age.

(2) Have good moral and responsible character and reputation.

(3) Possess educational background and experience in the principles and practices of child care.

(4) Possess the management and administrative ability to fulfill requirements of these regulations.

C. Direct Services Staff: The direct service staff of a facility licensed pursuant to these regulations must have the following minimum qualifications.

(1) Be at least eighteen (18) years of age.

(2) Have good moral and responsible character and reputation.

(3) Possess adequate education, training, or experience to provide for the needs of children.

(4) Physical, emotional, and mental capacity to ensure the health, safety, and welfare of children pursuant to these regulations.

[7.8.3.30 NMAC – N, 05/15/01]

7.8.3.31 STAFF EVALUATION AND DEVELOPMENT:

A. A facility licensed pursuant to these regulations must have a written plan for the orientation, ongoing staff development, supervision and evaluation of all staff members.

(1) A facility licensed pursuant to these regulations must document that direct service staff members have received appropriate training to include, but not limited to the following:

(a) The facility's emergency and safety procedures on a semi-annual basis.

(b) The principles and practices of child care.

(c) The facility's administrative procedures and overall program goals.

(d) Acceptable behavior management techniques.

(e) Crisis management.

(f) Use of restraints if used in the facility program.

(2) Each facility shall have an introductory orientation program for all staff. This program shall include orientation to emergency and safety procedures and the responsibilities of the staff member's job assignment.

B. Tuberculosis Clearance: Prior to employment each staff member must have a certificate from a physician or medical facility stating that they are free from tuberculosis in a transmissible form as required by Regulations Governing Control of Communicable Disease in Health Facility Personnel.

C. First Aid/CPR Qualifications:

(1) At least one (1) direct child care staff member on duty must have a current First Aid Certificate.

(2) At least one (1) direct child care staff member on duty must have a current Cardio Pulmonary Resuscitation certification.

D. Child Abuse And Neglect Training: Each staff member of a facility licensed pursuant to these regulations must be thoroughly instructed in the New Mexico State Children's Code concerning definition of abuse and neglect and on their responsibility to report all incidents of child abuse or neglect as provided in Section 32A-4-3 of the New Mexico Children's Code.

[7.8.3.31 NMAC – N, 05/15/01]

7.8.3.32 DIRECT SERVICE STAFF/CHILD RATIO:

The following direct services staff/child ratios must be maintained:

A. For children under the age of six (6) years at least one (1) direct service staff for every six (6) children or fraction thereof.

B. For children over the age of six (6) years at least one (1) direct service staff for every sixteen (16) children or fraction thereof. One (1) direct service staff for every six (6) children under the age of six (6) or fraction thereof, and one (1) direct services staff to every twelve (12) children during the sleeping hours.

[7.8.3.32 NMAC – N, 05/15/01]

7.8.3.33 SUPERVISION OF CHILDREN:

Children must be supervised at all times. In addition:

A. During the sleeping hours of children, a staff member must be immediately available to respond to their needs.

B. The facility must have at least one staff member on call to cover for any staff member on duty in case of illness or emergency.

[7.8.3.33 NMAC – N, 05/15/01]

7.8.3.34 STAFF RECORDS:

A. Each facility licensed pursuant to these regulations must maintain a complete record on file for each staff member or volunteer. Staff records are made available for review upon request of the Licensing Authority. Staff records contain at a minimum the following:

(1) Name;

(2) Address and telephone number;

(3) Position for which employed;

(4) Date first employed;

(5) Documentation of a minimum of three references checked;

(6) A person(s) to contact in case of an emergency;

(7) A copy of the current First Aid and CPR Certificate for direct child care staff;

(8) Health certificate stating that the employee is free from tuberculosis in a transmissible form as required by the New Mexico Department of Health regulations, Control of Communicable Disease in Health Facility Personnel, 7 NMAC 4.4.

(9) A clearance letter from the Department stating the Criminal Records Check has been conducted with negative results as referenced in NMSA 1978 32A-15-3;

B. A daily attendance record of all staff is kept in the facility.

C. The facility shall keep daily schedules of all staff. These schedules are kept on file for at least 12 months. The staff schedule reflects changes as they occur.

[7.8.3.34 NMAC – N, 05/15/01]

7.8.3.35 POLICIES AND PROCEDURES:

All facilities licensed pursuant to these regulations must have written policies and procedures for the following:

A. Reporting of suspected child abuse, neglect or exploitation, pursuant to these regulations.

B. Actions to be taken in case of accidents or emergencies involving a child, including death.

C. Disciplinary methods utilized by the facility.

D. Actions to be taken when a child is found to be absent without authorization.

E. The administration and preparation of medication.

F. The handling of children’s funds.

G. Confidentiality of the children’s records.

H. The use of seclusion rooms and/or restraints, if used by the facility.

I. Maintenance of building(s) and equipment.

J. Fire and evacuation.

K. The handling of complaints received from clients, parents, guardians or any other person.

[7.8.3.35 NMAC – N, 05/15/01]

7.8.3.36 PERSONNEL AND STAFF REQUIREMENTS CRIMINAL RECORDS CHECKS:

A. Criminal Record Checks pursuant to 32A-15-3 NMSA 1978

(1) The agency conducts appropriate, legally permissible and mandated State and federal criminal records inquiries into the background of agency personnel, including employees and volunteers, and prospective employees and volunteers.

(2) Non-compliance with these Criminal Records Checks Standards may result in sanction or loss of license.

B. Staff members who work directly with children and who are counted in the staff-to-child ratio are 18 years of age or older.

C. Persons employed solely for clerical, cooking, maintenance or other support activities who are not left with children unsupervised, are not included in the staff coverage.

[7.8.3.36 NMAC – N, 05/15/01]

7.8.3.37 OUTDOOR PLAY AREAS, EQUIPMENT, TOOLS, VEHICLES, AND OTHER LIKE ITEMS:

A. Facilities providing services to children 12 years of age and younger will have an outdoor play area, meeting the following requirements:

(1) The play area should be provided with equipment appropriate to the age level of the children.

(2) A play area located adjacent to a public street or highway will have the play area fenced with at least one latched gate available for emergency exits. All stationary outdoor play equipment for children should be positioned in a way that helps prevent accidents, permits freedom of action, and is securely fastened to the ground. Outdoor play equipment for children shall include energy-absorbing surfaces and be maintained in good repair at all times.

B. Power-driven tools and equipment, motor vehicles, chemicals, and like items of a dangerous nature are kept locked and secured from children. Any use of such items by the children is done only under the close supervision of a staff member.

[7.8.3.37 NMAC – N, 05/15/01]

7.8.3.38 COUNSELING AREA:

A facility will provide a designated room or area to allow private discussions and counseling sessions, as appropriate, between individual children, families, staff and others as appropriate.

[7.8.3.38 NMAC – N, 05/15/01]

7.8.3.39 EDUCATION:

Each facility licensed pursuant to these regulations ensures that every child in residence attend(s) an appropriate education program in accordance with New Mexico State law.

[7.8.3.39 NMAC – N, 05/15/01]

7.8.3.40 TRANSPORTATION:

Each facility licensed pursuant to these regulations, which transports children as part of their program activities, meets the following requirements:

A. Any vehicle used for transporting children must carry vehicle liability insurance. The amount of coverage may not to be less than the basic limits set by the Financial Responsibility Law.

B. Each vehicle used for transportation of children must be licensed, registered and meet all applicable laws of the State of New Mexico.

C. Occupancy in a vehicle cannot exceed the capacity recommended by the manufacturer.

D. Drivers of vehicles used to transport children must be licensed and abide by State and local laws;

E. Seat belt restraint laws of the State of New Mexico must be adhered to at all times; each child must remain seated while the vehicle is in motion and age-appropriate restraints must be used during transportation.

F. Children may not be transported in the open bed of trucks.

G. Each vehicle used for transportation of children must be equipped with a fire extinguisher, water, blanket, first aid kit, and first aid book.

H. Children must be loaded and unloaded at the curb side of the vehicle.

[7.8.3.40 NMAC – N, 05/15/01]

7.8.3.41 IMMUNIZATIONS:

A. Every child in the facility must be immunized according to the immunization schedule of the New Mexico Health Department, Public Health Division.

B. When an immunization record cannot be obtained for the child at the time of admission or within 30 days after admission, the facility arranges for all immunizations required by the Department of Health. EXCEPTION: Children's Crisis Shelters may accept children with no immunization schedule.

C. Exemptions from immunizations for religious or other grounds are only accepted if approved by the Public Health Division of the Department of Health.

[7.8.3.41 NMAC – N, 05/15/01]

7.8.3.42 NOTIFIABLE DISEASES:

A. A current list of notifiable diseases must be posted in each facility.

B. While in a facility, any child who becomes ill from a suspected notifiable disease, as defined by the New Mexico Department of Health is immediately referred to a physician or medical facility.

C. Each facility reports any notifiable disease occurring to a child to the local Public Health Field Office.

[7.8.3.42 NMAC – N, 05/15/01]

7.8.3.43 MANAGEMENT OF DRUGS AND PHARMACEUTICALS:

A. The facility must have written procedures, approved by a physician, pharmacist or nurse regarding how staff should administer over-the-counter medications to children in care. Other than over-the-counter medications, a facility does not acquire, store or dispense medications. EXCEPTION: Facilities providing services which require regular use of controlled and/or prescription medication for the children under care must hold and display an appropriate drug permit as determined by the State Board of Pharmacy.

B. All medications and poisonous substances must be kept in a locked cabinet or other container inaccessible to the children. The key to the medication storage container is only available to the authorized staff.

C. Poisonous substances and medications labeled for "external use only" are not accessible to children and are kept separate from other medication.

D. Medications prescribed for one child are not to be given to any other child.

E. All prescribed medications are kept in their original prescription containers. Only medications which can be self-administered by the child or with assistance and supervision in self-administration are kept in the facility. The staff member assisting in self administration of medication may hold the container, assist the child in opening the container and assist the child in self-administering the medication.

F. Medication for self-administration is not prepared in advance.

G. All medication given to a child is entered in the child's record with the date, time and dosage and initials of the staff member assisting with the self-administration of the medication.

H. Medications which require refrigeration are kept in a separate locked box within a refrigerator, a locked refrigerator, or a refrigerator in a locked room.

I. All outdated medications are disposed of in a manner approved by the State Board of Pharmacy.

[7.8.3.43 NMAC – N, 05/15/01]

7.8.3.44 CHILDREN'S ROOMS:

A. Each child's room must be provided with, but not limited to the following:

(1) A bed as defined in 7.8.3.44 of these regulations;

(2) A dresser or other adequate storage space for private use;

(3) An individual closet or closet areas with a clothes rack and a shelves accessible to the child;

(4) A table or desk with a reading lamp and chair, or a well-lighted area within the facility with desk or table for a study area;

(5) Window shades, drapes, or blinds in good repair.

B. Any item other than the bed may be removed from a child's room if it is documented in the child's record that such items would be a danger to the health or safety of the child.

C. For facilities providing care to children under two (2) years of age, no more than seven children of that age will occupy a designated bedroom space.

[7.8.3.44 NMAC – N, 05/15/01]

7.8.3.45 SPECIAL REQUIREMENTS FOR INFANT CARE:

A facility licensed pursuant to these regulations who cares for children under age two (2) must meet the following requirements:

A. Toilet training equipment must be kept clean and in a sanitary condition.

B. Staff members must wear non-porous single-use gloves and wash their hands with soap after diapering and before and after feeding any child.

C. Children's hands must also be washed with soap after diapering and before and after eating.

D. Bed linens, clothes, and diapers must be changed when soiled.

E. Diapers must be changed at the child's individual crib or at a diaper table which must be thoroughly cleaned following each use.

F. Dirty diapers must be kept in closed containers.

G. Infants must be held during feeding. Bottles must not be propped.

H. Children who prefer to bottle-feed themselves may be allowed to do so with supervision.

I. Provisions must be made to allow for each child's own eating and sleeping patterns.

J. Those children who are non-walking but capable of crawling or creeping, shall be given the opportunity to do so frequently during the day.

[7.8.3.45 NMAC – N, 05/15/01]

7.8.3.46 CHILDREN'S BEDS, CRIBS AND HIGH CHAIRS:

A. The following minimum requirements for beds must be met by a facility licensed pursuant to these regulations:

(1) Children's beds are at least 30 inches wide, of sturdy construction and in good repair.

(2) If bunk beds are used, the vertical distance between the mattresses is sufficient to allow each occupant to sit up comfortably in bed.

(3) Each bed has a clean, comfortable, nontoxic mattress which is waterproof or has a waterproof covering and a comfortable mattress pad.

(4) Each bed is provided with a clean, comfortable pillow and pillow case.

(5) Each bed is provided with two clean sheets and bedding that is appropriate for weather and climate.

(6) Beds are spaced at least 36 inches apart.

B. The following minimum requirements for cribs must be met by a facility licensed pursuant to these regulations:

(1) Cribs must be of sturdy construction with bars closely spaced so that a child's head cannot be caught between the bars.

(2) Cribs must have clean, individual crib size bedding.

(3) The crib mattress must be completely and securely covered with waterproof material.

(4) Stacking cribs is prohibited.

(5) The minimum spacing between cribs when occupied must be thirty (30") on all sides, except sides that are against a wall.

C. High chairs must have safety straps and be of non-tip construction.

[7.8.3.46 NMAC – N, 05/15/01]

7.8.3.47 LIVING AND/OR MULTI PURPOSE ROOMS:

Rooms for living or multi-purpose use are to be provided with reading lamps, tables, chairs, or couches. The furnishings must be well constructed, comfortable and kept in good repair.

[7.8.3.47 NMAC – N, 05/15/01]

7.8.3.48 DINING AREA:

A dining area is to be provided for meals.

A. Tables and chairs for the dining area shall accommodate the number of children for whom the facility is licensed and will be appropriate to the age of the clients served.

B. The living and/or multi purpose room may be used as a dining area if the dining area portion does not exceed 50 percent of the available floor space and still allows comfortable arrangement of necessary furnishings for a living area.

[7.8.3.48 NMAC – N, 05/15/01]

7.8.3.49 LAUNDRY AND LINEN SERVICES:

A. The facility provides laundry services to the children either on the premises or by use of a commercial laundry or linen service. The following are minimum requirements for clean linen:

(1) The sheets and pillow case are changed at least one time per week and/or when there is a change of occupant.

(2) The mattress pad, blankets and bedspread are laundered at least one time per month and/or when there is a change of an occupant. The mattress is turned at least one time per month.

(3) A face towel, bath towel, and washcloth are changed at least every other day.

B. If laundry services are provided on the premises, each laundry room or area is equipped with a washer and dryer.

C. Children may do their own laundry if they are capable and wish to do so, or if it is part of their training or rehabilitation program.

D. Soiled linen and clothing must be stored in containers which are waterproof, easily cleaned and have tight fitting lids, until washed.

E. Under no circumstance is collection, sorting, storage, or washing of soiled clothing or linens done in a food preparation, food storage, or food service area.

F. A separate, dry, well-ventilated storage area for clean linen shall be provided.

[7.8.3.49 NMAC – N, 05/15/01]

7.8.3.50 CLOTHING:

A. Each child shall have his or her own clothing which is clean, neat, in good repair and appropriate to the season.

B. If necessary, children's clothing may be inconspicuously marked with his or her name.

C. The use of a common clothing pool is strictly prohibited.

[7.8.3.50 NMAC – N, 05/15/01]

7.8.3.51 PERSONAL POSSESSIONS:

A. A facility will allow a child in care to bring his or her personal belongings to the facility and to acquire belongings of their own while living in the facility.

B. The facility may, within reason, and because of the child's program, limit or supervise the use of these items while the child is in residence.

C. Where extraordinary limitations are imposed, the child is informed by the facility of the reasons, and the reasons are recorded in the child's record.

D. The facility makes provisions for the protection of the children's property.

[7.8.3.51 NMAC – N, 05/15/01]

7.8.3.52 PETS:

A. Pets are permitted and encouraged in a facility licensed pursuant to these regulations for the enjoyment of the children.

B. Pets are not permitted to eat or sleep in the kitchen or food preparation areas.

C. Pets are inoculated as required by state or local law and records of inoculation kept on file in the facility.

[7.8.3.52 NMAC – N, 05/15/01]

7.8.3.53 PERSONAL HYGIENE:

Each child is provided with his/her own clearly identified toothbrush, comb, hair brush and other items for personal hygiene.

[7.8.3.54 NMAC – N, 05/15/01]

7.8.3.54 MEDICAL CARE:

A. A facility licensed pursuant to these regulations arranges for a general medical examination by a physician for each child in care within 90 calendar days of admission unless the child has received such an examination within 12 months before admission and the results of the examination are available to the facility.

B. The facility arranges to secure timely and medically appropriate treatment for any condition discovered by the medical examination.

C. The facility arranges periodic medical examination of all children at intervals recommended by the physician.

D. The facility ensures that children receive timely, competent medical care when they are ill and that they continue to receive necessary follow-up medical care.

E. The facility arranges to secure any necessary dental care.

F. Each child more than three years of age has an annual dental examination.

G. Each facility has a first aid kit and first aid manuals readily accessible to the staff and secure from the children.

H. The first aid kit contains, at a minimum, band aids, gauze pads, adhesive tape, scissors, soap, and syrup of Ipecac, gloves and a thermometer.

I. In case of accidental poisoning, the facility immediately contacts the Poison Control Center and its directions are followed.

J. Syrup of Ipecac is not given to any child without first contacting the Poison Control Center.

K. A facility will treat blood spills cautiously and promptly disinfect the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A facility will clean contaminated surfaces first with hot soapy water then with a disinfecting solution effective against HIV and Hepatitis B.

[7.8.3.54 NMAC – N, 05/15/01]

7.8.3.55 NUTRITION:

A. Each facility licensed pursuant to these regulations provides to the children a planned, nutritionally adequate diet.

B. When the food service of the facility is not directed by a nutritionist or dietitian, regular, planned consultation with a nutritionist or dietitian is obtained by the facility.

C. A copy of the current week's menu is posted in the kitchen of the facility.

D. Posted menus are followed and any substitution is of equivalent nutritional value and is recorded on the posted menu.

E. The facility must keep one month of menus as served on file.

F. The facility provides at least three meals a day served at regular times, as follows:

(1) Normally not more than a 14-hour span between the evening meal and breakfast the following day.

(2) Normally not less than 8 hours between breakfast and the evening meal of the same day.

G. The same main dishes are not served within a week period. Identical menus are not served on a one-week-cycle basis.

H. Time allowed for meals is sufficient to enable the children to eat at a leisurely rate, encourage socialization and to provide a pleasant mealtime experience.

[7.8.3.55 NMAC – N, 05/15/01]

7.8.3.56 FOOD MANAGEMENT:

A. Each facility meets the requirements of all state and local regulations governing food service, posts inspection reports in a conspicuous place and maintains a file of any deficiencies noted in an inspection.

B. Each facility has a copy of the current applicable Food Service Regulations as published by the Environmental Improvement Division. EXCEPTION: Those facilities which have a written exemption from the Environmental Improvement Division or recognized local authority.

C. Dry and evaporated milk may be reconstituted only if used for cooking purposes. All milk for drinking is Grade-A pasteurized and served directly from its original container or from a dispenser approved by the Environmental Improvement Division.

D. Potentially hazardous food such as meat, milk and custard are kept at 40 degrees F or below. Hot food is kept at 140 degrees F or above during preparation and service.

E. Each refrigerator and freezer contains an accurate thermometer reading within 2 degrees F, located in the warmest part of the appliance in which food is stored. The temperature of the refrigerator is 40 degrees F or below. The temperature for the freezer is 32 degrees or below.

F. Refrigerators, freezers, cupboards and other food storage areas are kept clean and sanitary at all times.

G. Drugs, biologicals, poisons, stimulants, detergents, and cleaning supplies are not kept in the same storage area used for storage of foods.

H. Dishes and utensils are properly washed, sanitized, and stored in accordance with food service regulations.

I. All garbage is stored in containers which are waterproof, easily cleaned, and have tight-fitting lids.

[7.8.3.56 NMAC – N, 05/15/01]

7.8.3.57 BUILDING REQUIREMENTS:

A. All facilities licensed pursuant to these regulations are accessible to, and usable by, disabled employees, staff, visitors, and clients.

B. Trailers and mobile homes are not used for living or activity areas for children.

C. In the design or selection of a building, attention is given to the special needs of the children and staff. Conditions which are detrimental to health, safety, and welfare of the children are to be avoided.

D. All buildings on the premises housing children will be considered part of the facility and must meet all requirements of these regulations. Children living in any building on the premises will be counted in the capacity of the facility.

E. A facility applying for licensure pursuant to these regulations may be subject to additional requirements not contained herein. Building and fire codes and other applicable standards of city, county, or municipal governments may establish such additional requirements. Applicable standards may be incorporated by the Licensing Authority in its licensing process.

[7.8.3.57 NMAC – N, 05/15/01]

7.8.3.58 MAINTENANCE OF BUILDINGS AND GROUNDS:

A. Facilities must maintain the building(s) and grounds in good repair at all times. Such maintenance includes, but is not limited to, the following:

(1) All electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems must be maintained in a safe and functioning condition, including regular inspections of these systems.

(2) All equipment used for client care must be kept clean and in good repair.

(3) All furniture and furnishings must be kept clean and in good repair.

B. The grounds of the facility must be maintained in a safe and sanitary condition at all times.

[7.8.3.58 NMAC – N, 05/15/01]

7.8.3.59 HOUSEKEEPING:

A. The facility must be kept free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

B. Children's rooms, examination rooms, meeting rooms, waiting rooms and other areas of daily usage must be cleaned daily.

C. Floors and walls shall be constructed of a finish that can be easily cleaned. The floor polishes will provide a slip-resistant finish.

D. Bathrooms, lavatories, and drinking fountains shall be cleaned daily and as often as necessary to maintain a clean and sanitary condition.

E. Deodorizers may not be used to mask odors caused by unsanitary conditions or poor housekeeping practices.

F. Combustibles such as cleaning rags and compounds must be kept in closed metal containers in areas providing adequate ventilation and away from childrens' rooms and common areas.

G. Poisonous or flammable substances must not be stored in residential sleeping areas, food preparation areas or food storage areas. All poisonous substances must be kept in a locked cabinet or other container inaccessible to the children and away from living and common areas.

H. Storage areas shall be kept free from accumulations of refuse, discarded equipment, furniture, paper, and the like.

[7.8.3.59 NMAC – N, 05/15/01]

7.8.3.60 WATER:

A. A facility licensed pursuant to these regulations shall be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system is inspected, tested, and approved by the New Mexico Environment Department prior to license. It is the facility's responsibility to ensure that subsequent periodic testing or inspection of such private water system is made at intervals prescribed by the New Mexico Environment Department or other recognized authority. The facility must maintain copies of all inspection reports and certificates pertaining to its water supply.

C. Hot and cold running water shall be distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

D. Back flow preventers (vacuum breakers) shall be installed on hose bibs, laboratory sinks, janitor's sinks, and on all other water fixtures to which hoses or tubing can be attached.

E. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water provided to hand washing facilities shall not exceed 110 degrees F.

[7.8.3.60 NMAC – N, 05/15/01]

7.8.3.61 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes must be disposed into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system in use is inspected and approved by the New Mexico Environment Department or recognized local authority. The facility must maintain copies of all inspection reports and certificates issued pertaining to its waste disposed system(s).

C. Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of solid wastes generated by the facility is inspected and approved by the New Mexico Environment Department or recognized local authority.

D. Facilities licensed pursuant to these regulations which generate infectious waste ensure that the method of disposal of such wastes meets the requirements of the New Mexico Environment Department or recognized local authority.

E. All garbage and refuse receptacles are durable, have tight fitting-lids, are insect/rodent proof, washable, leakproof and constructed of materials which do not absorb liquids. Receptacles are kept clean.

[7.8.3.61 NMAC – N, 05/15/01]

7.8.3.62 FIRE SAFETY CLEARANCES AND INSPECTIONS:

A. All current applicable requirements of State and local codes for fire prevention and safety must be met by the facility. The facility maintains a copy of all applicable inspection reports and certifications.

B. Each facility requests from the fire authority having jurisdiction an annual inspection of the facility. If the policy of the fire authority having jurisdiction does not

provide for an annual inspection of the facility, the facility documents the date the request was made and to whom. If the fire authority does conduct annual inspections, a copy of the latest inspection is kept on file in the facility.

C. Written documentation from the State Fire Marshal's office or fire authority having jurisdiction evidencing a facility's compliance with applicable fire prevention codes must be submitted to the Licensing Authority prior to issuance of an initial license.

D. Each facility must have an evacuation plan conspicuously posted in each separate area of the building showing routes of evacuation in case of fire or other emergency.

[7.8.3.62 NMAC – N, 05/15/01]

7.8.3.63 FIRE SAFETY:

A. All staff of the facility knows the location of, and is instructed in, proper use of fire extinguishers procedures to be observed in case of fire or other emergency. The facility requests the fire authority having jurisdiction to give periodic instruction in fire prevention and techniques of evaluation.

B. Facility staff is instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, faulty equipment, blocked exits or exit ways, and any other condition which could cause burns, falls, or other personal injury to the children or staff.

C. Each child is, upon being accepted into the facility, given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and is instructed in accordance with their abilities on actions to be taken in case of fire or other emergencies.

D. The facility must conduct a least one fire and evacuation drill each month.

(1) Logs are maintained by the facility showing the date, time, names of staff participating in the drill and outlining any problems noted in the conduct of the drill.

(2) Fire drills are held at different times of the day. When conducting fire drills, emphasis is placed upon orderly evacuation, under proper discipline, rather than upon speed.

E. An easily accessible telephone for summoning help in case of an emergency must be available in the facility.

F. A list of emergency numbers, including, but not limited to, fire department, police department, ambulance services, and Poison Control Center must be prominently posted by each telephone.

[7.8.3.63 NMAC – N, 05/15/01]

7.8.3.64 FIRE DETECTION AND RESPONSE SYSTEMS:

A. A manually-operated, electrically monitored fire alarm system must be installed in each facility as required by the National Fire Protection Association 101 (Life Safety Code or Uniform Building Code). Multiple-story facilities require manual alarm systems.

B. The facility must be equipped with smoke detectors as required by the NFPA 101 (Life Safety Code or Uniform Building Code) and approved in writing by the fire authority having jurisdiction as to number, type and placement.

C. Approved smoke detectors powered by house electrical service with battery back up must be installed to provide when activated an alarm which is audible in all sleeping areas.

D. Smoke detectors must be installed in corridors at no more than thirty (30) feet spacing. Areas of assembly such as the dining and living room must be provided with smoke detectors. All smoke detectors must be connected to the electrical system of the facility and have battery back up.

E. The facility must have a heat or smoke detector in the kitchen powered by the electrical system of the facility and which has battery back up.

F. Fire extinguishers as approved by the State Fire Marshal or fire prevention authority having jurisdiction must be located in the facility. Facilities must as a minimum have two (2) 2AIOBC fire extinguishers, one (1) located in the kitchen or food preparation area, and one (1) centrally located in the facility.

G. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment must be properly maintained and inspected as recommended by the manufacturer, State Fire Marshal or fire authority having jurisdiction.

H. All fire extinguishers shall be inspected yearly and recharged as specified by the manufacturer, State Fire Marshal, or fire authority having jurisdiction. All fire extinguishers must be tagged, noting the date of inspection.

I. Facility carpeting must be of at least a Class II rating.

[7.8.3.64 NMAC – N, 05/15/01]

7.8.3.65 LIGHTING AND LIGHTING FIXTURES:

A. The facility must ensure that lighting is sufficient to make all parts of each of the following areas clearly visible:

(1) All spaces occupied by children and staff, machinery, or equipment within buildings, approaches to buildings, and parking lots;

(2) All storerooms, stairways, hallways, entrances, exits, access ways, and other areas used by children and staff.

B. All lighting fixtures must be shielded.

[7.8.3.65 NMAC – N, 05/15/01]

7.8.3.66 EMERGENCY LIGHTING:

A. A facility must provide emergency lighting which activates automatically upon disruption of electrical service.

B. The emergency lighting must be sufficient to illuminate paths of entrance and egress to the facility.

[7.8.3.66 NMAC – N, 05/15/01]

7.8.3.67 EXITS:

A. Each facility and each floor of a facility must have exits as required/permitted by the National Fire Protection Association 101 (Life Safety Code) or Uniform Building Code.

B. Each facility must have at least two approved exits, remote from each other.

C. Each exit must be clearly marked with signs having letters at least six inches high whose principal strokes are at least : of an inch wide. Exit signs must be visible at all times.

D. Exits, exit paths, or means of egress must not pass through hazardous areas, storerooms, closets, bedrooms, or spaces subject to locking.

E. Sliding doors are not considered acceptable as required exits.

F. When illuminated exit signs are present, they are maintained in operable condition.

G. Exit ways must be kept free from obstructions at all times.

H. Exit doors must be at least 36" wide.

[7.8.3.67 NMAC – N, 05/15/01]

7.8.3.68 ELECTRICAL STANDARDS:

A. All electrical installation and equipment must comply with all current state and local codes.

B. Circuit breakers or fused switches that provide electrical disconnection and over current protection must be:

(1) Enclosed or guarded to provide a dead front assembly;

(2) Readily accessible for use and maintenance;

(3) Set apart from traffic lanes;

(4) Located in a dry, ventilated space, free of corrosive fumes or gases;

(5) Able to operate properly in all temperature conditions;

(6) Located on the same floor and in the same facility area as the circuits they serve;

(7) Marked, showing the area each circuit breaker or fused switch services;

C. The use of jumpers or devices to bypass circuit breakers or fused switches is prohibited.

[7.8.3.68 NMAC – N, 05/15/01]

7.8.3.69 ELECTRICAL CORDS AND RECEPTACLES:

A. Electrical cords and extension cords must be U/L approved.

B. Electrical cords and extension cords must be replaced as soon as they show wear.

C. Under no circumstances may extension cords be used as a general wiring method, or used in a series.

D. Extension cords must be plugged into an electrical receptacle within the room where used and are not connected in one room and extended to another room.

E. Duplex grounded type electrical receptacles (convenience outlets) must be installed in all areas in sufficient quantities for tasks to be performed as needed.

F. The use of multiple sockets (gang plugs) in electrical receptacles is strictly prohibited. Surge protectors are not considered gang plugs under these regulations.

G. The main electrical service line has a readily available disconnect switch. All staff of the facility must know the location of the electrical disconnect switch and how to operate it in case of an emergency.

H. Facilities that care for children less than six years of age must have safety electrical receptacles or provide protective covers.

[7.8.3.69 NMAC – N, 05/15/01]

7.8.3.70 HEATING, VENTILATION, AND AIR-CONDITIONING:

A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes.

B. The heating method used by the facility has a minimum of 68 degrees Fahrenheit with controls provided for adjusting the temperature as appropriate for client and staff comfort.

C. The use of unvented heaters, open flame heaters or portable heaters is prohibited.

D. A supply of outside air sufficient to assure proper combustion must be provided in all spaces where fuel-fired boilers, furnaces, or heaters are located to assure proper combustion.

E. All fuel-fired boilers, furnaces, or heaters must be connected to an approved venting system to take the products of combustion directly to the outside air.

F. Each facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means.

G. All gas-fired heating equipment must be provided with a 100 percent automatic cutoff control valve that operates in the event of pilot failure.

H. The facility must be provided with a system for maintaining client and staff comfort during periods of hot weather.

I. All boilers, furnaces or heater rooms are protected from other parts of the building by construction having a fire resistance rating of not less than one hour and doors which are self-closing with a three-quarters of an hour fire resistance.

J. All central ventilation and air condition systems must have provided filters having efficiencies greater than 25 percent.

K. All gas-burning heating and cooking equipment must be connected to an approved venting system to take the products of combustion directly to the outside air.

L. All openings to the outer air used for ventilation must be screened with screening material of not less than 16 meshes per lineal inch.

M. Screen doors must be equipped with self-closing devices.

N. A facility will install barriers or take other steps to ensure heating units are inaccessible to children. Heating units include hot water pipes, hot water baseboard heaters hotter than 110 degrees Fahrenheit, fireplaces, fireplace inserts and wood stoves.

[7.8.3.70 NMAC – N, 05/15/01]

7.8.3.71 WATER HEATERS:

A. Fuel-fired hot water heaters must be enclosed and separated from other parts of the building by construction as required by current state and local building codes. Any inspection report or certificate is maintained by the facility.

B. All water heaters must be equipped with a pressure relief valve (pop-off valve) vented to the outside or a drain in the building.

C. Water heaters must not be located in sleeping rooms, or rooms opening into sleeping rooms.

[7.8.3.71 NMAC – N, 05/15/01]

7.8.3.72 TOILETS, SINKS AND BATHING FACILITIES:

A. All fixture and plumbing must be installed in accordance with current state and local plumbing codes.

B. All toilets must be enclosed and vented.

C. All toilet rooms must be provided with a lavatory for hand washing.

D. All toilet rooms must be kept supplied with toilet paper.

E. All lavatories for hand washing must be kept supplied with disposable towels for hand drying or provided with a mechanical blower. The use of a common towel is prohibited.

F. The location, type and minimum number of toilets, sinks and bathing facilities are as follows:

(1) Toilets and sinks for children must be provided in a ratio of at least one (1) toilet and one (1) sink for every six children in care.

(2) Showers and/or tubs must be provided in a ratio of at least one (1) shower and/or tub for every six children in care.

G. If a facility provides services to both sexes, separate facilities must be provided for each sex in the same ratio as stated above.

H. A combination of a tub and shower is permitted.

I. Tubs and/or showers have a slip resistant surface.

J. Facilities serving disabled children must have grab bars in tubs and showers.

K. Facilities serving disabled children must have toilet room doors that swing out.

L. If a facility has live-in staff, a separate toilet, sink, and bathing facilities for staff must be provided and are not counted in the ratios stated above.

M. Toilets, sinks, and bathing facilities must be readily available to children. No passage through a child's room by another child to reach a toilet, sink or bathing facility is permitted.

N. New facilities must have a minimum of one (1) toilet and (1) bathing facility which meet the requirements for the disabled.

O. A facility providing services to children under age two (2) must have a hand washing sink in the bedroom area, or a bathroom in the bedroom area.

[7.8.3.72 NMAC – N, 05/15/01]

7.8.3.73 CORRIDORS:

A. Corridors in each facility must have a minimum width of 36 inches.

B. Corridors in newly constructed facilities must have a minimum width of 44 inches.

C. Corridors must have a clear ceiling height of not less than 7 feet measured from the lowest projection of the ceiling.

D. Corridors must remain clear and free of obstructions at all times.

E. In facilities contained within existing commercial or residential buildings, lesser corridor widths may be allowed if not in conflict with building or fire codes and if approved by the Licensing Authority prior to occupying the facility.

[7.8.3.73 NMAC – N, 05/15/01]

7.8.3.74 DOORS:

A. All exit doors must have a minimum width of 36 inches.

B. All sleeping room doors must have at least one and three quarter inches bonded solid core, with a minimum width of 32 inches.

C. All doors to toilet and bathing facilities must have a minimum width of 24 inches.

D. Locks on doors to toilets must be of a type that the lock can be released from the outside.

E. Exit doors leading to the outside of a facility with a capacity of ten or more children must open outward.

F. Exit doors leading to the outside of a facility must be provided with a night latch, dead bolt or security chain, provided such devices open from the inside without the use of a key or tool and are mounted at a height not to exceed 48 inches above the finished floor.

G. Sleeping room doors for non-mobile children must be at least one and three quarter inches bonded solid core, with a minimum width of 44 inches.

H. Each sleeping room housing non-mobile children must have a 44-inch exit door leading directly to the outside.

[7.8.3.74 NMAC – N, 05/15/01]

7.8.3.75 MINIMUM ROOM DIMENSIONS:

A. All habitable rooms in a facility must have a ceiling height of not less than seven feet, six inches.

B. Kitchens, halls, bathrooms and toilet compartments must have a ceiling height of not less than seven feet.

C. All habitable rooms other than a kitchen must not be less than seven feet in any dimension.

D. Any room with a sloped ceiling is subject to review and approval or disapproval by the Licensing Authority, based upon Uniform Building Code computation of minimum area.

[7.8.3.75 NMAC – N, 05/15/01]

7.8.3.76 WINDOWS:

A. Children's sleeping rooms and activity rooms must have a window area of at least one-tenth the floor area with the minimum allowed total being 10 square feet.

B. Sleeping rooms must provide at least one window for egress or rescue with a minimum net clear opening of 5.7 square feet. The minimum net clear opening for height dimensions is 24 inches. The minimum net clear opening width dimension is 20 inches.

C. Egress and rescue windows must have a finished sill height of not more than forty-four inches above the floor. EXCEPTION: If the sleeping room has a door leading directly to the outside, an egress/rescue window is not required.

D. Bars, grills, and grates or similar devices may be installed on emergency escape or rescue windows or doors only if equipped with release mechanisms which can be opened from the inside without the use of a key, knowledge or effort.

[7.8.3.76 NMAC – N, 05/15/01]

7.8.3.77 CHILDREN'S ROOMS:

A. Each child's room must be an outside room.

B. There must be no through traffic through children's rooms.

C. Single rooms must have at least 80 square feet of floor area. Closet and locker areas are not counted as part of the floor area.

D. Not more than four children over the age of two (2) may occupy a designated bedroom space. EXCEPTION: Children's Crisis Shelters may have dormitory type sleeping areas with no limitation on the number of children as long as minimum square footage requirements are met.

E. Facilities which provide care and services to non-mobile children must have at least 100 square feet of floor area for each non-mobile resident.

F. Rooms having more than one child must have at least 60 square feet for each bed; or at least 90 square feet of floor area for each bunk, if double bunks are used. Closet and locker area are not be counted as part of the available floor space.

[7.8.3.77 NMAC – N, 05/15/01]

7.8.3.78 FLOORS AND WALLS:

A. Floor material must be readily cleanable and wear resistant.

B. In all areas subject to wet cleaning, floor materials must not be physically degradable by liquid germicidal or cleaning solution.

C. Floors subject to traffic while wet must have a slip resistant surface.

D. Wall finishes must be washable and, in the proximity of plumbing fixtures, must be smooth and moisture resistant.

E. Wall bases in areas subject to wet cleaning must be covered with flooring and tightly sealed baseboards.

F. Floor and wall areas penetrated by pipes, ducts, and conduits must be tightly sealed to minimize the entry of rodents and insects. Joints of structural elements must be similarly sealed.

G. Threshold and expansion joint covers must be flush with the floor surface to facilitate the use of wheelchairs and carts.

[7.8.3.78 NMAC – N, 05/15/01]

7.8.3.79 ACCESS REQUIREMENTS FOR THE DISABLED IN NEW FACILITIES:

Accessibility to the disabled must be provided in all new facilities and includes, at a minimum, the following:

A. Main entry into the facility must be level or incorporate a ramp to allow for wheelchair access.

B. Building layout must allow for access to main living area and dining area.

C. At least one (1) bedroom must have a door clearance of 32 inches.

D. At least one (1) toilet/bathing facility must provide a 60-inch diameter turning radius.

E. If ramps are used, the slope of each ramp must provide at least a 12-inch horizontal run for each inch of vertical rise.

F. Ramps exceeding a six-inch rise must be provided with handrails.

G. Additional access requirements may apply depending upon the size and complexity of the facility.

[7.8.3.79 NMAC – N, 05/15/01]

7.8.3.80 DISCIPLINE:

A. Discipline used by a facility licensed pursuant to these regulations will be such that it trains the child to develop self control and orderly conduct in relationship to peers and adults.

B. Discipline shall be clear and understandable to the child, consistent, and explained to the child before and at the time of any disciplinary action.

C. Discipline shall include positive guidance, redirection, and the setting of clear cut limits which foster the child's own ability to become self disciplined.

D. Disciplinary practices established by the facility shall be designed to encourage the child to be fair, to respect property, and to assume personal responsibility and responsibility for others.

E. Examples of positive discipline include, but are not limited to, the following:

(1) Brief, supervised separation from the peer group.

(2) Giving additional responsibility for tasks.

(3) Withholding recreational privileges.

(4) Adding study periods, supervised by a responsible staff member.

F. A facility licensed pursuant to these regulations is prohibited from using all cruel, severe, unusual or unnecessary punishments including, but not limited to, the following:

(1) Physical exercises such as running laps or performing push-ups, when used solely as a means of punishment.

(2) Requiring or forcing the child to take an uncomfortable position, such as squatting or bending, or requiring or forcing the child to repeat physical movement when used solely as a means of punishment.

(3) Excessive denial of on-grounds program services or denial of any essential program services solely for disciplinary purposes.

(4) Depriving a child necessary food, water, rest, or opportunity for toileting.

(5) Denial of visiting or communication privileges solely as a means of punishment.

(6) Denial of shelter, clothing, or bedding

(7) Extensive withholding of emotional response or stimulation.

(8) Use of restraints as punishment.

(9) Exclusion of a child from entry to the facility.

(10) Verbal abuse such as shouting, screaming, swearing, name calling or any other verbal activity that is damaging to a child's self respect.

(11) Any form of discipline or punishment which is intended to frighten or humiliate a child.

(12) Spanking, hitting, shaking, or otherwise engaging in aggressive physical contact with a child.

(13) Seclusion or isolation of a child in a locked room. EXCEPTION: Facilities licensed pursuant to these regulations are allowed the use of seclusion or security rooms with policies and procedures for their use and under constant staff supervision during their use.

[7.8.3.80 NMAC – N, 05/15/01]

7.8.3.81 SPECIAL REQUIREMENTS FOR SECLUSION ROOMS:

Any facility licensed pursuant to these regulations that uses a seclusion room in its program must comply with all of the following:

A. The room must have no less than 80 square feet of floor area.

B. The door must be of substantial construction either one and three-quarter inches, bonded solid core or metal able to withstand unusual stress.

C. The door must be at least 32 inches wide, preferably 36 inches.

D. The door must swing outward to prevent children from barricading themselves in the room.

E. The door must have a fixed wired glass vision panel not to exceed 1,296 square inches, and mounted in steel or other approved metal frame.

F. A dual lock system that is simple to operate must be on the door. It must have a quickly-operated throw bolt and key lock.

G. The floor must be of substantial construction with a smooth surface so that it presents no danger in terms of materials that peel, splinter, or cause burns.

H. Walls must be of high-impact resistance with nothing protruding from the walls that would allow for climbing by children.

I. The ceiling must be of monolithic construction and unreachable to children.

J. Light fixtures must be security rated and recessed so children cannot break the lens, bulbs, etc.

K. Windows in the room must have security-rated screens with locks that cannot be picked.

L. There must be nothing else in the room, including electrical outlets, switches, holes, hardware, or places to hook things. All heating and air-conditioning registers must be out of reach. There must be no sharp edges in the room such as window sills, baseboards, or wainscots.

M. Rooms must be approved in writing from the State Fire Marshal or fire authority having jurisdiction. These records must be maintained by the facility.

N. There must be an observation room adjoining or nearby the seclusion room that permits continuous close observation by staff of a child placed in the seclusion room.

O. A toilet room with a sink must be immediately accessible to the seclusion room.

[7.8.3.81 NMAC – N, 05/15/01]

7.8.3.82 REGULATIONS GOVERNING COMMUNITY HOMES:

A. All facilities licensed as Community Homes pursuant to these regulations are subject only to Sections 7.8.3.1 through 7.8.3.5; Sections 7.8.3.7 through 7.8.3.9; Sections 7.8.3.11 through 7.8.3.24; and Sections 7.8.3.82 through 7.8.3.127 of these regulations.

B. Community Homes are exempt from all sections of these regulations except those cited in 7.8.3.2 (Scope) and 7.8.3.82 above. Community Homes are exempt from all references to the word ‘welfare’ in these regulations.

[7.8.3.82 NMAC – N, 05/15/01]

7.8.3.83 OBJECTIVE FOR COMMUNITY HOMES:

A. Establish minimum standards for licensing of Community Homes that provide services in order to promote the health and safety of children in need of such services.

B. Provide for monitoring of facility compliance with these regulations through surveys to identify any factors that could affect the health and safety of the clients or the staff.

[7.8.3.83 NMAC – N, 05/15/01]

7.8.3.84 LICENSING CATEGORY FOR COMMUNITY HOMES:

A. Community Home means a facility that operates twenty-four (24) hours a day providing full time care, supervision and support needed to not more than sixteen (16) resident children in a single residential building and which meets the definition incorporated in 9-8-13 NMSA 1978. The facility provides parenting, activities and experiences needed by a child to develop and realize their full potential.

B. Children's records required for a Community Home:

(1) Personal Information:

(a) Full name

(b) Date of birth

(c) Name address and telephone number of parents or legal guardian.

(d) Birthplace of the child.

(e) Date of admission and source of referral for placement.

(f) Documentation of the current legal status of the child.

(2) Medical Information:

(a) Developmental history.

(b) Immunization record.

(c) History of serious illness or injury.

(d) Physiological evaluation.

(e) Past and current use of prescribed medications.

(f) Any complaints by the child indicating a current need for diagnosis and treatment.

(g) Dates of any dental, visual, auditory, and physical examination and any treatment secured for any conditions discovered.

C. Location of Children's Records: When an agency has multiple Residential Shelter Care Facilities for Children located within the same city or town the primary record may be kept in a central office location, however, each facility must have the following information on file for each child in care.

(1) Full name.

(2) Age.

(3) Name address and phone number of person to contact in case of emergency.

(4) Name address and phone number of physician or medical facility to contact in case of emergency.

(5) Any special problems or medical condition that the child may have.

(6) Medications and dosage if applicable.

[7.8.3.84 NMAC – N, 05/15/01]

7.8.3.85 REPORTING OF INCIDENTS IN COMMUNITY HOMES:

All facilities licensed pursuant to these regulations must report immediately by phone and follow-up in writing to the Licensing Authority within 24 hours, any serious incident or unusual occurrence which has, or could threaten the health and/or safety of the clients or staff of the facility. Such incidents may include, but are not limited to:

A. Fire, flood, or other natural disaster which creates structural damages to the facility or poses health hazards;

B. Any suspected sexual or physical abuse, neglect or exploitation of a child.

[7.8.3.85 NMAC – N, 05/15/01]

7.8.3.86 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE COMMUNITY HOMES FACILITY:

A. Each facility licensed pursuant to these regulations maintains the following reports and records on file and makes them available for review upon request by the Licensing Authority:

(1) A copy of the current Residential Shelter Care Regulations;

(2) A copy of the latest fire inspection report by the fire authority having jurisdiction;

(3) A copy of the last survey conducted by the Licensing Authority including any variances granted;

(4) Records of monthly fire and emergency evacuation drills conducted by the facility;

(5) Health certificates of staff;

(6) Agreements or contracts with other health care providers to provide services that are not available in the facility, if applicable;

(7) Latest inspection of drug room by State Board of Pharmacy, if applicable; and

(8) New Mexico Environment Department approval of private waste, sewage disposal, or kitchen, if applicable.

B. New Mexico Environment Department approval of kitchen and food management and, if applicable, survey reports of private water supply, private waste and/or sewage disposal. EXCEPTION: Those facilities which have been exempted by the Environmental Improvement Division or recognized local authority from meeting the requirements for kitchens and food service, have the exemption on file.

C. One month of menus of meals served in the facility.

D. Documentation of staff Criminal Record Checks and verification of employment history as required by these regulations.

E. A valid drug permit issued by the State Board of Pharmacy for those facilities licensed pursuant to these regulations who as a regular part of their program supervise the administration and/or client's self-administration of medication and safeguard medications for the children in care.

F. A copy of the current American Red Cross and Cardiopulmonary Resuscitation certification, or other recognized organization's, Standard First Aid Certificate, for all direct care staff within 90 days of employment.

[7.8.3.86 NMAC – N, 05/15/01]

7.8.3.87 STAFF REQUIREMENTS FOR COMMUNITY HOMES:

A. Criminal Record Checks pursuant to 32A-15-3 NMSA 1978

(1) The agency conducts appropriate, legally permissible and mandated State and federal criminal records inquiries into the background of agency personnel, including employees and volunteers, and prospective employees and volunteers.

(2) Non-compliance with these Criminal Records Checks Standards may result in sanction or loss of license.

B. Staff members who work directly with children and who are counted in the staff-to-child ratio are 18 years of age or older.

C. Persons employed solely for clerical, cooking, maintenance or other support activities who are not left with children unsupervised, are not included in the staff coverage.

D. Tuberculosis Clearance: Prior to employment each staff member must have a certificate from a physician or medical facility stating that they are free from tuberculosis in a transmissible form as required by Regulations Governing Control of Communicable Disease in Health Facility Personnel.

E. First Aid/CPR Qualifications:

(1) At least one (1) direct child care staff member on duty must have a current First Aid Certificate.

(2) At least one (1) direct child care staff member on duty must have a current Cardio Pulmonary Resuscitation certification.

F. Child Abuse And Neglect Training: Each staff member of a facility licensed pursuant to these regulations must be thoroughly instructed in the New Mexico State Children's Code concerning definition of abuse and neglect and on their responsibility to report all incidents of child abuse or neglect as provided in Section 32A-4-3 of the New Mexico Children's Code.

[7.8.3.87 NMAC – N, 05/15/01]

7.8.3.88 DIRECT SERVICE STAFF/CHILD RATIO FOR COMMUNITY HOMES:

The following direct services staff/child ratios must be maintained:

A. For children under the age of six (6) years at least one (1) direct service staff for every six (6) children or fraction thereof.

B. For children over the age of six (6) years at least one (1) direct service staff for every sixteen (16) children or fraction thereof. (1) direct service staff for every six (6) children under the age of six (6) or fraction thereof, and one (1) direct services staff to every twelve (12) children during the sleeping hours.

[7.8.3.88 NMAC – N, 05/15/01]

7.8.3.89 STAFF RECORDS FOR COMMUNITY HOMES:

A. Each facility licensed pursuant to these regulations must maintain a complete record on file for each staff member or volunteer. Staff records are made available for

review upon request of the Licensing Authority. Staff records contain at a minimum the following:

(1) A copy of the current First Aid and CPR Certificate for direct child care staff;

(2) Health certificate stating that the employee is free from tuberculosis in a transmissible form as required by the New Mexico Department of Health regulations, Control of Communicable Disease in Health Facility Personnel, 7 NMAC 4.4.

(3) A clearance letter from the Department stating the Criminal Records Check has been conducted with negative results as referenced in NMSA 1978 32A-15-3;

B. A daily attendance record of all staff is kept in the facility.

C. The facility shall keep daily schedules of all staff. These schedules are kept on file for at least 12 months. The staff schedule reflects changes as they occur.

[7.8.3.89 NMAC – N, 05/15/01]

7.8.3.90 POLICIES AND PROCEDURES FOR COMMUNITY HOMES:

All facilities licensed pursuant to these regulations must have written policies and procedures for the following:

A. Reporting of suspected child abuse, neglect or exploitation, pursuant to these regulations.

B. Actions to be taken in case of accidents or emergencies involving a child, including death.

C. Actions to be taken when a child is found to be absent without authorization.

D. The administration of medication.

[7.8.3.90 NMAC – N, 05/15/01]

7.8.3.91 OUTDOOR PLAY AREAS, EQUIPMENT, TOOLS, VEHICLES, AND OTHER LIKE ITEMS IN COMMUNITY HOMES:

A. Facilities providing an outdoor play area will ensure the following:

(1) All stationary outdoor play equipment for children should be positioned in a way which helps prevent accidents, permits freedom of action, and is securely fastened to the ground.

(2) Outdoor play equipment for children shall include energy-absorbing surfaces and be maintained in good repair at all times.

B. Power-driven tools and equipment, motor vehicles, chemicals, weapons, firearms and like items of a dangerous nature must be kept secure from children. Any use of such items by the children shall be done only under the close supervision of a staff member.

C. A facility will prohibit the use of alcoholic beverages, tobacco, and illegal substances, such as street drugs, on the premises of the facility, including in vehicles.

[7.8.3.91 NMAC – N, 05/15/01]

7.8.3.92 TRANSPORTATION:

Each facility licensed pursuant to these regulations, which transports children as part of their program activities, meets the following requirements:

A. Any vehicle used for transporting children must carry vehicle liability insurance. The amount of coverage may not to be less than the basic limits set by the Financial Responsibility Law.

B. Each vehicle used for transportation of children must be licensed, registered and meet(s) all applicable laws of the State of New Mexico.

C. Occupancy in a vehicle cannot exceed the capacity recommended by the manufacturer.

D. Drivers of vehicles used to transport children must be licensed and abide by State and local laws.

E. Seat belt restraint laws of the State of New Mexico must be adhered to at all times; each child must remain seated while the vehicle is in motion and age-appropriate restraints must be used during transportation.

F. Children may not be transported in the open bed of trucks.

G. Each vehicle used for transportation of children must be equipped with a fire extinguisher, water, blanket, first aid kit, and first aid book.

H. Children must be loaded and unloaded at the curb side of the vehicle.

[7.8.3.92 NMAC – N, 05/15/01]

7.8.3.93 IMMUNIZATIONS FOR COMMUNITY HOMES:

A. Every child in the facility must be immunized according to the immunization schedule of the New Mexico Health Department, Public Health Division, immunization schedule.

B. When an immunization record cannot be obtained for the child at the time of admission or within 30 days after admission, the facility arranges for all immunizations required by the Department of Health. EXCEPTION: Children's Crisis Shelters may accept children with no immunization schedule.

C. Exemptions from immunizations for religious or other grounds are only accepted if approved by the Public Health Division of the Department of Health.

[7.8.3.93 NMAC – N, 05/15/01]

7.8.3.94 NOTIFIABLE DISEASES FOR COMMUNITY HOMES:

A. A current list of notifiable diseases must be posted in each facility.

B. While in a facility, any child who becomes ill from a suspected notifiable disease, as defined by the New Mexico Department of Health is immediately referred to a physician or medical facility.

C. Each facility reports any notifiable disease occurring to a child to the local Public Health Field Office.

[7.8.3.94 NMAC – N, 05/15/01]

7.8.3.95 MANAGEMENT OF DRUGS AND PHARMACEUTICALS IN COMMUNITY HOMES:

A. The facility must have written procedures, approved by a physician, pharmacist or nurse regarding how staff should administer over-the-counter medications to children in care.

B. Other than over-the-counter medications, a facility does not acquire, store or dispense medications. EXCEPTION: Facilities providing services which require regular use of controlled and/or prescription medication for the children under care must hold and display an appropriate drug permit as determined by the State Board of Pharmacy.

C. All medications must be kept in a locked cabinet or other container. The key to the medication storage container is only available to the authorized staff.

D. Poisonous substances and medications labeled for "external use only" are not accessible to children and are kept separate from other medication.

E. Medications prescribed for one child are not to be given to any other child.

F. All prescribed medications are kept in their original prescription containers. Only medications which can be self-administered by the child or with assistance and supervision in self-administration are kept in the facility. The staff member assisting in self administration of medication may hold the container, assist the child in opening the container and assist the child in self-administering the medication.

G. Medication prepared for self-administration is not prepared in advance.

H. All medication given to a child is entered in the child's record with the date, time and dosage and initials of the staff member assisting with the self-administration of the medication.

I. Medications which require refrigeration are kept in a separate locked box within a refrigerator, a locked refrigerator, or a refrigerator in a locked room.

J. All outdated medications are disposed of in a manner approved by the State Board of Pharmacy.

[7.8.3.95 NMAC – N, 05/15/01]

7.8.3.96 SPECIAL REQUIREMENTS FOR INFANT CARE IN COMMUNITY HOMES:

A facility licensed pursuant to these regulations who cares for children under age two (2) must meet the following requirements:

A. Toilet training equipment must be kept clean and in a sanitary condition.

B. Staff members must wear non-porous single-use gloves and wash their hands with soap after diapering and before and after feeding any child.

C. Children's hands must also be washed with soap after diapering and before and after eating.

D. Bed linens, clothes, and diapers must be changed when soiled.

E. Diapers must be changed at the child's individual crib or at a diaper table which must be thoroughly cleaned following each use.

F. Dirty diapers must be kept in closed containers.

G. Infants must be held during feeding. Bottles must not be propped.

H. Children who prefer to bottle-feed themselves may be allowed to do so with supervision.

I. Provisions must be made to allow for each child's own eating and sleeping patterns.

J. Those children who are non-walking but capable of crawling or creeping, shall be given the opportunity to do so frequently during the day.

[7.8.3.96 NMAC – N, 05/15/01]

7.8.3.97 CHILDREN'S BEDS, CRIBS AND HIGH CHAIRS IN COMMUNITY HOMES:

A. The following minimum requirements for beds must be met by a facility licensed pursuant to these regulations:

(1) Children's beds are at least 30 inches wide, of sturdy construction and in good repair.

(2) If bunk beds are used, the vertical distance between the mattresses is sufficient to allow each occupant to sit up comfortably in bed.

(3) Each bed has a clean, comfortable, nontoxic mattress which is waterproof or has a waterproof covering and a comfortable mattress pad.

(4) Each bed is provided with a clean, comfortable pillow and pillow case.

(5) Each bed is provided with two clean sheets and bedding that is appropriate for weather and climate.

(6) Beds are spaced at least 36 inches apart.

B. The following minimum requirements for cribs must be met by a facility licensed pursuant to these regulations:

(1) Cribs must be of sturdy construction with bars closely spaced so that a child's head cannot be caught between the bars.

(2) Cribs must have clean, individual crib size bedding.

(3) The crib mattress must be completely and securely covered with waterproof material.

(4) Stacking cribs is prohibited.

(5) The minimum spacing between cribs when occupied must be thirty (30") on all sides, except sides that are against a wall.

C. High chairs must have safety straps and be of non-tip construction.

[7.8.3.97 NMAC – N, 05/15/01]

7.8.3.98 LAUNDRY AND LINEN SERVICES IN COMMUNITY HOMES:

A. The facility provides laundry services to the children either on the premises or by use of a commercial laundry or linen service. The following minimum requirements for clean linen are:

(1) The sheets and pillow case are changed at least one time per week and/or when there is a of occupant.

(2) The mattress pad, blankets and bedspread are laundered at least one time per month and/or when there is a change of an occupant. The mattress is turned at least one time per month.

(3) A face towel, bath towel, and washcloth are changed at least every other day.

B. If laundry services are provided on the premises, each laundry room or area is equipped with a washer and dryer.

C. Children may do their own laundry if they are capable and wish to do so, or if it is part of their training or rehabilitation program.

D. Soiled linen and clothing must be stored in containers which are waterproof, easily cleaned and have tight fitting lids, until washed.

E. Under no circumstance is collection, sorting, storage, or washing of soiled clothing or linens done in a food preparation, food storage, or food service area.

F. A separate, dry, well-ventilated storage area for clean linen shall be provided.

[7.8.3.98 NMAC – N, 05/15/01]

7.8.3.99 PETS IN COMMUNITY HOMES:

A. Pets are not permitted to eat or sleep in the kitchen or food preparation areas.

B. Pets are inoculated as required by state or local law and records of inoculation kept on file in the facility.

[7.8.3.99 NMAC – N, 05/15/01]

7.8.3.100 PERSONAL HYGIENE IN COMMUNITY HOMES:

Each child is provided with his/her own clearly identified toothbrush, comb, hair brush and other items for personal hygiene.

[7.8.3.100 NMAC – N, 05/15/01]

7.8.3.101 MEDICAL CARE IN COMMUNITY HOMES:

A. A facility licensed pursuant to these regulations arranges for a general medical examination by a physician for each child in care within 90 calendar days of admission unless the child has received such an examination within 12 months before admission and the results of the examination are available to the facility.

B. The facility arranges to secure timely and medically appropriate treatment for any condition discovered by the medical examination.

C. The facility arranges periodic medical examination of all children at intervals recommended by the physician.

D. The facility ensures that children receive timely, competent medical care when they are ill and that they continue to receive necessary follow-up medical care.

E. The facility arranges to secure any necessary dental care.

F. Each child more than three years of age has an annual dental examination.

G. Each facility has a first aid kit and first aid manuals readily accessible to the staff and secure from the children.

H. The first aid kit contains, at a minimum, band aids, gauze pads, adhesive tape, scissors, soap, and syrup of Ipecac, gloves and a thermometer.

I. In case of accidental poisoning, the facility immediately contacts the Poison Control Center and its directions are followed.

J. Syrup of Ipecac is not given to any child without first contacting the Poison Control Center.

K. A facility will treat blood spills cautiously and promptly disinfect the area. Staff members will wear non-porous, single-use gloves when handling a blood spill, bloody diarrhea, bloody nose, or any other blood. A facility will clean contaminated surfaces first with hot soapy water then with a disinfecting solution effective against HIV and Hepatitis B.

[7.8.3.101 NMAC – N, 05/15/01]

7.8.3.102 NUTRITION IN COMMUNITY HOMES:

A. Each facility licensed pursuant to these regulations provides to the children a planned, nutritionally adequate diet.

B. When the food service of the facility is not directed by a nutritionist or dietitian, regular, planned consultation with a nutritionist or dietitian is obtained by the facility.

C. A copy of the current week's menu is posted in the kitchen of the facility.

D. Posted menus are followed and any substitution is of equivalent nutritional value and is recorded on the posted menu.

E. The facility must keep one month of menus as served on file.

F. The facility provides at least three meals a day served at regular times, as follows:

(1) Normally not more than a 14-hour span between the evening meal and breakfast the following day.

(2) Normally not less than 8 hours between breakfast and the evening meal of the same day.

G. The same main dishes are not served within a week period. Identical menus are not served on a one-week-cycle basis.

[7.8.3.102 NMAC – N, 05/15/01]

7.8.3.103 FOOD MANAGEMENT IN COMMUNITY HOMES:

A. Each facility must meet the requirements of all state and local regulations governing food service, post a copy of the required permit in a conspicuous place and maintain a file of any deficiencies noted in an inspection report.

B. Each facility has a copy of the current applicable Food Service Regulations as published by the Environmental Improvement Division. EXCEPTION: Those facilities which have a written exemption from the Environmental Improvement Division or recognized local authority.

C. Dry and evaporated milk may be reconstituted only if used for cooking purposes. All milk for drinking is Grade-A pasteurized and served directly from its original container or from a dispenser approved by the Environmental Improvement Division.

D. Potentially hazardous food such as meat, milk and custard are kept at 40 degrees F or below. Hot food is kept at 140 degrees F or above during preparation and service.

E. Each refrigerator and freezer contains an accurate thermometer reading within 2 degrees F, located in the warmest part of the appliance in which food is stored. The temperature of the refrigerator is 40 degrees F or below. The temperature for the freezer is 0 degrees or below.

F. Refrigerators, freezers, cupboards and other food storage areas are kept clean and sanitary at all times.

G. Drugs, biologicals, poisons, stimulants, detergents, and cleaning supplies are not kept in the same storage area used for storage of foods.

H. Dishes and utensils are properly washed, sanitized, and stored in accordance with food service regulations.

I. All garbage is stored in containers which are waterproof, easily cleaned, and have tight-fitting lids.

[7.8.3.103 NMAC – N, 05/15/01]

7.8.3.104 BUILDING REQUIREMENTS FOR COMMUNITY HOMES:

A. All facilities licensed pursuant to these regulations are accessible to, and usable by, disabled employees, staff, visitors, and clients.

B. Trailers and mobile homes are not used for living or activity areas for children.

C. In the design or selection of a building, attention is given to the special needs of the children and staff. Conditions which are detrimental to health and/or safety of the children are to be avoided.

D. All buildings on the premises housing children will be considered part of the facility and must meet all requirements of these regulations. Children living in any building on the premises will be counted in the capacity of the facility. EXCEPTION: The children of staff members who reside on the premises of the facility will not be counted in the capacity.

E. A facility applying for licensure pursuant to these regulations may be subject to additional requirements not contained herein. The complexity of building and fire codes and other applicable standards of city, county, or municipal governments establishes such additional requirements. Applicable standards may be incorporated by the Licensing Authority in its licensing process.

[7.8.3.104 NMAC – N, 05/15/01]

7.8.3.105 MAINTENANCE OF BUILDINGS AND GROUNDS FOR COMMUNITY HOMES:

A. Facilities must maintain the building(s) and grounds in good repair at all times. Such maintenance includes, but is not limited to, the following:

(1) All electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems are maintained in a safe and functioning condition, including regular inspections of these systems.

(2) All equipment used for client care is kept clean and in good repair.

(3) All furniture and furnishings are kept clean and in good repair.

B. The grounds of the facility are maintained in a safe and sanitary condition at all times.

[7.8.3.105 NMAC – N, 05/15/01]

7.8.3.106 HOUSEKEEPING IN COMMUNITY HOMES:

A. The facility is kept free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

B. Children's rooms, examination rooms, meeting rooms, waiting rooms and other areas of daily usage are cleaned daily.

C. Floors and walls are constructed of a finish that can be easily cleaned. The floor polishes will provide a slip-resistant finish.

D. Bathrooms, lavatories, and drinking fountains are cleaned daily and as often as necessary to maintain a clean and sanitary condition.

E. Deodorizers may not be used to mask odors caused by unsanitary conditions or poor housekeeping practices.

F. Combustibles such as cleaning rags and compounds are kept in closed metal containers in areas providing adequate ventilation and away from children's rooms and common areas.

G. Poisonous or flammable substances are not stored in residential sleeping areas, food preparation areas or food storage areas.

H. Storage areas are kept free from accumulations of refuse, discarded equipment, furniture, paper, and the like.

[7.8.3.106 NMAC – N, 05/15/01]

7.8.3.107 WATER FOR COMMUNITY HOMES:

A. A facility licensed pursuant to these regulations must be provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system is inspected, tested, and approved by the New Mexico Environment Department prior to license. It is the facility's responsibility to ensure that subsequent periodic testing or inspection of such private water system is made at intervals prescribed by the New Mexico Environment Department or other recognized authority. The facility must maintain copies of all inspection reports and certificates pertaining to its water supply.

C. Hot and cold running water shall be distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

D. Back flow preventers (vacuum breakers) shall be installed on hose bibs, laboratory sinks, janitor's sinks, and on all other water fixtures to which hoses or tubing can be attached.

E. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water provided to hand washing facilities shall not exceed 110 degrees F.

[7.8.3.107 NMAC – N, 05/15/01]

7.8.3.108 SEWAGE AND WASTE DISPOSAL FOR COMMUNITY HOMES:

A. All sewage and liquid wastes must be disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system used is inspected and approved by the New Mexico Environment Department or recognized local authority. The facility must maintain copies of all inspection reports and certificates issued pertaining to its waste disposed system(s).

C. Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of solid wastes generated by the facility is inspected and approved by the New Mexico Environment Department or recognized local authority.

D. Facilities licensed pursuant to these regulations which generate infectious waste ensure that the method of disposal of such wastes meets the requirements of the New Mexico Environment Department or recognized local authority.

E. All garbage and refuse receptacles are durable, have tight fitting-lids, are insect/rodent proof, washable, leakproof and constructed of materials which do not absorb liquids. Receptacles are kept clean.

[7.8.3.108 NMAC – N, 05/15/01]

7.8.3.109 FIRE SAFETY CLEARANCES AND INSPECTIONS FOR COMMUNITY HOMES:

A. All current applicable requirements of State and local codes for fire prevention and safety must be met by the facility. The facility maintains a copy of all applicable inspection reports and certifications.

B. Each facility requests from the fire authority having jurisdiction an annual inspection of the facility. If the policy of the Fire Authority having jurisdiction does not provide for an annual inspection of the facility, the facility documents the date the request was made and to whom. If the fire authority does conduct annual inspections, a copy of the latest inspection is kept on file in the facility.

C. Written documentation from the State Fire Marshal's office or Fire Authority having jurisdiction evidencing a facility's compliance with applicable fire prevention codes must be submitted to the Licensing Authority prior to issuance of an initial license.

D. Each facility must have an evacuation plan conspicuously posted in each separate area of the building showing routes of evacuation in case of fire or other emergency.

[7.8.3.109 NMAC – N, 05/15/01]

7.8.3.110 FIRE SAFETY COMMUNITY HOMES:

A. All staff of the facility knows the location of, and is instructed in, proper use of fire extinguishers procedures to be observed in case of fire or other emergency. The facility requests the fire authority having jurisdiction to give periodic instruction in fire prevention and techniques of evaluation.

B. Facility staff is instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, faulty equipment, blocked exits or exit ways, and any other condition which could cause burns, falls, or other personal injury to the children or staff.

C. Each child is, upon being accepted into the facility, given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and is instructed in accordance with their abilities on actions to be taken in case of fire or other emergencies.

D. The facility must conduct a least one fire and evacuation drill each month.

(1) Logs are maintained by the facility showing the date, time, names of staff participating in the drill and outlining any problems noted in the conduct of the drill.

(2) Fire drills are held at different times of the day. When conducting fire drills, emphasis is placed upon orderly evacuation, under proper discipline, rather than upon speed.

E. An easily accessible telephone for summoning help in case of an emergency must be available in the facility.

F. A list of emergency numbers, including, but not limited to, fire department, police department, ambulance services, and Poison Control Center must be prominently posted by each telephone.

[7.8.3.110 NMAC – N, 05/15/01]

7.8.3.111 FIRE DETECTION AND RESPONSE SYSTEMS FOR COMMUNITY HOMES:

A. A manually-operated, electrically monitored fire alarm system must be installed in each facility as required by the National Fire Protection Association 101 (Life Safety Code or Uniform Building Code). Multiple-story facilities require manual alarm systems.

B. The facility must be equipped with smoke detectors as required by the NFPA 101 (Life Safety Code or Uniform Building Code) and approved in writing by the fire authority having jurisdiction as to number, type and placement.

C. Approved smoke detectors powered by house electrical service with battery back up must be installed to provide when activated an alarm which is audible in all sleeping areas.

D. Smoke detectors must be installed in corridors at no more than thirty (30) feet spacing. Areas of assembly such as the dining and living room must be provided with smoke detectors. All smoke detectors must be connected to the electrical system of the facility and have battery back up.

E. The facility must have a heat or smoke detector in the kitchen powered by the electrical system of the facility and which has battery back up.

F. Fire extinguishers as approved by the State Fire Marshal or fire prevention authority having jurisdiction must be located in the facility. Facilities must as a minimum have two (2) 2AIOBC fire extinguishers, one (1) located in the kitchen or food preparation area, and one (1) centrally located in the facility.

G. Fire extinguishers, alarm systems, automatic detection equipment and other fire fighting equipment must be properly maintained and inspected as recommended by the manufacturer, State Fire Marshal or fire authority having jurisdiction.

H. All fire extinguishers shall be inspected yearly and recharged as specified by the manufacturer, State Fire Marshal, or fire authority having jurisdiction. All fire extinguishers must be tagged, noting the date of inspection.

I. Facility carpeting must be of at least a Class II rating.

[7.8.3.111 NMAC – N, 05/15/01]

7.8.3.112 LIGHTING AND LIGHTING FIXTURES FOR COMMUNITY HOMES:

A. The facility must ensure that lighting is sufficient to make all parts of each of the following areas clearly visible:

(1) All spaces occupied by children and staff, machinery, or equipment within buildings, approaches to buildings, and parking lots;

(2) All storerooms, stairways, hallways, entrances, exits, access ways, and other areas used by children and staff.

B. All lighting fixtures must be shielded.

[7.8.3.112 NMAC – N, 05/15/01]

7.8.3.113 EMERGENCY LIGHTING FOR COMMUNITY HOMES:

A. A facility must provide emergency lighting which activates automatically upon disruption of electrical service.

B. The emergency lighting must be sufficient to illuminate paths of entrance and egress to the facility.

[7.8.3.113 NMAC – N, 05/15/01]

7.8.3.114 EXITS FOR COMMUNITY HOMES:

A. Each facility and each floor of a facility must have exits as required/permitted by the National Fire Protection Association 101 (Life Safety Code) or Uniform Building Code.

B. Each facility must have at least two approved exits, remote from each other.

C. Each exit must be clearly marked with signs having letters at least six inches high whose principal strokes are at least : of an inch wide. Exit signs must be visible at all times.

D. Exits, exit paths, or means of egress must not pass through hazardous areas, storerooms, closets, bedrooms, or spaces subject to locking.

E. Sliding doors are not considered acceptable as required exits.

F. When illuminated exit signs are present, they are maintained in operable condition.

G. Exit ways must be kept free from obstructions at all times.

H. Exit doors must be at least 36" wide.

[7.8.3.114 NMAC – N, 05/15/01]

7.8.3.115 ELECTRICAL STANDARDS FOR COMMUNITY HOMES:

A. All electrical installation and equipment must comply with all current state and local codes.

B. Circuit breakers or fused switches that provide electrical disconnection and over current protection must be:

(1) Enclosed or guarded to provide a dead front assembly;

(2) Readily accessible for use and maintenance;

(3) Set apart from traffic lanes;

(4) Located in a dry, ventilated space, free of corrosive fumes or gases;

(5) Able to operate properly in all temperature conditions;

(6) Located on the same floor and in the same facility area as the circuits they serve;

(7) Marked, showing the area each circuit breaker or fused switch services;

C. The use of jumpers or devices to bypass circuit breakers or fused switches is prohibited.

[7.8.3.115 NMAC – N, 05/15/01]

7.8.3.116 ELECTRICAL CORDS AND RECEPTACLES FOR COMMUNITY HOMES:

A. Electrical cords and extension cords must be U/L approved.

B. Electrical cords and extension cords must be replaced as soon as they show wear.

C. Under no circumstances may extension cords be used as a general wiring method, or used in a series.

D. Extension cords must be plugged into an electrical receptacle within the room where used and are not connected in one room and extended to another room.

E. Duplex grounded type electrical receptacles (convenience outlets) must be installed in all areas in sufficient quantities for tasks to be performed as needed.

F. The use of multiple sockets (gang plugs) in electrical receptacles is strictly prohibited. Surge protectors are not considered gang plugs under these regulations.

G. The main electrical service line has a readily available disconnect switch. All staff of the facility must know the location of the electrical disconnect switch and how to operate it in case of an emergency.

H. Facilities that care for children less than six years of age must have safety electrical receptacles or provide protective covers.

[7.8.3.116 NMAC – N, 05/15/01]

7.8.3.117 HEATING, VENTILATION, AND AIR-CONDITIONING FOR COMMUNITY HOMES:

A. Heating, air-conditioning, piping, boilers, and ventilation equipment must be furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes.

B. The heating method used by the facility has a minimum of 68 degrees Farenheit with controls provided for adjusting the temperature as appropriate for client and staff comfort.

C. The use of unvented heaters, open flame heaters or portable heaters is prohibited.

D. A supply of outside air sufficient to assure proper combustion must be provided in all spaces where fuel-fired boilers, furnaces, or heaters are located to assure proper combustion.

E. All fuel-fired boilers, furnaces, or heaters must be connected to an approved venting system to take the products of combustion directly to the outside air.

F. Each facility must be adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means.

G. All gas-fired heating equipment must be provided with a 100 percent automatic cutoff control valve that operates in the event of pilot failure.

H. The facility must be provided with a system for maintaining client and staff comfort during periods of hot weather.

I. All boilers, furnaces or heater rooms are protected from other parts of the building by construction having a fire resistance rating of not less than one hour and doors which are self-closing with a three-quarters of an hour fire resistance.

J. All central ventilation and air condition systems must have provided filters having efficiencies greater than 25 percent.

K. All gas-burning heating and cooking equipment must be connected to an approved venting system to take the products of combustion directly to the outside air.

L. All openings to the outer air used for ventilation must be screened with screening material of not less than 16 meshes per lineal inch.

M. Screen doors must be equipped with self-closing devices.

N. A facility will install barriers or take other steps to ensure heating units are inaccessible to children. Heating units include hot water pipes, hot water baseboard heaters hotter than 110 degrees Farenheit, fireplaces, fireplace inserts and wood stoves.

[7.8.3.117 NMAC – N, 05/15/01]

7.8.3.118 WATER HEATERS FOR COMMUNITY HOMES:

A. Fuel-fired hot water heaters must be enclosed and separated from other parts of the building by construction as required by current state and local building codes. Any inspection report or certificate is maintained by the facility.

B. All water heaters must be equipped with a pressure relief valve (pop-off valve) vented to the outside or a drain in the building.

C. Water heaters must not be located in sleeping rooms, or rooms opening into sleeping rooms.

[7.8.3.118 NMAC – N, 05/15/01]

7.8.3.119 TOILETS, SINKS AND BATHING FACILITIES FOR COMMUNITY HOMES:

A. All fixture and plumbing must be installed in accordance with current state and local plumbing codes.

B. All toilets must be enclosed and vented.

C. All toilet rooms must be provided with a lavatory for hand washing.

D. All toilet rooms must be kept supplied with toilet paper.

E. All lavatories for hand washing must be kept supplied with disposable towels for hand drying or provided with a mechanical blower. The use of a common towel is prohibited.

F. The location, type and minimum number of toilets, sinks and bathing facilities are as follows:

(1) Toilets and sinks for children must be provided in a ratio of at least one (1) toilet and one (1) sink for every six children in care.

(2) Showers and/or tubs must be provided in a ratio of at least one (1) shower and/or tub for every six children in care.

G. If a facility provides services to both sexes, separate facilities must be provided for each sex in the same ratio as stated above.

H. A combination of a tub and shower is permitted.

I. Tubs and/or showers have a slip resistant surface.

J. Facilities serving disabled children must have grab bars in tubs and showers.

K. Facilities serving disabled children must have toilet room doors that swing out.

L. If a facility has live-in staff, a separate toilet, sink, and bathing facilities for staff must be provided and are not counted in the ratios stated above.

M. Toilets, sinks, and bathing facilities must be readily available to children. No passage through a child’s room by another child to reach a toilet, sink or bathing facility is permitted.

N. New facilities must have a minimum of one (1) toilet and (1) bathing facility which meet the requirements for the disabled.

O. A facility providing services to children under age two (2) must have a hand washing sink in the bedroom area, or a bathroom in the bedroom area.

[7.8.3.119 NMAC – N, 05/15/01]

7.8.3.120 CORRIDORS FOR COMMUNITY HOMES:

A. Corridors in each facility must have a minimum width of 36 inches.

B. Corridors in newly constructed facilities must have a minimum width of 44 inches.

C. Corridors must have a clear ceiling height of not less than 7 feet measured from the lowest projection of the ceiling.

D. Corridors must remain clear and free of obstructions at all times.

E. In facilities contained within existing commercial or residential buildings, lesser corridor widths may be allowed if not in conflict with building or fire codes and if approved by the Licensing Authority prior to occupying the facility.

[7.8.3.120 NMAC – N, 05/15/01]

7.8.3.121 DOORS FOR COMMUNITY HOMES:

A. All exit doors must have a minimum width of 36 inches.

B. All sleeping room doors must have at least one and three quarter inches bonded solid core, with a minimum width of 32 inches.

C. All doors to toilet and bathing facilities must have a minimum width of 24 inches.

D. Locks on doors to toilets must be of a type that the lock can be released from the outside.

E. Exit doors leading to the outside of a facility with a capacity of ten or more children must open outward.

F. Exit doors leading to the outside of a facility must be provided with a night latch, dead bolt or security chain, provided such devices open from the inside without the use of a key or tool and are mounted at a height not to exceed 48 inches above the finished floor.

G. Sleeping room doors for non-mobile children must be at least one and three quarter inches bonded solid core, with a minimum width of 44 inches.

H. Each sleeping room housing non-mobile children must have a 44-inch exit door leading directly to the outside.

[7.8.3.121 NMAC – N, 05/15/01]

7.8.3.122 MINIMUM ROOM DIMENSIONS FOR COMMUNITY HOMES:

A. All habitable rooms in a facility must have a ceiling height of not less than seven feet, six inches.

B. Kitchens, halls, bathrooms and toilet compartments must have a ceiling height of not less than seven feet.

C. All habitable rooms other than a kitchen must not be less than seven feet in any dimension.

D. Any room with a sloped ceiling is subject to review and approval or disapproval by the Licensing Authority, based upon Uniform Building Code computation of minimum area.

[7.8.3.122 NMAC – N, 05/15/01]

7.8.3.123 WINDOWS FOR COMMUNITY HOMES:

A. Children's sleeping rooms and activity rooms must have a window area of at least one-tenth the floor area with the minimum allowed total being 10 square feet.

B. Sleeping rooms must provide at least one window for egress or rescue with a minimum net clear opening of 5.7 square feet. The minimum net clear opening for height dimensions is 24 inches. The minimum net clear opening width dimension is 20 inches.

C. Egress and rescue windows must have a finished sill height of not more than forty-four inches above the floor. EXCEPTION: If the sleeping room has a door leading directly to the outside, an egress/rescue window is not required.

D. Bars, grills, and grates or similar devices may be installed on emergency escape or rescue windows or doors only if equipped with release mechanisms which can be opened from the inside without the use of a key, knowledge or effort.

[7.8.3.123 NMAC – N, 05/15/01]

7.8.3.124 CHILDREN'S ROOMS FOR COMMUNITY HOMES:

A. Each child's room must be an outside room.

B. There must be no through traffic through children's rooms.

C. Single rooms must have at least 80 square feet of floor area. Closet and locker areas are not counted as part of the floor area.

D. Not more than four children over the age of two (2) may occupy a designated bedroom space. EXCEPTION: Children's Crisis Shelters may have dormitory type sleeping areas with no limitation on the number of children as long as minimum square footage requirements are met.

E. Facilities which provide care and services to non-mobile children must have at least 100 square feet of floor area for each non-mobile resident.

F. Rooms having more than one child must have at least 60 square feet for each bed; or at least 90 square feet of floor area for each bunk, if double bunks are used. Closet and locker area are not be counted as part of the available floor space.

[7.8.3.124 NMAC – N, 05/15/01]

7.8.3.125 FLOORS AND WALLS FOR COMMUNTY HOMES:

A. Floor material must be readily cleanable and wear resistant.

B. In all areas subject to wet cleaning, floor materials must not be physically degradable by liquid germicidal or cleaning solution.

C. Floors subject to traffic while wet must have a slip resistant surface.

D. Wall finishes must be washable and, in the proximity of plumbing fixtures, must be smooth and moisture resistant.

E. Wall bases in areas subject to wet cleaning must be covered with flooring and tightly sealed baseboards.

F. Floor and wall areas penetrated by pipes, ducts, and conduits must be tightly sealed to minimize the entry of rodents and insects. Joints of structural elements must be similarly sealed.

G. Threshold and expansion joint covers must be flush with the floor surface to facilitate the use of wheelchairs and carts.

[7.8.3.125 NMAC – N, 05/15/01]

7.8.3.126 ACCESS REQUIREMENTS FOR THE DISABLED IN NEW FACILITIES FOR COMMUNITY HOMES:

A. Accessibility to the disabled must be provided in all new facilities and includes, at a minimum, the following:

B. Main entry into the facility must be level or incorporate a ramp to allow for wheelchair access.

C. Building layout must allow for access to main living area and dining area.

D. At least one (1) bedroom must have a door clearance of 32 inches.

E. At least one (1) toilet/bathing facility must provide a 60-inch diameter turning radius.

F. If ramps are used, the slope of each ramp must provide at least a 12-inch horizontal run for each inch of vertical rise.

G. Ramps exceeding a six-inch rise must be provided with handrails.

H. Additional access requirements may apply depending upon the size and complexity of the facility.

[7.8.3.126 NMAC – N, 05/15/01]

7.8.3.127 SPECIAL REQUIREMENTS FOR SECLUSION ROOMS IN COMMUNITY HOMES:

Any facility licensed pursuant to these regulations that uses a seclusion room in its program must complies with all of the following:

A. The room must have no less than 80 square feet of floor area.

B. The door must be of substantial construction either one and three-quarter inches, bonded solid core or metal able to withstand unusual stress.

C. The door must be at least 32 inches wide, preferably 36 inches.

D. The door must swing outward to prevent children from barricading themselves in the room.

E. The door must have a fixed wired glass vision panel not to exceed 1,296 square inches, and mounted in steel or other approved metal frame.

F. A dual lock system that is simple to operate must be on the door. It must have a quickly-operated throw bolt and key lock.

G. The floor must be of substantial construction with a smooth surface so that it presents no danger in terms of materials that peel, splinter, or cause burns.

H. Walls must be of high-impact resistance with nothing protruding from the walls that would allow for climbing by children.

I. The ceiling must be of monolithic construction and unreachable to children.

J. Light fixtures must be security rated and recessed so children cannot break the lens, bulbs, etc.

K. Windows in the room must have security-rated screens with locks that cannot be picked.

L. There must be nothing else in the room, including electrical outlets, switches, holes, hardware, or places to hook things. All heating and air-conditioning registers must be out of reach. There must be no sharp edges in the room such as window sills, baseboards, or wainscots.

M. Rooms must be approved in writing from the State Fire Marshal or fire authority having jurisdiction. These records must be maintained by the facility.

N. There must be an observation room adjoining or nearby the seclusion room that permits continuous close observation by staff of a child placed in the seclusion room.

O. A toilet room with a sink must be immediately accessible to the seclusion room.

[7.8.3.127 NMAC – N, 05/15/01]

PART 4: GENERAL REQUIREMENTS FOR BOARDING HOMES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.15 NMAC.]

CHAPTER 9: NURSING HOMES AND INTERMEDIATE CARE FACILITIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR LONG TERM CARE FACILITIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.16 NMAC.]

CHAPTER 10: FREESTANDING BIRTH CENTERS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR FREESTANDING BIRTH CENTERS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.17 NMAC.]

CHAPTER 11: OUTPATIENT FACILITIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR FACILITIES PROVIDING OUTPATIENT MEDICAL SERVICES AND INFIRMARIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.18 NMAC.]

CHAPTER 12: HOSPICE CARE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR INHOME AND INPATIENT HOSPICE CARE [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.19 NMAC.]

CHAPTER 13: ADULT DAY CARE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR ADULT DAY CARE FACILITIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.20 NMAC.]

CHAPTER 14: COMMUNITY BASED SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: QUALITY MANAGEMENT SYSTEM AND REVIEW REQUIREMENTS FOR PROVIDERS OF COMMUNITY BASED SERVICES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.21 NMAC.]

PART 3: INCIDENT REPORTING AND INVESTIGATION REQUIREMENTS FOR PROVIDERS OF COMMUNITY BASED SERVICES [REPEALED]

[This part was repealed on February 28, 2006.]

CHAPTER 15: DENTAL HEALTH CARE [RESERVED]

CHAPTER 16: PHARMACEUTICALS [RESERVED]

CHAPTER 17: RADIOLOGY FACILITIES [RESERVED]

CHAPTER 18: AQUATIC VENUES

PART 1: PUBLIC AQUATIC VENUES: GENERAL PROVISIONS

7.18.1.1 ISSUING AGENCY:

New Mexico Environmental Improvement Board.

[7.18.1.1 NMAC - N, 8/1/16]

7.18.1.2 SCOPE:

Owners and operators of public aquatic venues or other public bathing attractions.

[7.18.1.2 NMAC - N, 8/1/16]

7.18.1.3 STATUTORY AUTHORITY:

Sections 74-1-1 through 74-1-16 NMSA 1978.

[7.18.1.3 NMAC - N, 8/1/16]

7.18.1.4 DURATION:

Permanent.

[7.18.1.4 NMAC - N, 8/1/16]

7.18.1.5 EFFECTIVE DATE:

August 1, 2016, unless a later date is cited at the end of a section.

[7.18.1.5 NMAC - N, 8/1/16]

7.18.1.6 OBJECTIVE:

To protect public health and safety by establishing standards and provisions for the regulation of public aquatic venues and other public bathing attractions.

[7.18.1.6 NMAC - N, 8/1/16]

7.18.1.7 DEFINITIONS:

[RESERVED]

7.18.1.8 ENFORCEMENT AUTHORITY:

A. Private aquatic venues shall not be subject to the provisions of this regulation or 7.18.2 NMAC, Aquatic Venues: Fees.

B. Authorized department representatives shall be responsible for the enforcement of this rule.

[7.18.1.8 NMAC - Rp, 7.18.2.9 NMAC, 8/1/16]

7.18.1.9 ADOPTION OF MODEL AQUATIC HEALTH CODE:

Except as otherwise provided, the United States department of health and human services center for disease control and prevention Model Aquatic Health Code, 1st Edition is hereby incorporated by reference.

[7.18.1.9 NMAC - N, 8/1/16]

7.18.1.10 ADOPTION BY REFERENCE:

Outside standards, listings, and publications referenced in this rule are part of this rule.

[7.18.1.10 NMAC - Rp, 7.18.2.8 NMAC, 8/1/16]

7.18.1.11 MODIFICATIONS, ADDITIONS, AND OMISSIONS:

Except as otherwise provided, the following modifications, exceptions and omissions are made to the Model Aquatic Health Code, 1st Edition.

A. Modifications to Aquatic Code definitions. The following terms defined in the Model Aquatic Health Code, 1st Edition have the meanings set forth herein, in lieu of the meanings set forth in the Model Aquatic Health Code, 1st Edition:

(1) "Aquatic venue" means any artificially constructed structure that is expressly designated or used with the knowledge or consent of the owner or operator for swimming, water recreation, or bathing for the use of any segment of the public. Such structures do not necessarily contain standing water, so water exposure may occur via contact, ingestion, or aerosolization. The term "aquatic venue" includes all class A, class B, class C, and class D aquatic venues and spas. This term does not include residential housing or lodging facilities having five or fewer living units. Plumbing fixtures associated with a specific living unit, hot springs, and fill-and-draw tubs are also excluded. The term "aquatic venue" includes, but is not limited to, public pools and spas owned or operated by:

(a) travelers' accommodations including hotels, motels, inns, lodging and bed and breakfast facilities, hostels and recreational vehicle parks;

(b) residential housing or lodging facilities having six or more living units;

(c) apartments or apartment complexes, condominiums and mobile home parks;

(d) recreation parks;

(e) colleges or universities;

(f) schools and group homes;

(g) organizational camps;

(h) clubs;

(i) associations;

(j) business establishments for their patrons or employees;

(k) private persons with pools that are open to the public;

(l) recreation districts; or

(m) cities, municipalities, counties, the state of New Mexico or other political subdivisions.

(2) "Interactive water play aquatic venue" means any indoor or outdoor installation that includes sprayed, jetted or other water sources contacting bathers and

not incorporating standing or captured water as part of the bather activity area. Only those intended for public use and recreation shall be regulated. These aquatic venues are also known as splash pads, spray pads, wet decks.

B. Additions to the Aquatic Code definitions. The following terms not defined in the Model Aquatic Health Code 1st Edition have the meanings set forth herein:

(1) Abbreviations.

(a) "CC" means combined chlorine.

(b) "DPD" means diethyl-p-phenylene diamine.

(2) "Approved" means accepted in writing by the department.

(3) "Class A aquatic venue" means any public aquatic venue including, but not limited to, general admission pools, aquatic centers, recreation parks, schools, colleges and universities, organizational camps, daycare facilities, clubs, recreation districts, city, municipal, county and state pools and pools operated by other political subdivisions as defined by law. Class A aquatic venues shall not include pools located at boarding schools, colleges and universities exclusively associated with specific living units but would not be open to the entire boarding school, college or university population or the general public.

(4) "Class B aquatic venue" means any public aquatic venue, located at, and operated to serve a facility having six or more living or guest units at:

(a) travelers' accommodations, including hotels, motels, inns, lodging, campgrounds, bed and breakfast facilities;

(b) apartments, condominiums, retirement homes, assisted-living facilities, mobile home parks;

(c) class A exclusions for boarding schools, colleges, and universities, and group homes;

(d) businesses that employ 10 or more people and own a swimming pool or spa that is for the exclusive use of employees and their guests; or

(e) homeowners associations, if the pool is for the exclusive use of the association members and their guests only and no memberships are sold to outside persons.

(5) "Class C aquatic venue" means a public aquatic venue that is designed specifically as a bathing attraction or for sporting or recreational purposes and may include, but is not limited to, special features such as:

(a) wave pools;

(b) diving pools;

(c) splash pools;

(d) zero depth pools;

(e) waterslides;

(f) vortex pools;

(g) interactive play attractions;

(h) watercourse rides;

(i) activity pools;

(j) portable pools;

(k) spray pads;

(l) lazy rivers; or

(m) wading pools.

(6) "Class D aquatic venue" means any public aquatic venue used for physical therapy or rehabilitation including, but not limited to, post-operative strength training, assistance of buoyancy of water, and other one-on-one training.

(7) "Club" means a facility constructed to provide entertainment, athletic or physical conditioning for its members, guests, invitees, occasional users, patrons, or clientele. It includes, but is not limited to, racquetball clubs, country clubs, golf clubs, health spas, fitness, sports and wellness facilities or aerobics instruction facilities.

(8) "Combined chlorine (CC)" means that portion of the total residual chlorine that is combined with ammonia or nitrogen compounds and will not react chemically with undesirable or pathogenic organisms.

(9) "Department" means the New Mexico environment department.

(10) "Department representative" means the secretary of the environment department or his/her designees.

(11) "Engineer" means any individual currently registered and in good standing under the "New Mexico Engineering and Surveying Practice Act."

(12) "New construction" means the activity of building or installing a public aquatic venue, and its component parts, where no such structure has previously existed or where previously existing aquatic venue structures have been removed.

(13) "Non-substantial alteration" means the alteration, modification, or renovation of an aquatic venue (for outdoor or indoor aquatic facilities) where the total cost of the work does not exceed fifty percent of the replacement cost of the aquatic venue.

(14) "Person" means:

(a) any person, individual, any public or private firm, partnership, corporation, company, society, association, and every managing body, officer, agent or employee thereof; or

(b) the state, local government, or any agency, institution or political subdivision thereof, including any governing or managing body.

(15) "Private aquatic venue" means:

(a) any pool or spa owned by no more than four individuals, either jointly, individually or through association, incorporation or otherwise, for the exclusive use of the occupants thereof and their guests or invitees; or

(b) an aquatic venue owned by a business employing fewer than 10 persons if the aquatic venue is for the exclusive use of employees and their guests.

(16) "Service animal" means a guide dog, signal dog, or other animal trained to do work or perform tasks for the benefit of an individual with a disability including, but not limited to, guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, or providing minimal protection or rescue work, such as pulling a wheelchair or fetching dropped items. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals.

(17) "Variance" means written permission from the department to use an alternative measure of compliance with any provision in the aquatic venue rules, except those specifically prohibited in the rule. The alternative measure shall provide public health and safety protection that is equal to or greater than the protections provided in this rule.

C. Omissions to the Aquatic Code. The following provisions of the Model Aquatic Health Code, 1st Edition are omitted:

(1) Subpart 4.1.4: Compliance Certificate;

(2) Section 4.1.5.3: Permit Issuance;

(3) Section 4.7.3.2.7.1: Feeders for pH Adjustment – Provided;

(4) Section 4.7.3.2.8.1.1: Automated Controllers – Installed;

(5) Subpart 5.2.2: Exemptions;

(6) Section 5.6.7.4: Water Replenishment;

(7) Section 5.7.5.2: Manual Disinfectant Feed System; and

(8) Section 6.3.2.1(4): List of aquatic facilities requiring qualified lifeguards.

[7.18.1.11 NMAC - N, 8/1/16]

7.18.1.12 CONSTRUCTION PERMITS:

A. No person shall construct or substantially alter a public aquatic venue, or part thereof, or convert a private aquatic venue into a public aquatic venue without first:

(1) submitting a construction permit application that shall include plans, specifications, supporting material, and other information required by the department;

(2) receiving a construction permit; and

(3) paying all applicable fees.

B. No person shall deviate from the approved plans and specifications during the construction or alteration of public aquatic venues described in this rule without first receiving prior written approval from the department.

C. Construction permits will be issued only to the owner or authorized agent of the owner.

D. A construction permit may be issued only when the facility owner or agent has provided sufficient information for the department to determine that the aquatic venue will:

(1) operate continuously in a clean and sanitary manner;

(2) not constitute a hazard to public health and safety; and

(3) provide health and safety protection equal to or greater than that required by the aquatic venue rules.

E. Persons submitting plans and specifications for a proposed public aquatic venue that demonstrate a new technology or alternative mode of operation not contemplated in these rules shall apply for a variance.

F. The department shall issue a construction permit, issue a construction permit with conditions, or deny the construction permit application. The department may revoke a construction permit under 7.18.1.19 NMAC or suspend a construction permit if the department determines that the provisions of the aquatic venue rules are not met.

G. The department shall notify the applicant in writing that the application is complete or incomplete within 30 days of receipt of the application.

H. Once the department determines that the application is complete, for class B aquatic venues, the department shall have up to 30 working days to issue the permit, issue the permit with conditions, or deny the permit application. For class A, C, and D aquatic venues, the department shall have up to 90 working days to issue the permit, issue the permit with conditions, or deny the permit application. All construction permit denials shall be in writing stating the reason the permit was denied. The applicant for a permit that has been denied may request an administrative hearing. The request for a hearing shall be made in writing to the department within 15 calendar days after notice of the department's decision has been received by the applicant. Hearings on permit denials shall be held in accordance with 7.18.1.21 NMAC and 20.1.5 NMAC.

I. Private aquatic venues that are converted into public aquatic venues or public aquatic venues that were previously operating without a permit shall be subject to the aquatic venue rules including, but not limited to, the requirement to obtain a construction permit.

J. Non-substantial alterations do not require a construction permit; however an aquatic facility owner planning a non-substantial alteration shall contact the department to review proposed changes prior to starting the non-substantial alteration.

[7.18.1.12 NMAC - Rp, 7.18.2.10 NMAC, 8/1/16]

7.18.1.13 PLANS AND SPECIFICATIONS:

A. Nothing in the swimming pool rules shall prevent the department from requiring the correction of errors in plans and specifications after those plans have been approved or the specifications accepted. The department may also revoke any construction permits or approvals that are issued in error, or obtained based upon material misrepresentations or erroneous information provided by the applicant.

B. The department may also issue a stop work order whenever construction work deviates from approved plans and specifications without prior written approval from the department, violates any permit condition, or is in violation of this or any other law or regulation. The department shall provide written notice of the stop work order to the

person performing the work or causing the work to be performed, and the person receiving such notice shall cease and desist from performing, or causing the performance of, the work until authorized in writing by the department to proceed.

[7.18.1.13 NMAC - Rp, 7.18.2.11 NMAC, 8/1/16]

7.18.1.14 OPERATING PERMITS:

A. No person shall operate an aquatic venue without an operating permit from the department. Each aquatic venue in an aquatic facility shall be permitted separately.

B. Operating permits shall be issued for a period of 12 consecutive months and are non-transferrable between facilities or persons.

C. No person shall operate an aquatic venue without:

(1) receiving a construction permit from the department, if applicable;

(2) obtaining an approved final construction inspection, if applicable;

(3) initially applying for a permit to operate such aquatic venue;

(4) successful completion of a department inspection;

(5) receiving a permit from the department; and

(6) paying all applicable fees.

D. The permit shall remain the property of the department and shall be removed by the department representative when a permit is suspended or revoked.

E. Operating permits for all public aquatic venues shall expire on the last day of the anniversary month of the date of original issue.

F. Any public aquatic venue that has been closed or not operated for a period of 30 days or more shall be granted permission to re-open only after completion of a department re-opening inspection that demonstrates compliance with applicable aquatic venue rules.

G. The designated qualified operator shall request a re-opening inspection for an aquatic venue that has been closed for a period of 30 days or more, at least two weeks prior to the desired re-opening date. The department may require the qualified operator to be present for this inspection.

H. Operating permits are non-transferable between facilities or persons.

[7.18.1.14 NMAC - Rp, 7.18.2.12 NMAC, 8/1/16]

7.18.1.15 INSPECTION FREQUENCY:

The department shall inspect each public aquatic venue at least annually and shall make as many re-inspections as necessary for enforcement of the aquatic venue rules.

[7.18.1.15 NMAC - Rp, 7.18.2.14 NMAC, 8/1/16]

7.18.1.16 SERVICE OF NOTICE:

A. Notice shall be deemed to be properly served when the original or a true copy of the inspection report form or other written notice has been delivered personally to the permit holder, the permit holder's agent, or a qualified operator; or when such notice has been sent by registered or certified mail to the last known address of the permit holder or qualified operator on file with the department.

B. A copy of such notice shall be filed in the department's records.

[7.18.1.16 NMAC - Rp, 7.18.2.15 NMAC, 8/1/16]

7.18.1.17 TEMPORARY SUSPENSION OF PERMITS:

A. The department may suspend a permit at any time when it determines that there is a violation that may affect public health or safety.

B. Whenever a permit holder or operator has failed to comply with any of the requirements of this rule, the permit holder or operator shall be notified in writing.

C. The notice shall:

(1) identify and reference the conditions that violate the aquatic venue rules;

(2) specify the time period within which such condition shall be brought into compliance, if any;

(3) state that failure to comply with any notice issued pursuant to the aquatic venue rules may result in immediate permit suspension; and

(4) advise that the permit shall be suspended if the permit holder or operator is still out of compliance at the end of five working days following the deadline for compliance, unless a request for a hearing is delivered to the department by the permit holder within the five-day period.

D. Immediate suspension: notwithstanding other provisions of this regulation, whenever a department representative finds a condition in a public aquatic venue's

operation that constitutes an immediate hazard to public health, welfare, or safety, the department representative may, without prior warning, notice, or hearing, issue a written notice to the permit holder or operator citing such condition. The department's notice shall state that the permit is immediately suspended and all swimming or bathing of any kind is to be immediately discontinued.

E. All persons receiving a permit suspension notice shall immediately comply with the notice's terms.

F. For immediate suspensions, suspensions upheld after a hearing, and where no request for a hearing has been received, the department shall post a sign stating that the aquatic venue is closed.

G. The department may also require a written compliance plan.

[7.18.1.17 NMAC - Rp, 7.18.2.16 NMAC, 8/1/16]

7.18.1.18 REINSTATEMENT OF SUSPENDED PERMITS:

A. Any person whose permit has been suspended may make application for reinstatement of the permit in writing to the department. Within five working days following receipt of such a request, a department representative shall inspect the aquatic venue or premises or both. If the applicant is in compliance with the requirements of the aquatic venue rules and other applicable laws, regulations, and ordinances, the permit shall be reinstated.

B. The department may require a qualified operator or aquatic venue employee to attend additional training courses in aquatic venue sanitation and safety.

[7.18.1.18 NMAC - Rp, 7.18.2.18 NMAC, 8/1/16]

7.18.1.19 REVOCATION OF PERMIT:

A. A permit may be revoked when:

(1) it appears that a violation may affect public health or safety;

(2) any conditions of a permit are violated;

(3) there are willful or repeated violations of any of the requirements in the aquatic venue rules;

(4) the permit has been obtained through nondisclosure, misrepresentation, or misstatement of a material fact; or

(5) the owner or the owner's agent interferes with the department's performance of its duties.

B. Prior to such revocation, the department shall provide an opportunity for a hearing. A department representative shall notify the permit holder in writing stating the reason the permit is subject to revocation and advising that the permit shall be revoked at the end of five working days following service of such notice, unless a request for a hearing is delivered to the department by the permit holder within the five-day period.

C. Owners and operators of public aquatic venues who fail to comply with the provisions of a suspension notice or open their facility to the public without an approved permit will be subject to the penalties described in 7.18.1.56 NMAC.

[7.18.1.19 NMAC - Rp, 7.18.2.19 NMAC, 8/1/16]

7.18.1.20 OTHER REMEDIES:

[RESERVED]

7.18.1.21 HEARINGS:

A. Hearings provided for in the aquatic venue rules shall be held within 15 working days of a petitioner's delivery of a hearing request to the department.

B. Hearings provided for in this regulation shall be conducted in accordance with 20.1.5 NMAC.

[7.18.1.21 NMAC - Rp, 7.18.2.22 NMAC, 8/1/16]

7.18.1.22 VARIANCE:

A. The department may grant a variance from the design and construction or operation and maintenance provisions of the aquatic venue rules through written permission for the use of alternative measures that will provide public health and safety protection that is equal to or greater than the protections provided in the aquatic venue rules. No variances shall be granted for procedural requirements, such as submitting construction or operating permit applications, including paying fees, obtaining construction or operating permits, operator certifications, or requesting a hearing.

B. Specific variance requests shall be made by the owner or the owner's designated agent. Designated agents shall provide written documentation signed by the owner that they are representing the owner regarding the specific variance application. All variance applications shall be signed by the owner and upon change of ownership or transfer of property, the new owner or their designated agent must re-apply for the variance.

C. It is the applicant's responsibility to provide all necessary information to support the request for a variance.

D. Any person applying for a variance from any provision of the aquatic venue rules shall do so by filing a written application with the department. Applications shall:

(1) be made on forms obtained from the department;

(2) remit applicable fee by check or money order made payable to the "water recreation facilities fund;"

(3) state the applicant's name and mailing address;

(4) state the date of the application;

(5) state the provision or provisions of this regulation for which the variance is sought;

(6) state in detail the extent to which the applicant wishes to vary from the provision or provisions;

(7) state the period of time for which the variance is sought;

(8) state why the applicant believes the variance is justified;

(9) be accompanied by any relevant documents or material which the applicant believes would support the application for a variance; and

(10) contain other relevant information the department may request.

E. Within 20 working days following receipt of a completed variance application, the department shall grant the variance, grant the variance subject to conditions, or deny the variance. The action taken by the department shall be by written order, a copy of which shall be sent to the applicant. The order shall:

(1) state the applicant's name and address;

(2) state the date the order is made;

(3) describe the location of the public aquatic venue; and

(4) state the department's decision and its reasons.

F. If a variance is granted, the order will state the effective period of time and any conditions that apply.

G. All variances shall be reviewed at the time of the annual operating permit inspection to determine whether all variance conditions have been met. If conditions of the variance have not been met, an operating permit shall not be issued.

H. Petitioners who are dissatisfied with the department's decision may request a hearing from the department secretary.

(1) The request shall be made in writing to the department secretary within 15 calendar days after notice of the department's decision has been received by the petitioner.

(2) Unless a request has been received within the 15 calendar day period, the department's decision shall be final.

(3) If a request has been received within the 15 calendar day period, the department secretary or his/her designated representative shall hold a hearing within 15 working days after the receipt of the request.

I. The department shall notify the petitioner by certified mail of the date, time and place of the hearing.

J. In the hearing, the burden of proof shall be upon the petitioner.

[7.18.1.22 NMAC - Rp, 7.18.2.23 NMAC, 8/1/16]

7.18.1.23 VOIDING OF VARIANCES:

A. An approved variance shall be void one year after the date of approval if the permitted activities granted thereby have not been utilized. If the department voids a variance for any reason, the department will serve written notice on the permit holder.

B. The department may void a variance if conditions of the variance have not been met, or if subsequent events show that the variance has created or may create conditions hazardous to the public health, safety, or welfare.

C. An approved variance shall be void if it is utilized in a way that violates the terms and conditions of the variance. Voiding a variance is in addition to, and not instead of, other remedies available to the department at any time for violation of the aquatic venue rules.

D. All variances shall become void upon change of ownership. Upon change of ownership, the new owner shall re-apply for a variance.

E. Any person who has been granted a variance shall sign a department approved indemnification and release of liability statement form. Variances shall not be valid

unless and until the department receives a completed and signed indemnification and release of liability statement form back from the applicant.

[7.18.1.23 NMAC - Rp, 7.18.2.24 NMAC, 8/1/16]

7.18.1.24 RIGHT OF ENTRY:

A. Upon presentation of credentials, department representatives may enter any premises where a public aquatic venue is located or where records required by the aquatic venue rules are located during the aquatic venue's operating hours.

B. When entry is denied by the property owner, the department may seek a district court order to:

(1) have a right of entry to, upon, or through any premises where an aquatic venue is located;

(2) have a right of entry on any premises where any records required by the aquatic venue rules or by permit condition are kept;

(3) have access to and copy any records that the aquatic venue rules or a permit requires the facility to maintain;

(4) inspect any premises or equipment to determine compliance with the aquatic venue rules or any permit or variance condition; and

(5) obtain any sample(s) required to determine compliance with the aquatic venue rules or any permit or variance condition.

[7.18.1.24 NMAC - Rp, 7.18.2.25 NMAC, 8/1/16]

7.18.1.25 LIFEGUARDS:

When swim teams and swimming exercise classes are the only users of an aquatic facility, in lieu of a qualified lifeguard the owner or designated agent may allow substitution of a swim coach attendant, who is certified by the *American red cross* or an equivalent organization in first aid and cardiopulmonary resuscitation (CPR) and is trained to deal with safety hazards. Both the owner of the public aquatic venue and the sponsoring organization furnishing the swim coach shall be responsible for assuring proper credentials, training and bather controls are maintained in accordance with these requirements.

[7.18.1.25 NMAC - N, 8/1/16]

7.18.1.26 POOL WATER QUALITY:

A. Testing equipment:

(1) All public aquatic venues shall have fully functional water quality testing devices for measuring the pH, free and combined chlorine concentration, or bromine, (or concentration of other approved disinfectant), and cyanuric acid if stabilized chlorine is used.

(2) Water quality testing devices shall use environmental protection agency (EPA) approved methods.

(3) Water quality testing devices for measuring free and total chlorine or bromine shall use *diethyl-P-phenylene diamine* (DPD) as the reagent.

(4) Feeders for pH adjustments and automated controllers shall be required on all aquatic venues within two years of the effective date of these regulations.

(5) All aquatic venues using a manual disinfectant feed system that does not have an automated controller shall be tested before the venue opens for the day and every four hours while open to the public.

B. The total available bromine in aquatic venues shall not exceed 8ppm.

C. Cyanuric acid shall not be used in indoor aquatic facilities.

D. Swim-up bars are considered an increased risk aquatic venue and shall install a secondary disinfection system.

[7.18.1.26 NMAC - N, 8/1/16]

7.18.1.27 TEMPORARY SPECIAL USE AQUATIC VENUES:

Owners of aquatic venues that are used for public events at sports fields, county fairs, portable pools and similar special uses shall be reviewed by the department on an individual case basis. The department may require special conditions as part of approval of such pools to assure health and safety.

[7.18.1.27 NMAC - N, 8/1/16]

7.18.1.28-7.18.1.50 [RESERVED]

7.18.1.51 CONSTRUCTION:

This part shall be liberally construed to carry out its purpose.

[7.18.1.51 NMAC - Rp, 7.18.2.51 NMAC, 8/1/16]

7.18.1.52 SEVERABILITY:

If any provision or application of this part is held invalid, the remainder of this part, or its application to other situations or persons, shall not be affected.

[7.18.1.52 NMAC - Rp, 7.18.2.52 NMAC, 8/1/16]

7.18.2.53 REFERENCES IN OTHER REGULATIONS:

Any reference to the aquatic venue regulations or to any prior version of the aquatic venue regulations in any other rule shall be construed as a reference to this rule. References to the "aquatic venue rules" in this part refer to all provisions contained in 7.18.1 through 7.18.2 NMAC.

[7.18.1.53 NMAC - Rp, 7.18.2.53 NMAC, 8/1/16]

7.18.1.54 SAVINGS CLAUSE:

Repeal or supersession of prior versions of this part or the public swimming pool rules shall not affect any administrative or judicial action initiated under those prior versions.

[7.18.1.54 NMAC - Rp, 7.18.2.54 NMAC, 8/1/16]

7.18.1.55 COMPLIANCE WITH OTHER REGULATIONS:

Compliance with the aquatic venue rules or this part does not relieve a person from the responsibility to comply with any other applicable federal, state, or local regulations.

[7.18.1.55 NMAC - Rp, 7.18.2.55 NMAC, 8/1/16]

7.18.1.56 PENALTY:

Any person who violates any provision of this rule shall be subject to the penalty provisions in Section 74-1-10 NMSA 1978 of the Environmental Improvement Act, in addition to any other penalties provided for in the aquatic venue rules.

[7.18.1.56 NMAC - Rp, 7.18.2.56 NMAC, 8/1/16]

7.18.1.57 LIMITATION OF DEFENSE:

The existence of a valid permit for the installation, modification or operation of an aquatic venue shall not constitute a defense to a violation of any section of this rule, except the requirement for obtaining a permit.

[7.18.1.57 NMAC - Rp, 7.18.2.57 NMAC, 8/1/16]

PART 2: PUBLIC AQUATIC VENUES: FEES

7.18.2.1 ISSUING AGENCY:

New Mexico Environmental Improvement Board.

[7.18.2.1 NMAC - Rp, 7.18.2.1 NMAC, 8/1/16]

7.18.2.2 SCOPE:

Owners and operators of public aquatic venues and other public bathing attractions.

[7.18.2.2 NMAC - Rp, 7.18.2.2 NMAC, 8/1/16]

7.18.2.3 STATUTORY AUTHORITY:

Sections 74-1-1 through 74-1-16 NMSA 1978.

[7.18.2.3 NMAC - Rp, 7.18.2.3 NMAC, 8/1/16]

7.18.2.4 DURATION:

Permanent.

[7.18.2.4 NMAC - Rp, 7.18.2.4 NMAC, 8/1/16]

7.18.2.5 EFFECTIVE DATE:

August 1, 2016, unless a later date is cited at the end of a section.

[7.18.2.5 NMAC - Rp, 7.18.2.5 NMAC, 8/1/16]

7.18.2.6 OBJECTIVE:

To establish fees for the administration of rules and standards regarding the inspection, enforcement, training, review of plans, and other appropriate program components for public aquatic venues and other public bathing attractions as specified in 7.18.1 NMAC, Public Aquatic Venues: General Provisions.

[7.18.2.6 NMAC - Rp, 7.18.2.6 NMAC, 8/1/16]

7.18.2.7 DEFINITIONS:

[RESERVED] [See 7.18.1 NMAC for Definitions.]

7.18.2.8 ADOPTION BY REFERENCE:

Outside standards, listings, and publications referenced in this rule are part of this rule.

[7.18.2.8 NMAC - Rp, 7.18.5.8 NMAC, 8/1/16]

7.18.2.9 ENFORCEMENT AUTHORITY:

A. Private aquatic venues shall not be subject to the provisions of this rule or to 7.18.1 NMAC.

B. Department representatives shall be responsible for the enforcement of this rule.

[7.18.2.9 NMAC - Rp, 7.18.5.9 NMAC, 8/1/16]

7.18.2.10 CONSTRUCTION PERMIT FEES:

A. Permit fees for new construction, remodeling, or renovation issued pursuant to Section 7.18.1.12 NMAC, Construction Permits, shall be the following:

(1) for a class A, class B, class C, or class D aquatic venue, or for a spa, the fee shall be $150.00;

(2) for multiple class A, class B, class C or class D aquatic venues or spas located in the same aquatic facility, the fee shall be $150.00 for each aquatic venue;

B. All applicable fees shall be paid at the time the construction permit application is submitted to the department.

C. All fees shall be remitted to the department by check or money order made payable to the "water recreation facilities fund" or "New Mexico environment department (NMED)."

D. Any check returned for non-payment for any reason shall result in cancellation of the construction permit.

E. All fees are non-refundable.

[7.18.2.10 NMAC - Rp, 7.18.5.10 NMAC, 8/1/16]

7.18.2.11 OPERATING PERMIT FEES:

A. Operating permit fees issued pursuant to 7.18.1.14 NMAC, Operating Permits, shall be the following:

(1) for all class A aquatic venues, the fee shall be $150.00 per year;

(2) for class B aquatic venues, the shall be:

(a) up to 600 square feet of aquatic venue surface area, $100.00 per year;

(b) from 601 square feet to 1000 square feet of aquatic venue surface area, $125.00 per year;

(c) from 1001 square feet of aquatic venue surface area and greater, $150.00 per year;

(3) for all class C aquatic venues, the fee shall be $150.00 per year.

(4) for all class D aquatic venues, the fee shall be $150.00 per year.

(5) for all public spas, the fee shall be $150.00 per year.

B. Payment of fees.

(1) An operating permit fee shall be assessed for each separate aquatic venue at a facility or site.

(2) Fees are payable in the month that the permit is to be issued. Operating permits will not be issued until the department receives all appropriate fees.

(3) All fees shall be remitted to the department by check or money order made payable to the "water recreation facilities fund" or "New Mexico environment department (NMED)."

(4) Non-payment of all appropriate fees, including the return of any check for non-payment for any reason, shall result in cancellation of the operating permit.

(5) All fees are non-refundable.

[7.18.2.11 NMAC - Rp, 7.18.2.11 NMAC, 8/1/16]

7.18.2.12 RE-INSPECTION PENALTY:

If a site inspection results in the issuance of a written notice of non-approval or suspension, the department may assess a re-inspection penalty of $50.00 to re-inspect each public aquatic venue in the aquatic facility. For each additional re-inspection required, an additional $50 will be added to the re-inspection penalty for each aquatic venue, up to $250 per aquatic venue per year. The re-inspection fee shall be remitted to the department prior to a subsequent re-inspection being conducted. Re-inspection penalties shall not be charged for aquatic venues that have been closed for 30 days or more and require a re-opening inspection.

[7.18.2.12 NMAC - Rp, 7.18.5.12 NMAC, 8/1/16]

7.18.2.13 VARIANCE FEE:

If a variance is requested pursuant to 7.18.2.22 NMAC, Variance, an application fee of $50.00 shall be remitted by the applicant at the time the variance application is submitted to the department. The fee is non-refundable.

[7.18.2.13 NMAC - Rp, 7.18.5.13 NMAC, 8/1/16]

7.18.2.14 RIGHT OF ENTRY:

A. Upon presentation of credentials, department representatives may enter any premises where a public aquatic venue is located or where records required by the aquatic venue rules are located during the aquatic venue's operating hours.

B. When entry is denied by the property owner, the department may seek a district court order to:

(1) have a right of entry to, upon, or through any premises where a public aquatic venue is located;

(2) have a right of entry on any premises where any records required by the aquatic venue rules or by permit condition are kept;

(3) have access to and copy any records that the aquatic venue rules or a permit requires the facility to maintain;

(4) inspect any premises or equipment to determine compliance with the aquatic venue rules or any permit condition; and

(5) obtain any sample(s) required to determine compliance with the aquatic venue rules or any permit condition.

[7.18.2.14 NMAC - Rp, 7.18.5.14 NMAC, 8/1/16]

7.18.2.15 to 7.18.2.50 [RESERVED]

7.18.2.51 CONSTRUCTION:

This part shall be liberally construed to carry out its purpose.

[7.18.2.51 NMAC - Rp, 7.18.5.51 NMAC, 8/1/16]

7.18.2.52 SEVERABILITY:

If any provision or application of this part is held invalid, the remainder of this part, or its application to other situations or persons, shall not be affected.

[7.18.2.52 NMAC - Rp, 7.18.5.52 NMAC, 8/1/16]

7.18.2.53 REFERENCES IN OTHER REGULATIONS:

Any reference to the aquatic venue regulations or any prior version of the aquatic venue regulations in any other rule shall be construed as a reference to this rule. References to the "aquatic venue rules" in this part refer to all provisions contained in 7.18.1 through 7.18.2 NMAC.

[7.18.2.53 NMAC - Rp, 7.18.5.53 NMAC, 8/1/16]

7.18.2.54 SAVINGS CLAUSE:

Repeal or supersession of prior versions of this part or the aquatic venue rules shall not affect any administrative or judicial action initiated under those prior versions.

[7.18.2.54 NMAC - Rp, 7.18.5.54 NMAC, 8/1/16]

7.18.2.55 COMPLIANCE WITH OTHER REGULATIONS:

Compliance with the aquatic venue rules or this part does not relieve a person from the responsibility to comply with any other applicable federal, state, or local regulations.

[7.18.2.55 NMAC - Rp, 7.18.5.55 NMAC, 8/1/16]

7.18.2.56 PENALTY:

Any person who violates any provision of this rule shall be subject to the penalty provisions in Section 74-1-10 NMSA 1978 of the Environmental Improvement Act, in addition to any other penalties provided for in the aquatic venue rules.

[7.18.2.56 NMAC - Rp, 7.18.5.56 NMAC, 8/1/16]

7.18.2.57 LIMITATION OF DEFENSE:

The existence of a valid permit for the installation, modification or operation of an aquatic venue shall not constitute a defense to a violation of any section of this regulation, except the requirement for obtaining a permit.

[7.18.2.57 NMAC - Rp, 7.18.5.57 NMAC, 8/1/16]

PART 3: PUBLIC SWIMMING POOLS, SPAS AND BATHS: DESIGN AND CONSTRUCTION [REPEALED]

[This part was repealed on August 1, 2016.]

PART 4: PUBLIC SWIMMING POOLS, SPAS AND BATHS: MAINTENANCE AND OPERATION REQUIREMENTS [REPEALED]

[This part was repealed on August 1, 2016.]

PART 5: PUBLIC SWIMMING POOLS, SPAS AND BATHS: FEES [REPEALED]

[This part was repealed on August 1, 2016.]

CHAPTER 19: BURIAL PRACTICES [RESERVED]

CHAPTER 20: MENTAL HEALTH

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: COMPREHENSIVE BEHAVIORAL HEALTH STANDARDS [REPEALED]

[This part was repealed on May 15, 2018.]

PART 3: REQUIREMENTS FOR COMMUNITY MENTAL HEALTH CENTERS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.321.6 NMAC.]

PART 4: BEHAVIORAL HEALTH CAPITAL FUND PROGRAM [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.321.7 NMAC.]

PART 5-10: [RESERVED]

PART 11: CERTIFICATION REQUIREMENTS FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

7.20.11.1 ISSUING AGENCY:

Children, Youth and Families Department.

[7.20.11.1 NMAC - Rp 7 NMAC 20.11.1, 03/29/02]

7.20.11.2 SCOPE:

This policy applies to all child and adolescent behavioral health programs described herein.

[7.20.11.2 NMAC - Rp 7 NMAC 20.11.2, 03/29/02]

7.20.11.3 STATUTORY AUTHORITY:

1978 NMSA Sections 32A-12.1.et seq.

[7.20.11.3 NMAC - Rp 7 NMAC 20.11.3, 03/29/02]

7.20.11.4 DURATION:

Permanent

[7.20.11.4 NMAC - Rp 7 NMAC 20.11.4, 03/29/02]

7.20.11.5 EFFECTIVE DATE:

March 29, 2002 unless a later date is cited at the end of section.

[7.20.11.5 NMAC - Rp 7 NMAC 20.11.5, 03/29/02]

7.20.11.6 OBJECTIVES:

A. to establish certification requirements for behavioral health services provided to children and adolescents of New Mexico through the medicaid program (Title XIX of the Social Security Act);

B. to provide for monitoring of agency compliance with these certification requirements to identify any factors that could affect the health, safety, and welfare of the clients or the staff;

C. to assure that the agency establishes and follows written policies and procedures that specify how these certification requirements are met; and

D. to assure that adequate supervision is provided at all times.

[7.20.11.6 NMAC - Rp 7 NMAC 20.11.6, 03/29/02]

7.20.11.7 DEFINITIONS:

A. ABUSE means an intentional or negligent infliction of physical or psychological harm; intentional or negligent sexual contact or sexual exploitation; intentional or negligent behavior that jeopardizes life or health; torture, cruel confinement or corporal punishment.

B. ACCREDITED means written acknowledgement from a national organization that an agency or program meets the published standards of the organization issuing the accreditation.

C. ACCREDITED RESIDENTIAL TREATMENT CENTER (ARTC) means a facility with 16 beds or less that may be attached to, or housed within, a hospital or other institution; that provides residential treatment services pursuant to these requirements; and that is accredited by JCAHO.

D. ACTION PLAN means a written document that may be required by the licensing and certification authority (LCA) detailing an agency's proposed actions for resolving deficiencies identified by the LCA.

E. ACTIVE STATUS means a type of certification granted to a program currently serving clients.

F. ADMINISTRATOR means the person in charge of the day-to-day operation of an agency. The administrator may also be referred to as the director or operator.

G. ADMISSIONS HOLD means a type of sanction under which a program is prohibited from admitting new clients until the LCA determines that identified deficiencies are corrected, and lifts the sanction.

H. ADVANCE DIRECTIVES means an optional component of the comprehensive service plan. An individual has the right to make decisions in advance, including behavioral health treatment decisions, through a process called advance directive. An advance directive can be used to state the individual's treatment choices, preferences or instructions regarding pre-cursor crisis strategies, or can be used to name a health care agent that is someone that will make health care decisions for the individual. This section of the comprehensive service plan provides the individual the opportunity to take part in behavioral health care decisions if at some point in the future the individual is unable. This document allows the individual to express consent or refusal to medications and other health care decisions, including use of the seclusion and restraints.

I. AGENCY means the legally responsible organizational entity administering the facility or program(s) of specific services identified and certified pursuant to these certification requirements.

J. ASSISTANCE WITH SELF-ADMINISTRATION OF MEDICATION means the supervision and assistance given to a client in the self-administration of a drug.

K. BEHAVIORAL HEALTH ASSESSMENT means an assessment by an integrated series of procedures conducted with an individual to provide the basis for the development of an effective, comprehensive and individualized treatment plan.

L. BEHAVIORAL HEALTH SERVICES means services designed to meet behavioral and mental health and substance abuse needs of medicaid recipients in certified services.

M. BEHAVIOR MANAGEMENT means the use of basic techniques, such as reinforcement, redirection and voluntary time-outs to teach clients skills for managing and improving their own behavior; and the use of verbal de-escalation, therapeutic holds, personal restraint and seclusion in order to maintain a safe and therapeutic environment and to enhance the abilities of clients and care givers to manage client behavior.

N. BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES (BMS) means services provided on a staff-to-child ratio of at least 1:1. Behavior management skills development services are for children and adolescents with psychological, emotional, behavioral, neurobiological or substance abuse problems in the home, community or school when such problems are of such severity that highly supportive and structured therapeutic behavioral interventions are required. These services are designed to maintain the client in his/her home, community or school setting.

O. BEHAVIOR MANAGEMENT SERVICES PLAN means a service plan used in behavior management skills development services.

P. CANCELLATION means an LCA action nullifying a program's certification.

Q. CAPACITY means the maximum number of clients allowed to receive services in a licensed facility at any specified time in accordance with these certifications requirements.

R. CASE MANAGEMENT SERVICES means services provided in order to assist children and adolescents with identifying and meeting multiple and complex, special physical, cognitive and behavioral health care needs through planning, securing, monitoring, advocating and coordinating services.

S. CARF means council on accreditation of rehabilitation facilities.

T. CERTIFICATION means an authorized status conferred by the department on a program that meets these certification requirements for providing service(s) to children and adolescents.

U. CERTIFIED FAMILY SPECIALISTS (CFS) means an individual 18 years of age or older who has personal experience navigating any of the child or family-serving systems or advocating for family members who have a knowledge of and are involved with the behavioral health systems and are certified by an approved state of New Mexico certification program.

V. CERTIFIED PEER SPECIALISTS (CPS) means a self-identified current or former consumer, 18 years of age or older, of mental health or substance abuse services and has at least one year of mental health or substance abuse recovery and is certified as a CPS by an approved state of New Mexico certification program.

W. CHEMICAL RESTRAINT means the administration of a medication(s) which is neither a standard treatment for the client's medical or psychiatric condition nor a part of the client's daily medication regimen, and is used for the primary purpose of controlling a client's behavior or restricting a client's freedom of movement.

X. CHILD/ADOLESCENT means a person under the chronological age of 21 years.

Y. CLEARED STAFF MEMBER means an individual who has been approved by the department for employment in the immediate presence of children and adolescents by means of a state and federal criminal background clearance.

Z. CLIENT means any child or adolescent who receives treatment from a service certified by the department.

AA. COA means council on accreditation for children and family services.

AB. CLINICAL STAFF means licensed mental health practitioners and treatment coordinators.

AC. CLINICAL SUPERVISOR means a staff member who is a licensed independent practitioner and who has responsibility and authority for supervising other clinical staff.

AD. COMMUNITY SUPPORTS means the coordination of resources to individuals/families necessary for them to implement strategies to promote recovery, rehabilitation and resilience.

AE. COMMUNITY SUPPORT WORKER (CSW) means the primary staff responsible for assisting the client and family with implementation of the comprehensive service plan and coordinating or facilitating family and treatment team meetings and is certified by an approved state of New Mexico certification program.

AF. COMPREHENSIVE COMMUNITY SUPPORT SERVICES (CCSS) means a variety of interventions, primarily face-to-face and in community locations that address barriers that impede the development of skills necessary to independent functioning in the community. It provides assistance with identifying and coordinating services and supports identified in an individual's comprehensive service plan; supporting an individual and family in crisis situations; and providing individual interventions to develop or enhance an individual's ability to make informed and independent choices. The target population for CCSS includes children, youth and adults with significant behavioral health disorders and who meet other criteria as identified by the collaborative.

AG. CONTRACTOR means an individual who provides direct services to clients through contracts with the agency.

AH. CORPORAL PUNISHMENT means a form of discipline or behavior control that involves forced exercise or touching a child's body with the intent to induce pain and includes, but is not limited to, shaking, spanking, hitting, hair pulling, and ear pulling.

AI. CRIMINAL RECORDS CHECK (CRC) means the process of submitting state and FBI approved fingerprint cards and any additional required background information to the department for the purpose of determining whether or not an individual has state or federal convictions on record that may disqualify the individual from direct unsupervised contact with children/adolescents and, when applicable, for the purpose of obtaining and reviewing a record of convictions.

AJ. CRIMINAL RECORDS CLEARANCE means a determination made by the department, based on the results of the criminal records check, that an individual may work directly and unsupervised with children and adolescents.

AK. CRISIS MANAGEMENT SERVICES means those services identified in the individual's crisis plan. Such services are located in the community, include natural supports and are available to the client and family after the agency's normal operating hours.

AL. CRISIS PLAN means a component of the comprehensive service plan that clearly identifies the level of intensity and severity of potential crisis events and how they will be managed after normal business hours with specific resources identified for the client, family and natural supports. The crisis plan shall include defined client, family and treatment team roles and activities.

AM. CULTURAL COMPETENCE means the involvement, integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs. Cultural competence is illustrated by congruent behaviors, attitudes and policies that match a client's culture to increase the quality and appropriateness of behavioral health care and outcomes.

AN. CULTURALLY COMPETENT ASSESSMENT means the relevant cultural considerations in the assessment of the behavioral health needs of a client.

AO. DAY TREATMENT SERVICES (DTS) means a coordinated and intensive set of structured individualized therapeutic services, in a school, or a facility licensed by the LCA, provided for children, adolescents and their families who are living in the community.

AP. DEFICIENCY means a violation of, or failure to comply with, a provision(s) of these certification requirements.

AQ. DENIAL means a sanction imposed by the LCA to refuse to issue a certification, based on a determination made by the LCA.

AR. DEPARTMENT means the New Mexico children, youth and families department.

AS. DESIGNATED AGENCY means the agency that has the primary responsibility of partnering with the client and family for implementation of the comprehensive service plan.

AT. DIRECT PHYSICAL SUPERVISION means, with reference to criminal records clearances, either continuous visual observation or live video observation of a non-cleared agency staff member by a cleared agency staff member or by the client's legal guardian, while the non-cleared staff is in immediate presence of the client.

AU. DIRECT SERVICE STAFF means supervisors, physicians, nurses, therapists, client care workers, coordinators or other agency personnel who work in immediate direct unsupervised contact with children.

AV. DIRECT UNSUPERVISED CONTACT means physical proximity to clients, such that physical contact or abuse could occur, without being observed or noticed by another staff member who has been cleared by the department.

AW. DIRECTED ACTION means a formal action(s) specified by the LCA that the agency is required to undertake or complete in order to correct a deficiency(ies) within a specified time frame.

AX. DISCHARGE CRITERIA means specific clinically-based indicator(s) used to measure the client's degree of readiness for release from a given level of care stated in terms of achievement of treatment goals or reduction of symptoms; discharge criteria may also include indicators that a given level of care is inappropriate for a client due to such factors as dangerousness or non-responsiveness to treatment.

AY. DISCHARGE PLAN means a written section of a treatment plan/service plan and treatment plan/service plan reviews containing the following elements: behavioral and other clinical criteria that describe the conditions under which discharge will occur, identification of barriers to discharge; the level of care, specific services to be delivered, and the living situation into which discharge is projected to occur; the projected date of discharge, individuals responsible for implementing each action specified in the discharge plan, and, when indicated, revisions.

AZ. DISCIPLINE means non-abusive training that enables a client to develop self-control and orderly conduct in relationship to others.

BA. DOCUMENTATION means the written or printed record of information supporting the facts related to the certified services being provided to clients found in client files, personnel files, and other pertinent printed sources.

BB. EARLY AND PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means periodic, comprehensive services to persons under 21 years of age; these services are defined in the medicaid program policies.

BC. EMERGENCY SAFETY INTERVENTION means personal restraint or seclusion.

BD. EMERGENCY SANCTION means an immediate requirement that is imposed on a program by the LCA in response to a finding of health or safety deficiency(ies).

BE. EMERGENCY SERVICE means an unanticipated admission to an acute medical or psychiatric facility or the provision of other medical services by paramedics or other emergency or urgent care personnel.

BF. EMERGENCY SUSPENSION means an immediate and temporary cancellation of a certification due to an existing health or safety deficiency(ies), pending an appeal hearing and correction of health or safety deficiencies. During a period of emergency suspension, the medicaid provider agreement is not in effect.

BG. EMPLOYMENT HISTORY means a verifiable written summary of employment including names, addresses and telephone numbers of employers, immediate supervisors as well as dates of and explanations for any period(s) of unemployment for a minimum of three years immediately prior to hire for employment by a certified program.

BH. ENHANCED SERVICE means, in the medicaid managed care system, any and all services beyond the scope of the medicaid (fee-for-service) benefit package available to recipients in the medicaid managed care program.

BI. EXCLUSIONARY CRITERIA means agency-written criteria that define the diagnoses, behaviors, or conditions that preclude admission to the certified program.

BJ. EXEMPLARY means a certified status conferred by the LCA on a program that has no history of temporary certification, sanctions or loss of certification in the previous two years and meets all of the certification requirements with minor or no deficiencies.

BK. EXPANSION HOLD means a type of sanction under which an agency is prohibited from obtaining certification for additional services until the LCA determines that identified deficiencies are corrected and lifts the sanction.

BL. EXPLOITATION means the act or process of using a client or client's property for another person's profit, advantage or benefit.

BM. FACILITY means the physical plant and building(s) licensed by the LCA in which residential or day treatment mental health services are provided.

BN. FUNCTIONAL LEVEL means a determination of the client and as applicable, his family's, functional skills in multiple domains.

BO. GENERAL PROVISIONS means the series of certification requirements found in Sections 9 through 25 of these certification requirements.

BP. GOVERNING BODY means the organizational entity of an agency that has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a program certified pursuant to these certification requirements.

BQ. GROUP HOME SERVICES (GHS) means mental and behavioral health services offered in a supervised, licensed facility that provides structured therapeutic group living for children/adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, when clinical history and opinion establish that the needs of the client cannot be met in a less restrictive environment.

BR. HEALTH OR SAFETY DEFICIENCY means a deficiency that poses an immediate threat to the welfare of clients up to and including loss of life; physical harm; physical, sexual, psychological abuse or exploitation.

BS. HUMAN SERVICES DEGREE means an approved bachelors or masters degree from an accredited school in one of the following degrees: counseling and therapy, rehabilitation, psychology, criminal justice, social work/social services, or human development. If workforce issues are identified in a region of the state, the some other defined degrees may be considered as human services degrees. However, any experience required in the service definition must be met. In order for an agency to utilize staff with these degrees, they must submit a written waiver request to LCA with documentation supporting the workforce issues. Those alternative degrees may include nursing, sociology, public health, education, occupational therapy, speech and hearing sciences, speech-language pathology, communication sciences and disorders, gerontology, or social sciences.

BT. INACTIVE STATUS means a type of certification granted to a program that is not currently serving clients.

BU. INCIDENT REPORT means the document(s) describing a serious incident or alleged serious incident.

BV. INFORMAL RESOLUTION CONFERENCE means an informal meeting and problem-solving process between the department and an agency to resolve any filed or potential appeal arising from the imposition or potential imposition of a sanction(s).

BW. INFORMED CONSENT means a document that reflects that a client and the legal guardian(s) are advised of the benefits, risks, and alternatives of a given medication or treatment and agree to the use of the medication or treatment. Clients age 14 and above may consent to the use of a medication or treatment without the approval of their legal guardian(s).

BX. INITIAL CERTIFICATION means a type of certification granted to a program that has met the minimum requirements to implement a program to provide services pursuant to these requirements.

BY. INVESTIGATION means a formal process of inquiry used by the LCA to: determine the validity of complaints or allegations made against certified agencies; or to determine whether trends in incidents reported to the LCA that affect the health and safety of clients are the result of negligent practices, insufficient supervision of personnel or clients, or any other factor that requires correction; or to determine whether or not an agency has made corrective responses to resolve matters of threat to client health and safety substantiated by the LCA.

BZ. JCAHO means the joint commission on accreditation of healthcare organizations.

CA LICENSE means the written authorization issued by the LCA pursuant to 7.20.12 NMAC granting right to operate the designated facility for a specified period of time; or, in context, any necessary authorization by the appropriate credentialing authority to undertake the professional activity in question.

CB. LICENSED INDEPENDENT PRACTITIONER means New Mexico-licensed clinical staff who are authorized to practice at the independent level.

CC. LICENSED INDEPENDENT MEDICAL PRACTITIONER means a New Mexico licensed medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), clinical nurse specialist (LCNS), or physician assistant (PA).

CD. LICENSING AND CERTIFICATION AUTHORITY (LCA) means the licensing and certification unit of the children’s behavioral health and community services bureau of the prevention and intervention division of the department.

CE. MAINTENANCE OR REDUCTION IN PROGRAM CAPACITY means a sanction that directs the agency to maintain or reduce the capacity of the program to a designated census until the LCA determines that deficiencies resulting in the sanction have been corrected.

CF. MECHANICAL RESTRAINT means use of a mechanical device(s) to physically restrict a client's freedom of movement, performance of physical activity, or normal access to his or her body, and is distinct from personal restraint as defined below.

CG. MEDICAID means Title XIX of the Social Security Act; the joint federal-state program that pays for medical care for low-income persons.

CH. MONITORING means the ongoing review of a program's progress in correcting deficiencies. During a period of certification, monitoring is done at the discretion of the LCA. Monitoring may be implemented by means of a monitoring plan, and may require that specified documentation be submitted to the LCA by the agency or may include the use of on-site surveys by the LCA to ascertain compliance in specified areas.

CI. MONITORING PLAN means a written set of guidelines and instructions specified by the LCA for a program to follow for the purpose of correcting deficiencies.

CJ. MORAL TURPITUDE means conduct contrary to justice, honesty, modesty or good morals, as further specified in 8.8.3 NMAC.

CK. MULTISYSTEMIC THERAPY (MST) is an intensive family and community-based treatment program that addresses the known determinants of serious antisocial behavior in adolescents and their families. MST treats the factors in the youth's environment that are contributing to his or her behavior problems. Such factors might pertain to individual characteristics of the youth (poor problem solving skills), family relations (inept discipline), peer relations (association with deviant peers) and school performance. Treatment goals for therapeutic change are developed on an individualized basis in collaboration with the family.

CL. NEGLECT by individuals or an agency means:

(1) failure to provide any treatment, service, care, medication or item that is reasonably necessary to maintain the health or safety of a client; or

(2) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a client; or

(3) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good service or medication reasonably necessary to maintain the health or safety of a client; or

(4) failure to take any reasonable precaution that would prevent the physical abuse, sexual abuse, or sexual exploitation of a client, as defined in the Children's Code at 1978 NMSA 32A-4-2, or the lack of which causes the client to become an abused child or neglected child as defined in the Children's Code at NMSA 1978 32A-4-2.

CM. NON-ACCREDITED RTC means a program that provides residential treatment services pursuant to these requirements that is not accredited by JCAHO.

CN. NON-RENEWAL means a sanction whereby certification is cancelled on or about the date of expiration.

CO. NON-RESIDENTIAL SERVICES means a program that provides certified services other than twenty-four-hour continuous care within the confines of a facility or treatment foster home.

CP. NOTICE OF CONTEMPLATED ACTION means a letter issued by the LCA identifying grounds for sanction of a program.

CQ. NOTICE OF EMERGENCY SANCTION means a letter issued by the LCA when an emergency sanction is imposed.

CR. NOTICE OF FINAL ACTION means a letter issued by the LCA stating that the sanctions proposed in a previous notice of contemplated action are in effect. This letter is issued upon the conclusion of any appeal/informal resolution proceeding or the expiration of the appeal period to the notice of contemplated action.

CS. PARTIAL COMPLIANCE means a determination by the LCA that a program is found to have moderate and few deficiencies, none of which immediately compromises the health or safety of the clients.

CT. PARTIALLY SUBSTANTIATED COMPLAINT means a complaint that the LCA has determined is factually accurate in part, but not factually accurate in its entirety.

CU. PERMANENCY PLAN means the long-term plan for the child/adolescent developed by the protective services division of the department with one of the following outcomes: reunification, permanent guardianship, adoption, permanent placement with a fit and willing relative, or planned permanent living arrangements.

CV. PERSONAL RESTRAINT means the application of physical force without the use of any device, for the purposes of restraining the free movement of a client's body. The term personal restraint is distinct from therapeutic hold and mechanical restraint as defined herein and does not include briefly holding a client, without undue force, in order to calm or comfort him or her, or holding a client's hand to safely escort a client from one area to another.

CW. PHYSICAL ESCORT means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purposes of inducing a client who is exhibiting unsafe or potentially unsafe behavior to walk to a safe location.

CX. PHYSICAL HARM means physical injury that requires treatment beyond basic first aid; or that results in loss of functional use of a bodily member or organ or of a major life activity for a prolonged period of time; or results in loss of consciousness for any amount of time.

CY. PHYSICIAN means an individual who has received a degree of doctor of medicine or doctor of osteopathic medicine and is licensed to practice medicine in the state of New Mexico.

CZ. POLICY means a statement of principle that guides and determines present and future decisions and actions.

DA. PREMISES means all parts of buildings, grounds, vehicles and equipment of a facility.

DB. PRE-SERVICE TRAINING means training that is provided to a newly hired employee prior to the employee's provision of direct services.

DC. PROCEDURE means the action(s) that will be taken to implement a policy; and the written description of such action(s) that serves as instruction to agency staff.

DD. PROGRAM means an agency, or subdivision of an agency, operated with the intent to provide certified services.

DE. PROVIDER means an agency or its personnel who have a medicaid provider number and deliver direct services to clients.

DF. PSYCHIATRIST means a physician who specializes in the treatment of psychiatric disorders, has completed an accredited psychiatric residency program, and holds a current license to practice medicine in the state of New Mexico.

DG. PSYCHOLOGICAL HARM means harm that causes symptoms of mental or emotional trauma, or that causes distress of sufficient magnitude to cause behavioral change, or physical symptoms that may require psychological or psychiatric evaluation or treatment.

DH. PSYCHOLOGIST means a doctoral level psychologist who specializes in assessing and treating psychological disorders and holds a current license to practice in the state of New Mexico.

DI. PUNISHMENT means a penalty imposed on a child/adolescent by one in authority for wrongdoing.

DJ. RECOVERY means the process, outlook, vision and guiding principle that stresses that hope and restoration of a meaningful life are possible, despite serious

mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society (adapted from *Mental Health: A Report to the Surgeon General, Chapter 2, 1999*).

DK. RECOVERY/RESILIENCY MANAGEMENT PLAN means the foundational component for building the comprehensive service plan. The recovery/resiliency management plan component focuses on strengths and preferences based on identified competencies, the process of autonomy (independence), and developing a system of natural supports (satisfying and supportive social relationships). The recovery/resiliency management plan component shall include:

(1) the client and family's personal choice of service options and priorities in service delivery with a client centered focus;

(2) client driven interventions including attainable objective to address the client's defined needs;

(3) a clear identification of the environment in which the client lives including: family, school peers, community and home, and how each will play a part in the comprehensive service plan; and

(4) a clear approach to the development of resiliency based on life skills identified by the client and service team.

DL. REFERENCE CHECK means a documented contact with previous employers, supervisors, co-workers, or other sources, initiated by the agency to evaluate a prospective employee prior to hire by establishing the accuracy of his/her employment history and to obtain other information relevant to potential hire.

DM. REHABILITATION means a process that enhances the efficacy of clients with functional limitations due to behavioral health disorders to obtain information, develop skills and access resources needed to make decisions and implement strategies to be successful and satisfied in the living, working, learning, and social environments of their choice. Rehabilitation services are driven by the client's desire for recovery and resiliency based outcomes and are individualized, collaborative and person directed.

DN. RESIDENTIAL FACILITY means a facility licensed by the LCA, in which 24-hour continuous therapeutic care is provided to a group of children/adolescents in accordance with these certification requirements.

DO. RESIDENTIAL TREATMENT SERVICES means a program that provides 24-hour therapeutic care to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in a residential facility.

DP. RESTRAINT/SECLUSION CLINICIAN means a New Mexico licensed medical doctor (MD), doctor of osteopathy (DO), certified nurse practitioner (CNP), clinical nurse specialist (LCNS), physician assistant (PA) or doctoral level psychologist (Psy.D., Ph.D., or Ed.D.), who is trained in the use of emergency safety interventions.

DQ. REVOCATION means a type of sanction making a certification null and void through its cancellation.

DR. SANCTION means a measure imposed by the LCA on a certified program, pursuant to these certification requirements, in response to findings(s) of a deficiency(ies), with the intent of obtaining increased compliance with these certification requirements.

DS. SECLUSION means a behavior management technique that involves locked isolation. Seclusion is distinct from therapeutic time-out.

DT. SERIOUS INCIDENT means an incident involving the death of a client, suicide attempt by a client; psychological or physical harm to a client; serious homicidal threat to or by a client; physical or sexual abuse/perpetration to, or by, a client or a staff member; the use, possession, or distribution of illegal substances by clients or staff; neglect or exploitation of a client by staff; AMA or emergency discharge; arrest or detention of a client; natural disasters, or contagious disease outbreaks; or agency knowledge that a staff member has been charged with, or convicted of, a felony or of a misdemeanor involving moral turpitude, including but not limited to convictions referenced in 8.8.3 NMAC.

DU. SEXUAL ABUSE means any intentional and uninvited contact, demand or enticement of a sexual nature, including contact with another person’s clothed or unclothed genital area, anus, buttocks, or breast(s) if the recipient is female; or, intentional causing of another person to touch any of these areas on one’s own or a third party’s body; or, consensual contact with any of these areas if the initiator is in a position of significant influence over the recipient by reason of differences in age, physical size, development, intellectual sophistication, sexual sophistication, or position of authority; or, a verbal request, offer, or demand such as would initiate such contact when the initiator of the verbal behavior is in a position of significant influence as described above. Physical contact, as described above, includes contact between clothed or unclothed body parts of individuals, or may be between clothed or unclothed body parts of one person and an object.

DV. STAFF means a person who has contact with children in a certified program and includes the owner, operator or director of a program, volunteers, full-time, part-time, contract employees, and treatment foster parents.

DW. STAY means the department is temporarily refraining from taking an action on a sanction, revocation, or suspension of certification.

DX. SUBSTANTIAL COMPLIANCE means a determination by the LCA that a program is found to be without deficiencies, or with minor and few deficiencies, none of which compromise the health and safety of clients.

DY. SUBSTANTIATED COMPLAINT means a complaint or allegation that the LCA has determined is factual.

DZ. SUPERVISION means one of the following, as indicated by context: the monitoring of clients' whereabouts and activities by the program staff in order to ensure their health, safety, and welfare; or the clinical or managerial oversight of staff.

EA. SURVEY means examination, or other review, of a program's premises, records or other documents; or interview of client(s) or staff, at the discretion of the LCA, pursuant to these certification requirements.

EB. SUSPENSION means a type of sanction whereby certification is temporarily revoked, during which time the medicaid provider agreement is not in effect.

EC. THERAPEUTIC HOLD means the brief physical holding of a client, without undue force, used as part of a behavioral plan by an individual trained and certified by a state recognized body in the use of therapeutic holds and personal restraints, in a manner consistent with written agency policy, for the purpose of providing emotional comfort or calming to the client, or physical safety to the client, other clients, staff member(s) or others. Therapeutic hold is distinct from personal restraint and mechanical restraint as defined above.

ED. THERAPEUTIC LEAVE means a period of time during which a treatment foster care services client is temporarily placed in a different treatment foster home. This affords the primary treatment foster parents a period of authorized leave.

EE. THERAPEUTIC TIME-OUT means a technique involving individual isolation used as part of a written behavioral plan to prevent or decrease the potential for unsafe behavior and to give the client the opportunity to regain control.

EF. THERAPIST means a person who has a license from an appropriate licensing authority to provide direct clinical care services such as individual, family, or group therapy.

EG. TREATMENT FOSTER CARE SERVICES (TFC) LEVEL I means a program that provides therapeutic services to children or adolescents who are psychologically or emotionally disturbed, or behaviorally disordered, in a foster family setting, pursuant to these certification requirements.

EH. TREATMENT FOSTER CARE SERVICES LEVEL II means a program that provides therapeutic services to children or adolescents who are psychologically or emotionally disturbed, or behaviorally disordered, in a foster family setting, pursuant to

these certification requirements. It is distinct from treatment foster care services level I in that it is provided to children and adolescents who have successfully completed treatment foster care services level I as determined by the treatment team, and are in the process of returning to biological family and community, or who meet other established criteria.

EI. TREATMENT FOSTER HOME means a licensed residence overseen by a certified program and licensed child placement agency in which treatment foster care services are being provided to agency clients by licensed treatment foster parents.

EJ. TREATMENT PLAN means a written document formulated on an ongoing basis by a treatment team that guides and records for each client: individualized therapeutic goals and objectives; individualized therapeutic services provided; individualized discharge plans and aftercare plans.

EK. TREATMENT PLANNING means an ongoing process, based on assessment and regular reassessment of a client's needs, of documenting those needs, the interventions intended to address those needs, and the client's behavioral responses to interventions. Treatment planning includes initial treatment plans, comprehensive treatment plans, treatment plan reviews and discharge plans.

EL. TREATMENT TEAM means the group of individuals that assesses, plans, coordinates, implements, evaluates, reviews, and adjusts all aspects of a client's care over the course of treatment in a certified program. The treatment team includes the client, and as applicable, the client's family or legal guardian(s), therapist, direct service staff, treatment coordinators, treatment foster parents, the department's social worker or juvenile probation/parole officer, case manager, a representative from an educational agency, or other significant individuals in the client's life.

EM. UNSUBSTANTIATED COMPLAINT means a complaint or allegation that could not be verified by the LCA based on its investigation.

EN. VARIANCE means a deviation from a portion(s) of these certification requirements approved in writing at the sole discretion of the LCA. It is based upon stipulated conditions to be met by the agency, for an unlimited time period, provided that the health, safety, and welfare of the clients and staff are not in danger.

EO. VOLUNTEER means an individual who works without compensation at an agency in the physical presence or proximity of clients.

EP. WRAPAROUND means a team-based activity that helps groups of people involved in a family's life work together toward a common goal.

EQ. WAIVE/WAIVER means a deviation(s) from any part of these certification requirements approved in writing by the LCA, at the sole discretion of the LCA. It is

based on stipulated conditions to be met by the agency, for a limited period of time, provided the health, safety, and welfare of clients and staff is not in danger.

[7.20.11.7 NMAC - Rp 7 NMAC 20.11.7, 03/29/02; A, 04/14/05; A, 01/01/08; A, 12/31/08]

7.20.11.8 RELATED REGULATIONS, LAWS AND CODES:

These certification requirements supplement and apply in conjunction with the following regulations laws and codes and any future amendments to such regulations or superseding regulations.

A. Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC.

B. Health Facility Sanctions and Civil Monetary Penalties, 7 NMAC 1.8 (1996).

C. New Mexico Children's Code NMSA 1978 32A-1-1 et Seq. (1997).

[7.20.11.8 NMAC - Rp 7 NMAC 20.11.8, 03/29/02]

7.20.11.9 ISSUANCE OF CERTIFICATION:

A. Application for initial certification:

(1) Applications for the initial certification of a new program offering case management services, behavior management skills development services, day treatment services, group home services, all residential treatment services, or treatment foster care services are submitted to the LCA for review and approval. The application for initial certification of a program includes, but is not limited to, the following:

(a) a letter of intent naming the service for which the agency is requesting initial certification and describing how and where the proposed service will be delivered.

(b) policies and procedures showing that the agency complies with both the general provisions and the service-specific requirements of the program for which the agency is requesting initial certification; and an index that references each policy and procedure by the applicable certification requirement that the policy is designed to meet.

(c) job descriptions, required qualifications, resumes, current licenses, proof of credentials, and criminal records clearances for professional staff;

(d) job descriptions, required qualifications and criminal records clearances for direct service staff; and

(e) a complete set of the forms that will be used to document the services being provided.

(2) At the discretion of the LCA, the application process may include interviews with staff, administrators, or program directors.

(3) When applicant agencies have an established in-state or out-of-state history of providing mental health or substance abuse services for children and adolescents, whether or not the agency is currently providing such services, the agency's record with regulatory compliance will be considered during review of the new application;

(4) Applications will be reviewed by the LCA within 15 business days and a written response will be sent to the agency. The findings of the review will determine which of the following responses will be issued by the LCA:

(a) Complete applications that comply with all the requirements of these certification requirements will be issued an initial certification for a period of up to 120 days.

(b) Incomplete applications will be returned with a letter detailing what elements of the application are missing. initial certification will not be issued.

(c) When an application is complete, but fails to show that the agency has fully or substantially complied with all of these certification requirements, the LCA will issue a letter detailing the findings of the review, with a list of the changes required to show the new program to be in compliance with these certification requirements. An initial certification will not be issued.

(5) If, three months subsequent to the issuance of an LCA letter detailing missing or insufficient elements of an application, the agency has not responded with a completed application or has not achieved compliance with these certification requirements sufficient to warrant initial certification, the application will be considered void. The agency may reapply for certification of the service, but will be required to begin a new application process.

(6) COA/CARF/JCAHO Accreditation does not confer state certification status on a program.

B. Types of certification:

(1) FULL CERTIFICATION: Full certification is granted to a program currently serving clients and found by the LCA to be in substantial compliance with these certification requirements. At the discretion of the LCA, the duration of full certification status is 12 to 24 months.

(2) EXEMPLARY STATUS is a type of full certification that may be granted to a program that has no history of temporary certification, sanctions or loss of certification in the previous two years and that, based on a determination made by the LCA, adheres to these certification requirements with only minor deficiencies, which pose no health and safety risks to clients. Exemplary status may be granted for up to 24 months.

(3) FULL CERTIFICATION: This certification is granted to a program currently serving clients and found to be in substantial compliance with these certification requirements, when only minor and few deficiencies, none of which compromise client health and safety, are identified in the LCA certification report. The program submits an action plan for the LCA's approval within the time frame specified by the LCA, detailing the measures that will be used to correct the deficiencies. At the discretion of the LCA, the program may also be required to implement a directed action(s) within specified time frames; or may be required to comply with monitoring as specified by the LCA during the period of certification. Based on a determination made by the LCA, the program produces proof of correction of deficiencies and/or compliance with directed action(s) and/or monitoring through submission of relevant documentation and/or by subsequent on-site review. The terms and the timeframes for monitoring are established in writing in the certification report.

(a) The LCA provides written notification indicating whether the program's action plan is approved. Action plans may be approved with amendments recommended and/or required within a time frame specified by the LCA. If an action plan is not approved, the LCA will specify items that require revision or supplementation in order to receive LCA approval.

(b) If another survey reveals additional deficiencies, the LCA may require amendment of the action plan, and/or issue new written directed actions, and/or implement a revised monitoring plan, and/or sanction the program based on new deficiencies identified.

(4) TEMPORARY CERTIFICATION: Temporary certification is granted to a program currently serving clients that is found by the LCA to be in partial compliance with the certification requirements, or to a program that has been on inactive status and is returning to active status.

(a) The LCA determines the duration of a temporary certification. Temporary certification may be granted for a period of up to 180 days. The LCA determines the duration of temporary certification based on factors that may include severity of deficiencies and the program's history of compliance with certification requirements.

(b) The program submits an action plan for the LCA's approval within 14 days of receipt of the LCA certification report detailing its findings of deficiencies, unless otherwise specified by the LCA. At the discretion of the LCA, the program may also be required to implement directed action(s) within specified time frames. The program may

be required to comply with terms of monitoring specified by the LCA during the period of temporary certification, based on a determination made by the LCA.

(c) Items 9.B(3)(a) and (b) above are applicable for action plans that accompany temporary certification.

(d) For programs returning to active status, an action plan, directed action, and/or monitoring are not required unless specified by the LCA.

(e) If the program does not achieve substantial compliance with these certification requirements at the end of a temporary certification period, a sanction(s) may be imposed including non-renewal of certification.

(f) At the discretion of the LCA, a second consecutive temporary certificate may be issued for a period of up to 180 days, or certification may be allowed to expire without renewal.

(5) INITIAL CERTIFICATION: This certification is granted for a period of 120 days to a program that has met the minimum requirements to provide child and adolescent mental health or substance abuse services as determined by the application process described in certification requirement 9.A above. If the program has no clients at the end of 120 days, a second 120-day initial certification may be granted. If the program remains without clients beyond 240 days, the program's initial certificate expires and re-application for certification is required; or, at the discretion of the LCA, inactive status may be granted.

(6) INACTIVE STATUS: This certification is granted to a program not presently serving clients, but which has served clients within the current period of certification. A certificate of inactive status covers a period of time not to exceed 180 days from the date of issue. If the program continues without clients beyond 180 days, a second 180-Day certificate of inactive status may be granted upon request. If the program remains without clients beyond 365 days, the program's inactive status expires and re-application for initial certification is required.

(a) To return to active status from inactive status for a certified service, the program must notify the LCA in writing at least two weeks prior to its intended admission of clients. In addition to the written notice, the agency must submit the following to the LCA: information on any changes in personnel or agency policies and procedures during inactive status; proof of criminal records clearances, qualifications, and, as applicable, licensure for new supervisory and direct service staff of the certified program.

(b) Upon review of the submitted information, the LCA may grant temporary certification. The agency will not admit any client(s) until the LCA issues and the program receives temporary certification.

(7) AMENDED CERTIFICATE: This certification is granted to a program currently serving clients that has had a change of ownership or licensee, or that chooses to change its name. The agency submits a written request for an amended certificate to the LCA ten business days prior to the change.

(8) DEEMED CERTIFICATION: The LCA has discretion to grant deemed certification when a program is accredited by the council on accreditation (COA), the council on accreditation of rehabilitation facilities (CARF), or for residential treatment services, by the joint commission on accreditation of health care organizations (JCAHO), and the LCA determines that the standards of the accrediting body apply substantially to the program for which deemed certification is being considered. A certified program that is accredited by one of these organizations and wishes to request deemed certification must provide a copy of the accreditation report to the LCA within 30 days of receipt of the report, and must provide any other accreditation-related documentation to the LCA upon request. Upon receipt and review of the COA, CARF or JCAHO survey reports, the LCA, at its discretion, may issue deemed certification status effective for up to 24 months. For those intervening years that the above-mentioned accrediting bodies do not conduct on-site visits, the LCA may conduct annual or biennial certification on-site surveys.

(a) EXCEPTION: The deemed certification may not apply when COA, CARF or JCAHO identify any condition that the LCA, at its sole discretion, determines to be a significant violation of certification or accreditation standards, or that requires follow-up by the accrediting body; or when any condition reported to the LCA appears to pose a threat to health and/or safety; or when there is any other information indicating the existence of such a threat.

(b) All agencies and programs that receive deemed certification must comply with all applicable provisions of the Children’s Health Act of 2000 and these certification requirements.

C. AUTOMATIC EXPIRATIONS OF A CERTIFICATION:

(1) A certificate automatically expires at midnight on the day a certified program discontinues or suspends operation or changes location.

(2) A certificate automatically expires at midnight on the tenth day after a certified program is sold, leased, or otherwise changes ownership and/or licensee, unless the agency has made a timely written request for amended certification. In such a case, the automatic expiration is stayed, and previous certification remains in effect if the agency has until the LCA acts on the application or takes other certification action.

D. WAIVERS AND/OR VARIANCES: Upon written request of the agency and at the discretion of the LCA, the LCA may issue a waiver and/or variance

E. CERTIFICATION REVIEWS: When possible, the LCA schedules on-site program reviews prior to expiration of certification. If the LCA does not perform a certification on-site review of a program prior to the expiration of its certification, and the program has not received a written report from the LCA recommending that the program's certification be allowed to expire, the certification continues in effect until the LCA performs a certification review.

F. The LCA, at its sole discretion, may extend any certification for a period of up to 12 months.

G. In the event that a program's certification is revoked, suspended, denied, or not renewed, the medicaid provider agreement terminates on the date of the revocation, suspension or denial.

[7.20.11.9 NMAC - Rp 7 NMAC 20.11.9, 03/29/02; A, 04/14/05]

7.20.11.10 EMERGENCY REVOCATION, SUSPENSION, NON-RENEWAL OF CERTIFICATION OR IMPOSITION OF EMERGENCY SANCTIONS, WITHOUT PRIOR HEARING:

If immediate action is required to protect human health and/or safety, the LCA may immediately revoke, suspend, not renew, or impose an emergency sanction(s) against the certification status of a program pending a hearing, provided that such hearing is held within five business days of the above-mentioned action and/or sanction(s), unless the program waives its right to a hearing. The medicaid provider agreement terminates on the date of the revocation, suspension, or non-renewal of certification.

[7.20.11.10 NMAC - Rp 7 NMAC 20.11.10, 03/29/02]

7.20.11.11 GROUNDS FOR IMPOSITION OF SANCTIONS:

Sanctions may be imposed by the LCA based on its specific findings, including but not limited to any of the following:

A. failure to comply with any provision(s) of these certification requirements;

B. failure to allow surveys by authorized representatives of the LCA;

employment of any person convicted of a felony or misdemeanor without clearance by the department, including a misdemeanor involving moral turpitude;

C. allowing any agency personnel to work under the influence of alcohol or mood-altering drugs (if after employment, a staff member is charged and/or convicted of a felony or misdemeanor involving moral turpitude and this fact is known to the agency, it must be immediately reported to the LCA);

D. purposeful, deliberate or intentional misrepresentation(s) or falsification(s) of any information on application forms or other documents provided to the LCA;

E. repeated violations of these certification requirements, or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous certification periods;

F. presence of, and/or a history of, certification/licensure revocation, suspension, non-renewal, or denial of certification, sanction(s) or penalties or other similar disciplinary actions taken by regulatory bodies in other states or countries and/or within New Mexico regardless of whether any of these actions resulted in a settlement in lieu of a sanction;

G. failure to provide a client in the program with care, supervision and services or to protect client rights as outlined in these certification requirements;

H. any neglect as defined in these certification requirements;

I. presence of, and/or a history of health and/or safety deficiencies found in current or previous surveys or on-site visits;

J. death or serious injury to a client;

K. psychological harm or cruelty and indifference to the welfare of a client;

L. incidents that include acts of physical harm to a client(s) by staff;

M. regulatory deficiencies that jeopardize the health and/or safety of a client;

N. numerous deficiencies, that in combination, jeopardize the health and/or safety of a client; or

O. non-disclosure and/or deceit regarding condition of a facility/program or the services it provides.

[7.20.11.11 NMAC - Rp 7 NMAC 20.11.11, 03/29/02]

7.20.11.12 SANCTIONS:

A. Sanctions, as follows, may be imposed for the reasons listed in Section 11. The severity of the action taken by the department depends upon the specific facts in each case, the seriousness and history of the events prompting the department to take action, and the ability and willingness of the agency to promptly take adequate corrective action.

(1) REVOCATION: The LCA cancels certification, making it void. The medicaid provider agreement terminates on the date of revocation.

(2) SUSPENSION: The LCA temporarily revokes certification until the identified deficiencies are corrected and the LCA approves the corrections. The medicaid provider agreement terminates on the date of suspension.

(3) NON-RENEWAL: The LCA refuses to renew certification and issues a notice stating that the certification is void as of a specific date, on or about the date of expiration. The medicaid provider agreement terminates on the effective date of non-renewal.

(4) DENIAL: The LCA refuses to issue certification.

(5) ADMISSIONS HOLD: The LCA restricts the program from accepting any new clients until the identified deficiencies are corrected and the LCA approves the corrections.

(6) EXPANSION HOLD: The LCA restricts the program from expanding into additional services until the identified deficiencies are corrected and the LCA approves the corrections.

(7) MAINTENANCE OR REDUCTION IN PROGRAM CAPACITY: The LCA directs the program to maintain or reduce the capacity of the program to a designated client census until the LCA determines that all of the deficiencies resulting in the sanction have been corrected.

(8) COMPLIANCE MONITOR: The LCA may select and assign a compliance monitor and assign it to an agency for a specified period of time to oversee an agency's compliance efforts. The compliance monitor has the authority to review all applicable facility records, including financial records and policies, and the authority to interview facility staff and clients. The compliance monitor may also advise the program regarding steps to correct violations and improve overall clinical programming. The compliance monitor reports to the LCA on a weekly basis or more often when indicated. The agency pays all costs of the compliance monitor.

(9) TEMPORARY MANAGEMENT: The LCA appoints temporary professional management with expertise in the field of the child and adolescent mental health and/or substance abuse services provided by the program. The temporary management assumes primary responsibility to oversee the operation of the program; to protect the health and safety of its clients; to assess and direct the correction of deficiencies; and/or to facilitate an orderly closure. The temporary management reports to the LCA. The agency pays all costs of temporary management.

B. EXTENUATING CIRCUMSTANCES: In assessing the appropriateness or severity of sanctions, the LCA may consider any relevant factor(s) that may mitigate or exacerbate the situation precipitating the sanction.

C. CORRECTION OF DEFICIENCIES: When the LCA determines that deficiencies exist, the program must correct the deficiencies according to the following time frames or further sanctions may be imposed:

(1) Health and/or safety deficiencies are corrected immediately.

(2) Deficiencies that do not compromise health and/or safety are corrected within a period of time specified by the LCA.

D. SERVICE OF NOTICE: The department provides notification, by fax and certified mail or personal service/delivery, of its imposition of any emergency sanction against a program. A notice of contemplated action under these certification requirements may be sent by fax and mail, personal service or delivery, or by certified mail. Each notice of emergency sanction or contemplated action will be forwarded by fax to the medical assistance division immediately. (The medical assistance division of the human services department is responsible for any notices related to medicaid payments sent to the provider.)

E. NEW OWNERSHIP: In the event a provider sells or otherwise transfers its interest in its certified program to another entity, and a sanction or other corrective measure is pending, the sale of the certified program does not stay or otherwise impact the pending sanction. The new owner/entity must comply with all areas of correction noted in the sanction or action plan. If a sanction(s) is pending, the LCA will proceed with the appeals process and may issue a notice of final action pursuant to these certification requirements.

[7.20.11.12 NMAC - Rp 7 NMAC 20.11.12, 03/29/02]

7.20.11.13 APPEALS AND HEARINGS:

A. HEARING OFFICER: The department appoints an impartial hearing officer to conduct any administrative appeal.

B. PROCEDURES: Adjudicatory Hearing procedures, 7.1.2 NMAC, apply in all administrative appeals.

C. ADDRESS FOR REQUESTING AN ADMINISTRATIVE APPEAL: All requests for appeal must be addressed to: Licensing and Certification Unit; Children’s Behavioral Health and Community Services Bureau; Children, Youth and Families Department; Post Office Drawer 5160; Santa Fe, New Mexico 87502-5160 (facsimile 505-827-4595).

D APPEALS OF EMERGENCY SANCTIONS:

(1) If an emergency sanction is imposed, the LCA conducts a hearing within five business days of the Notice. The LCA notifies the agency of the name of the hearing officer and the date and time of the hearing.

(2) The emergency sanction takes effect immediately, and is not stayed by any request for administrative hearing or for an informal resolution conference.

(3) Any informal resolution conference, if requested, will be held within five business days of the date of the notice of emergency sanction.

E. APPEALS OF ADVERSE ACTIONS OTHER THAN EMERGENCY SANCTIONS:

(1) A program may appeal any adverse action set forth in a notice of contemplated action. The notice of contemplated action will include instructions and time frames for the program to request an appeal and/or an informal resolution conference. The program must request the appeal in writing within ten business days of receipt of the notice of contemplated action.

(2) When an appeal has been requested, the adverse action(s) is stayed until either of the following events occurs:

(a) the administrative hearing officer has conducted the hearing and issued an opinion; or

(b) the LCA and the program reach agreement through an informal resolution process.

(3) The administrative hearing will be held within 30 calendar days, unless both the LCA and the program agree to an extension. The LCA will inform the program of the date and location of the administrative hearing, and will identify the hearing officer.

(4) After the appeal process is concluded, or upon expiration of the time for appeal if no appeal is requested, the LCA will issue a notice of final action which will state the final decision of the LCA and the effective date of sanction(s) or any other adverse action. The notice of final action is not appealable.

F. INFORMAL RESOLUTION CONFERENCE: The department and the program may resolve any filed or potential administrative appeal through an informal resolution conference. The informal resolution conference provides an opportunity for the program to present new evidence or arguments regarding the deficiencies cited by, or corrective action proposed by, the department, and to present information regarding plans to remedy deficiencies and discuss possible pre-hearing disposition. The LCA has discretion to accept or reject any proposal made by the program. The informal resolution conference does not postpone any deadlines for appeal unless the LCA and the program both explicitly agree in writing to the extension.

[7.20.11.13 NMAC - Rp 7 NMAC 20.11.13, 03/29/02]

7.20.11.14 PROGRAM SURVEYS, INVESTIGATIONS, AND REPORTS:

A. Application for certification, whether initial or renewal, constitutes permission for entry into, and surveys of a program by the authorized LCA representatives at reasonable times while the application is pending.

B. LCA surveyors may enter the premises of an agency at any time and review any and all records of medicaid recipients, CYFD custody clients and agency staff; the LCA may conduct interviews with staff and/or clients in programs that are certified or required to be certified, whether or not an application for certification has been made, for the purpose of determining compliance with these certification requirements.

C. The LCA may conduct a survey(s) to assess/monitor progress with correction of violations found on previous surveys; or to investigate complaints or allegations of abuse, neglect or exploitation. The LCA may also conduct inquiry into matters of potential health and/or safety risk to clients as identified in serious incident reports or other information received by the LCA.

D. Findings made by the LCA during on-site surveys or investigations described in these certification requirements may result in changes of certification status, sanction(s), suspension, revocation, non-renewal, or denial of certification in accordance with all of the guidelines governing such actions as defined in these certification requirements.

E. When certification on-site surveys are conducted concurrently with licensing on-site surveys and there are violations found of both licensing and certification requirements that do not directly overlap, the LCA may issue a single report citing deficiencies with reference to both licensing and certification requirements.

F. When, during a certification survey, the LCA finds a violation(s) of these certification requirements that also constitute(s) a violation(s) of the licensing regulations of the department, the LCA may issue a single report addressing the violation(s) with reference to certification requirements only.

G. REPORTS:

(1) The LCA issues a written report of the findings for all required certification surveys within 30 business days of completion of the survey.

(2) When a survey is conducted for purposes of investigation, the LCA issues a report in instances of partial or fully substantiated complaint(s)/allegation(s) within 30 business days of the completion of the investigation.

(3) When a survey is conducted for purposes of investigation and the complaint(s)/allegation(s) are unsubstantiated, the LCA issues a letter indicating that the complaint was not substantiated, but does not issue a report.

(4) When a survey is conducted for the purposes of inquiry into questions of compliance arising from incident reports or other reports, the LCA may issue a report of any findings of noncompliance. If such a report is issued, it will be issued within 30 calendar days after completion of the survey.

(5) When a survey is conducted for purposes of following-up a monitoring plan, the LCA issues a follow up letter, but does not issue a report unless information obtained during such a visit indicates the need for a full program review and/or additional investigation(s).

(6) When a survey is conducted for purposes of technical assistance, the LCA does not issue a report.

(7) A report of a survey or investigation may be combined with a notice of contemplated action or notice of emergency sanction.

[7.20.11.14 NMAC - Rp 7 NMAC 20.11.14, 03/29/02]

7.20.11.15 CRIMINAL RECORDS CHECKS AND CLEARANCES:

A. Every program that provides child**/**adolescent mental health and/or substance abuse services pursuant to these certification requirements, operating in the state of New Mexico, must initiate and provide to the department two completed **s**tate-and FBI-approved fingerprint cards for each employee who will serve as direct services staff. The agency must have received the criminal records clearance from the prevention and intervention division of the department prior to the employee's direct, unsupervised contact with clients of the program. Non-compliance with this requirement may result in sanction up to loss of certification as referenced in NMSA 1978 32A-15-3.

B. All agencies must comply with 8.8.3 NMAC Regulations governing criminal records checks.

C. Student trainees in psychiatry, psychology, social work and/or nursing, or other related health, social or human-services disciplines who are enrolled in a clinical training program of a New Mexico state accredited institution of higher learning, and who are under the supervision of a cleared licensed independent practitioner, may be allowed to work with children without direct physical supervision during their enrolled student tenure if the trainee signs a sworn affidavit attesting that he or she has never been convicted of a crime that would disqualify him or her from providing direct services to children.

D. The certification requirements governing criminal records clearances remain in effect while a program is accredited by COA, CARF or JCAHO.

E. If a prospective employee has not lived in the United States continuously for the five years previous to hire, the equivalent of a criminal records clearance is required from any country in which he/she has lived within the last five years, for a period longer than one year.

F. If the agency receives reliable evidence that indicates that an employee or prospective employee poses a potential risk of child abuse, sexual abuse, exploitation, moral turpitude, cruelty, or indifference to children, the agency is in violation of these certification requirements and subject to sanction up to loss of certification if that individual is hired or retained.

G. Upon request by the LCA, the agency will provide a list of employees who are not required to have a criminal records clearance, and the reason why not.

H. Non-compliance with any certification requirement relating to criminal records checks and clearances may result in sanction or loss of certification. In addition to the foregoing, the following certification requirements relate to criminal records checks and clearances:

(1) 16.G.1(f) concerning prospective employee history verification and reference checks;

(2) 16.G.1(h) concerning letters of attestation for employees pending clearances;

(3) 16.G. 2 concerning disclosure of arrests/convictions;

(4) 16.H.1-5 concerning staff schedules.

[7.20.11.15 NMAC - Rp 7 NMAC 20.11.15, 03/29/02]

7.20.11.16 PERSONNEL:

A. The agency provides personnel who are trained, supervised and in all respects qualified to perform the functions for which they are responsible.

B. Each position, or group of like positions, is detailed in a written job description that clearly states qualifications, responsibilities and requirements.

C. Each agency employee meets all state registration, licensing and/or certification requirements applicable to his or her position and/or use of professional title(s) and the agency has copies of such licenses, etc. on file.

D. Orientation of personnel:

(1) The agency orients its personnel to the agency's goals, services, policies and procedures, and to the responsibilities of the staff member's position. Initial and ongoing orientation is documented in the personnel record.

(2) Orientation includes training on the establishment and maintenance of appropriate and responsive relationships and boundaries with clients.

E. Personnel training, development, responsibilities and supervision:

(1) The agency provides a training and development program to allow personnel to improve their knowledge, skills and abilities and to promote awareness and appreciation of the cultural background and need of persons served by the agency. This training will be documented in the personnel file.

(2) The agency provides staff development opportunities for personnel, including in-service training.

(3) Staff who require training to qualify for a position in which they are responsible for the care of children do not have sole responsibility for the care of children until after the successful completion of the training.

(4) Staff designated as direct service staff under service-specific certification requirements receive ongoing training related to the age and/or emotional development of the children for whom they are responsible.

(5) All certified services are provided under supervision of a clinical director who provides clinical oversight of the program, by way of documented supervision and consultation to all agency staff. Supervision may be direct, or may occur through a clinical supervisor who is directly supervised by the clinical director.

(6) All clinical supervision/consultation is documented and documentation includes the theme, date, length of time of supervision and signatures of those participating.

(7) In the event that the therapist and clinical supervisor are the same person, another properly credentialed clinician, either from within the agency or from outside the agency, provides supervision at least one time per month to the clinical supervisor.

(8) The responsibilities of the therapist include providing therapy and participating in the development of a treatment plan. These activities are documented.

(9) When the agency utilizes the services of professionals on a per interview, hourly, part-time, or independent contractor basis, the agency documents regular assessment of the quality of services provided.

F. Accountability:

(1) The agency ensures that the performance of all employees, consultants, contractors, and volunteers is consistent with agency policy and these certification requirements.

(2) At least once a year, written performance reviews are conducted jointly between each staff member, including volunteers, and the person's supervisor.

G. Personnel records:

(1) A personnel record is maintained for each employee and volunteer. Each personnel record is readily accessible to the LCA at each site visit, and contains, at a minimum:

(a) documentation of all orientation and training, including dates, hours or credits, names of trainer and trainee, and written confirmation by trainer or training organization that the training has occurred;

(b) employee's name, current address, telephone number and emergency contact(s);

(c) job title and description;

(d) evidence of licensure for those employees required to be licensed;

(e) date first employed and dates of transfers or changes in position;

(f) documentation of a minimum of three employment reference checks within three weeks prior to employment (if this process yields fewer than three employment reference checks, additional professional and/or personal references are obtained to achieve the required minimum of three references);

(g) a copy of the employee's current CPR and first aid certificates;

(h) for cleared staff, the criminal records clearance letter, or for uncleared staff, a signed statement by the administrator, director, or operator attesting to direct supervision of the uncleared employee by a cleared employee until the clearance is received;

(i) application for employment or resume consistent with agency policy;

(j) performance reviews, as applicable.

(2) The agency's written policies and practices require that an applicant for employment disclose any prior criminal convictions, and employees report any arrests and/or convictions that occur while employed.

(3) The agency's written policies provide personnel with access to their records and a process to review the record and to make additions and corrections to the record.

H. Schedules of direct service staff in day treatment and residential facilities:

(1) Each facility or licensed unit maintains a written, legible schedule clearly identifying direct service staff responsible for care of clients.

(2) Each uncleared employee is identified on the staff schedule.

(3) The staff schedule is updated daily to reflect actual hours staff are present and changes in attendance as they occur.

(4) Original updated staff schedules are kept on file for at least 12 months.

(5) The updated schedule documents the client census for each unit of a residential treatment services center or group home service on a daily basis.

[7.20.11.16 NMAC - Rp 7 NMAC 20.11.16, 03/29/02; A, 10/29/04]

7.20.11.17 ALLEGATIONS OF ABUSE/NEGLECT, COMPLAINTS, AND SERIOUS INCIDENT REPORTING:

A. The agency maintains and follows policies and procedures consistent with these certification requirements for timely reporting of any serious incidents and allegations of abuse or neglect. The agency immediately reports allegations of abuse or neglect to all appropriate entities, including but not limited to the protective services division of the department via statewide ventral intake/tribal social services agency, the client's legal guardian, the jurisdictional law enforcement agency, and the LCA.

B. The agency reports all serious incidents to the LCA by fax within 24 hours of any staff member becoming aware of the incident or allegation of incident. Incidents involving minor illnesses or injuries not requiring emergency services do not need to be reported to the LCA. Day treatment services, case management services, and behavioral management skills development services are not required to report serious incidents that do not occur during program hours, with the exception that all deaths must be reported.

C. Additional reporting requirements for deaths: Deaths are reported to the LCA immediately by telephone and followed by fax within 24 hours, whether or not the death occurs during program hours. Agencies are required to report any client death to the

regional office of the federal centers for medicare and medicaid services by no later than by the close of business the next business day after the client's death, and must document in the client's record that the death was reported to the centers for medicare and medicaid services.

D. Each serious incident report is written by the staff who have personal or firsthand knowledge of the incident/allegation, and is signed and dated by that person(s). Once written, the report is not altered, but may be amended. Any amendment is signed and dated by its author and filed with the original report. The report clearly distinguishes between events witnessed by the reporter and statements made to the reporter. The report contains, but is not limited to the following information regarding the incident: date, time, and location of the incident, behavioral description(s) of relevant event(s), descriptions of health/safety risk(s) relevant to the incident, identification of person(s) present, birth date(s) of client(s) involved, level of care of the client(s) involved, initial actions in response to the incident, names of persons providing information to the reporter, and identification of other entities receiving the report.

E. Each serious incident for which a report to the LCA is required herein and that involves possible criminal activity is reported immediately to the appropriate law enforcement agency.

F. The agency responds in a timely manner to protect its clients from physical or psychological risks of which it is or reasonably should be aware, in order to reduce and prevent future risks.

G. Outcomes, dispositions, and descriptions of any voluntary corrective action(s) taken by the agency in response to serious incidents are faxed or mailed to the LCA in a timely manner.

H. The program will not rely on the fact that it has made a serious incident report to the LCA, or the fact that it may not have received a response from the LCA, to delay appropriate corrective or protective action in response to an incident.

I. The agency maintains and follows policies and procedures for investigating and responding to allegations of abuse or neglect in a confidential and timely manner.

J. The agency maintains and follows policies and procedures for investigating and responding to complaints in a timely manner.

K. The agency provides a written response, in a timely manner, to the complaining party and, as applicable, the parent, legal or treatment guardian, regarding the resolution of each complaint or allegation.

[7.20.11.17 NMAC - N, 03/29/02; A, 04/14/05]

7.20.11.18 AGENCY IN THE COMMUNITY:

A. The agency identifies a defined purpose, uses a multi-disciplinary approach in which services are coordinated within the agency and within the provider community, and collaborates with other agencies in provision of services for its clients.

B. Agency purpose: The agency's statement of purpose includes a description of its primary function as providing services that:

(1) serve those clients in need of treatment who are most vulnerable or at risk;

(2) are habilitative in focus; and

(3) are consistent with the least restrictive means principle.

C. Community access to services:

(1) The agency provides culturally competent services and serves the needs of those clients who are bicultural and/or who are non-English speaking through the use of:

(a) bilingual/bicultural professional and qualified paraprofessional personnel;

(b) translators to meet the clients' communication needs.

(2) The agency provides public information concerning its services to persons in the community who are non-English-speaking. This information is designed to encourage full participation of non-English speaking clients.

[7.20.11.18 NMAC - Rp 7 NMAC 20.11.18, 03/29/02]

7.20.11.19 AGENCY GOVERNANCE AND ADMINISTRATION:

A. The agency is legally authorized to operate, identifies the members of its governing body, and administers its program in accordance with its own policies, which support compliance with these certification requirements.

B. The agency's governing body is responsible for adopting bylaws and policies and defining the scope of its services. The agency is legally authorized to operate as one of the following:

(1) Not-profit agency, incorporated in the state in which it operates, with a charter, constitution, and by laws;

(2) Not-profit agency operated by its own independent governing body, under the aegis of a religious body or other organization recognized under the laws of the state;

(3) Public agency authorized and established by statute, or a sub-unit of a public agency with which clear administrative relationship exists;

(4) Proprietary agency organized as a legal entity as a corporation, partnership, or association, but excluding therefrom sole proprietors; or

(5) Agency of a tribal government, or subdivision thereof.

C. Policies and procedures: The agency maintains a manual containing current policies and procedures for agency administration, service delivery, and protection of consumer rights.

(1) The agency makes a copy of its policies and procedures manual available to new personnel upon employment.

(2) The agency documents that it keeps all personnel advised regularly of revisions to its policies and procedures manual as revisions occur.

(3) The agency conducts annual reviews of its policies and procedures and makes revisions as necessary to maintain compliance with applicable laws, regulations, and these certification requirements.

[7.20.11.19 NMAC - Rp 7 NMAC 20.11.19, 03/29/02]

7.20.11.20 QUALITY IMPROVEMENT AND UTILIZATION REVIEW:

A. The agency has a continuous quality improvement process, reviewed annually, through which the agency systematically evaluates the effectiveness of services provided by determining whether its services meet pre-determined quality improvement expectations and outcomes, and corrects any observed deficiencies identified through the quality improvement process.

B. The agency explicitly details the desired expectations and service outcomes for each of its programs and has a written plan to achieve them.

C. The agency establishes a committee or other mechanism for the timely and regular evaluation of serious incidents, complaints, grievances, and related investigations. Committee evaluations include identification of events***,*** trends and patterns that may affect client health, safety, and/or treatment efficacy. Committee evaluation findings and recommendations are documented and submitted to agency management for corrective action. Actions implemented and outcomes are documented, and trends are analyzed over time. The agency has a well-defined plan for correcting problems. When problems (or potential problems) are identified, the facility acts as soon as possible to avoid any risks to clients by taking corrective steps that may include, but are not limited to:

(1) changes in policies and/or procedures;

(2) staffing and assignment changes;

(3) additional education or training for staff;

(4) addition or deletion of services.

D. The agency develops a system to utilize its collected data regarding the outcome of its activities for delivering continuously improving services.

E. Formal and informal feedback from consumers of services and other collateral sources is aggregated and used to improve management strategies and service delivery practices.

F. The agency collects and maintains information necessary to plan, manage, and evaluate its programs effectively. The outcomes are evaluated on a quarterly basis, the results of which are used continuously to improve performance.

G. The agency implements and maintains ongoing utilization review processes.

[7.20.11.20 NMAC - Rp 7 NMAC 20.11.20, 03/29/02]

7.20.11.21 LEGAL, REGULATORY, AND ACCREDITATION COMPLIANCE FOR PROGRAM OPERATION, INCLUDING HEALTH, SAFETY AND PHYSICAL PLANT REQUIREMENTS:

A. The agency promotes and protects the health and safety of its clients, demonstrates compliance with all applicable laws and regulations, adheres to the requirements of its accrediting bodies, if any, and possesses all applicable licenses required by law and departmental policy.

(1) License(s) required: The agency possesses a license(s) and complies with applicable licensing requirements for each service required by state and local law and departmental regulation including, but not limited to the following:

(a) Each treatment foster care child placement agency is licensed by the protective services division of the department as a child placement agency.

(b) All residential facilities are licensed by the department. Each maintains a separate license.

(c) Day treatment services are licensed as day treatment centers by the department. Each day treatment services facility maintains a separate license. Exception: day treatment services provided in a public school facility do not require licensure by the department.

(2) Residential treatment services and group home services are certified only when provided in a facility licensed by the LCA for 16 beds or fewer per unit.

B. An agency accredited by an accrediting organization recognized by the LCA complies with the current requirements of the accrediting organization. The accrediting organizations recognized by the LCA are:

(1) Council on accreditation for children and family services (COA);

(2) Joint commission on accreditation of healthcare organizations (JCAHO); and

(3) Council on accreditation of rehabilitation facilities (CARF).

[7.20.11.21 NMAC - Rp 7 NMAC 20.11.21, 03/29/02]

7.20.11.22 CLIENT PARTICIPATION, PROTECTION, AND CASE REVIEW:

A. The agency takes all reasonable action(s) to protect the health, safety, confidentiality, and rights of its clients. The agency informs the client of his or her rights and responsibilities and develops and implements policies and procedures that support and facilitate the client's full participation in treatment and related agency activities. The agency protects the confidentiality of client records through adherence to its own set of policies and procedures governing access to, and release of, confidential information.

B. Materials describing services offered, eligibility requirements and client rights and responsibilities are provided in a form understandable to the client and client's legal guardian(s) with consideration of the client's/guardian's primary language, and the mode of communication best understood by persons with visual or hearing impairments.

(1) If the client is unable to understand the materials for any reason, every effort is made to explain his or her rights and responsibilities in a manner understandable to the client. These efforts will be documented in the client's record.

(2) Materials are available or posted in the agency's reception area and/or handed to potential clients during their initial contact with the agency.

C. The agency explains to each client what his or her legal rights are in a manner consistent with the client's ability to understand and makes this information available to the client in writing, or in any other medium appropriate to the client's level of development. A written explanation of these rights is given to the parent/legal guardian upon admission.

(1) A client who receives residential treatment services has the rights enumerated in the New Mexico children's mental health and developmental disabilities

Code, NMSA 1978, Sections 32A-6-1 et seq. (1995). Explanation of rights to the client and parents/legal guardian is documented in the client's record.

(2) The agency maintains and follows written policy affirming that clients may refuse any treatment or medication, unless the right to refuse treatment(s) has been limited by law or court order. The agency informs the individual of the risks of such refusal. Client refusal of treatment and advisement of risks of the refusal is documented in the client's record.

(3) The agency specifies in written policies and procedures the conditions under which it serves minors without parental/legal guardian consent, and when parental/legal guardian consent is not possible, designates who is authorized to give consent to treat the minor.

(a) The client record contains all applicable consents for treatment, including consent for emergency medical treatment and informed consent for prescription medication.

(b) Exception: Day treatment services, behavioral management skills development services and case management services programs are not required to file consents for prescription medications that are not taken during program hours unless the medications are prescribed by a program physician.

(c) Consent forms must contain the information identifying the specific treatment, prescription medication, information release, or event for which consent is being given prior to being signed by a client or guardian.

(4) Upon admission, each client receives an orientation to the agency's services that includes the basic expectations of the clients, the hours during which services are available, and any rules established by the agency regarding client conduct, with specific reference to behavior that could result in discontinuation of a service. Orientation of the client and parents/legal guardians is documented in the client's record.

(5) The agency maintains a written grievance/complaint procedure that is reviewed with the client and parent/legal guardian upon admission. The client's record contains documentation of the agency's explanation of the grievance procedure to the client and the parent/legal guardian.

(6) Financial arrangements are fully explained to the client and/or his or her parent/legal guardian upon admission, and at the time of any change in the financial arrangements.

(7) Procedures for protecting client assets: The agency establishes and follows written policies and procedures to identify how it manages, protects, and maintains accountability for client assets, including the segregation of client funds when

an agency assumes fiduciary responsibility for a client's assets and/or disburses funds such as maintenance or allowance funds to clients.

(8) The agency establishes written procedures for providing client access to emergency medical services.

(9) Written agency policy specifies clinically appropriate and legally permissible methods of behavior management and discipline and provides training in their use to all direct service staff. The agency prohibits in policy and practice the following:

(a) degrading punishment;

(b) corporal or other physical punishment;

(c) group punishment for one individual's behavior;

(d) deprivation of an individual's rights and needs (e.g., food, phone contacts, etc.) when not based on documented clinical rationale;

(e) aversive stimuli used in behavior modification;

(f) punitive work assignments;

(g) isolation or seclusion, except as delineated in Section 24;

(h) harassment; and

(i) chemical or mechanical restraints, except as delineated in Section 24.I.

(10) The agency establishes and follows written policies and procedures for the use of therapeutic time-out in accordance with these certification requirements, including the following directives:

(a) therapeutic time-out can only be used for the length of time necessary for the client to resume self-control and/or to prevent harm to the client or others;

(b) therapeutic time-out is not used as a means of punishment;

(c) therapeutic time-out is not used for the convenience of staff; and

(d) therapeutic time-out is monitored closely and frequently to ensure the client's safety.

D. The agency prohibits the use or depiction of individuals (residents, clients, etc.), either personally or by name or likeness (e.g., photograph), in material (photographs,

videotape or audiotape), presented in a context that is either commercial or public-service oriented in nature. An exception to this prohibition applies to children presented on the "Wednesday's child" television program, Los Ninos or other adoption exchange publications, in which case any participation and presentation is in accordance with the department's rules and regulations and with the knowledge, consent and active participation of the department.

E. Client information and case review: The agency maintains records and follows policies and procedures governing the access to, and release of, confidential information. The agency provides adequate facilities for the storage, processing and handling of clinical records, including suitably locked and secured rooms.

(1) The agency's written policies govern the retention, maintenance, and destruction of board administrative records, and records of former clients and personnel. These policies address:

(a) protection of the privacy of former clients and personnel; and

(b) legitimate future requests by former personnel or clients for information, particularly information that may not be available elsewhere.

(2) The agency has policies governing the disposition of records, security of records and timely access and retrieval of records in case of the agency's dissolution. The retention of records is required for the later of:

(a) four years after the client is released from treatment; or

(b) two years after the client reaches age 18; or

(c) two years after a client has been released from most recent legal guardianship, and is no longer under legal guardianship.

(3) The agency specifies in written policies and procedures how it releases information. Any release is in accordance with applicable state and federal laws. The agency does not request or use any information release form that has been signed by a client, parent, guardian or other party prior to pertinent information being completed on the form.

(4) In the event of a medical emergency that warrants immediate intervention in order to protect the life or safety of the client, access to information regarding the client's diagnoses and treatment plan/service plan may be provided to medical personnel.

F. Contents of the client record:

(1) Agency policy defines information to be contained in the client record. At the time of admission, the client's date of admission to each and any certified service is documented in a consistent location in the client record.

(2) Agency policy and practice provide that entries in the client record are made in an accurate, objective, factual, legible, timely, and clinically-based manner.

(a) Entries made in the client record pursuant to these certification requirements clearly identify the person completing the entry and his or her credentials.

(b) Late entries are identified as such; late entries include the actual date of the entry and the signature of the person completing the entry.

G. When prescribing medication or other treatments, the prescribing professional documents the indication for any medical procedures and/or prescription medications.

(1) When a client is seen by the prescribing professional, subsequent to a medical prescription or treatment, the professional documents the response to the prescription or treatment and any observed side effects.

(2) Medication, including non-prescription medication that is administered by a nurse or is self-administered, is documented by the agency staff with the date and time of administration, the name and dosage and any side effects observed.

H. A written discharge summary is placed in the client's record within 15 days of termination of services and includes:

(1) clinical and safety status;

(2) medications being taken at discharge*;*

(3) documentation of notification to primary care physician;

(4) specification of referrals/appointments made with specific names*;*

(5) target behaviors addressed;

(6) services provided;

(7) progress attained, or lack thereof;

(8) description of interventions to which the client did and did not respond, including medications;

(9) recommendations for continued treatment and services.

I. Client review of case record:

(1) An individual may review his or her case record in the presence of a therapist or licensed independent practitioner of the agency on the agency's premises unless to do so would not be clinically indicated. The reasons why review is not clinically indicated are documented in the client's record. The confidentiality of other individuals is protected.

(2) The agency's policies and procedures allow the client to insert a statement into the record about his or her needs or about services he or she is receiving or may wish to receive. Any agency statements or responses are documented with evidence that the client was informed of insertion of such responses.

[7.20.11.22 NMAC - Rp 7 NMAC 20.11.22, 03/29/02; A, 04/14/05]

7.20.11.23 INTAKE, ASSESSMENT, TREATMENT PLANNING, DISCHARGE PLANNING, AND DISCHARGE:

A. The agency establishes criteria for admission, conducts ongoing clinical assessments, and develops, reviews, revises treatment plans and provides ongoing discharge planning with the full participation of the treatment team.

B. Clinical decisions are made only by qualified clinical personnel.

C. Intake and screening:

(1) The agency establishes and follows written criteria for admission to its program(s) and service(s), including exclusionary criteria.

(2) The agency establishes and follows written intake procedures to address clinical appropriateness for admission.

(3) The agency's eligibility criteria are consistent with EPSDT requirements and Licensing Requirements for Child and Adolescent Mental Health Facilities, 7.20.12 NMAC.

D. Assessments: The following applies to all certified services, except case management services. Each client is assessed at admission and reassessed at regularly specified times to evaluate his or her response to treatment, and specifically when significant changes occur in his or her condition or diagnosis. The assessment process is multidisciplinary, involves active participation of the family or guardian, whenever possible, and includes documented consideration of the client's and family's perceptions of treatment needs and priorities. Assessment processes include consideration of the client's physical, emotional, cognitive, educational, nutritional, and social development, as applicable. At a minimum, the following assessments are conducted and documented:

(1) An initial screening, conducted at admission, of physical, psychological, and social functioning, to determine the client's need for treatment, care, or services, and the need for further assessment; and assessment of risk of behavior that is life-threatening or otherwise dangerous to the client or others, including the need for special supervision or intervention.

(2) A full EPSDT screen (tot-to-teen health check) within 30 days of the initiation of services, unless such an examination has taken place and is documented within the 12 months prior to admission. The documented content of the history and physical examination must meet EPSDT requirements.

(3) The agency conducts a comprehensive assessment of each client's clinical needs. The comprehensive assessment is completed prior to writing the comprehensive treatment plan, and includes the following:

(a) Assessment of the client's personal, family, medical and social history, including:

(i) relevant previous records and collateral information;

(ii) relevant family and custodial history, including non-familial custody and guardianship;

(iii) client and family abuse of substances;

(iv) medical history, including medications;

(v) history, if available, as a victim of physical abuse, sexual abuse, neglect, or other trauma;

(vi) history as a perpetrator of physical or sexual abuse;

(vii) the individual's and family's perception of his or her current need for services;

(viii) identification of the individual's and family's strengths and resources; and

(ix) evaluation of current mental status.

(b) A psychosocial evaluation of the client's status and needs relevant to the following areas, as applicable:

(i) psychological functioning;

(ii) intellectual functioning;

(iii) educational/vocational functioning;

(iv) social functioning;

(v) developmental functioning;

(vi) substance abuse;

(vii) culture; and

(viii) leisure and recreation.

(c) Evaluation of high risk behaviors or potential for such;

(d) A summary of information gathered in the clinical assessment process, in a clinical formulation that includes identification of underlying dynamics that contribute to identified problems and service needs.

(4) If the comprehensive assessment is completed prior to admission, it is updated at the time of admission to each certified service.

(5) Assessment processes include the following:

(a) within 30 days of admission, an educational evaluation or current, age-appropriate individualized educational plan (IEP), or documented evidence that the client is performing satisfactorily at school;

(b) when indicated by clinical severity, a psychiatric evaluation;

(c) a psychological evaluation, when specialized psychological testing is indicated;

(d) monthly updates on mental status and current level of functioning, performed by a New Mexico licensed master's or doctoral level behavioral health practitioner.

(6) Assessment information is reviewed and updated as clinically indicated, and is documented in the client's record. For clients who have been in the service for one year or longer, an annual mental status exam and psychosocial assessment are conducted and documented in the client's record as an addendum to previous assessment(s). The agency makes every effort to obtain all significant collateral information and documents its efforts to do so. As collateral information becomes available, the comprehensive assessment is amended.

E. Treatment planning and discharge planning: The treatment planning process is individualized and ongoing, and includes initial treatment planning, comprehensive

treatment planning, discharge planning, and regular re-evaluation of treatment plans and discharge criteria.

(1) For certified services other than case management services and behavior management skills development services, an initial treatment plan is developed and documented within 72 hours of admission to each service. Based on information available at the time, the initial treatment plan contains the treatment planning elements identified above in 23.E (3) (a) through (j) below, with the exception that individualized treatment goals and objectives are targeted the first 14 days of treatment.

(2) For certified services other than case management and behavior management skills development services, a comprehensive treatment plan based on the comprehensive assessment is developed within 14 days of admission. The comprehensive treatment plan contains the treatment planning elements identified above in 23.E (3) (a) through (j) below.

(3) Each initial and comprehensive treatment plans fulfill the following functions:

(a) involves the full participation of treatment team members, including the client and his or her parents/legal guardian, who are involved to the maximum extent possible; reasons for nonparticipation of client and/or family/legal guardian are documented in the client's record;

(b) is conducted in a language the client and/or family members can understand, or is explained to the client in language that invites full participation;

(c) is designed to improve the client's motivation and progress, and strengthen appropriate family relationships;

(d) is designed to improve the client's self-determination and personal responsibility;

(e) utilizes the client's strengths;

(f) is conducted under the direction of a person who has the authority to effect change and who possesses the experience and qualifications to enable him/her to conduct treatment planning; treatment plans meet the provisions of the Children's Code, NMSA 1978, Sections 32A-6-10, as amended, and are otherwise implemented in accordance with the provisions of Article 6 of the Children's Code;

(g) documents in measurable terms the specific behavioral changes targeted, including potential high-risk behaviors; corresponding time-limited intermediate and long-range treatment goals and objectives; frequency and duration of program-specific intervention(s) to be used, including medications, behavior management practices, and specific safety measures; the staff responsible for each intervention; projected

timetables for the attainment of each treatment goal; a statement of the nature of the specific problem(s) and needs of the client; and a statement and rationale for the plan for achieving treatment goals;

(h) specifies and incorporates the client's permanency plan, for clients in the custody of the department;

(i) provides that clients with known or alleged history of sexually inappropriate behavior, sexual aggression or sexual perpetration are adequately supervised so as to ensure their safety and that of others; and

(j) documents a discharge plan that:

(i) requires that the client has achieved the objectives of the treatment plan;

(ii) requires that the discharge is safe and clinically appropriate for the client;

(iii) evaluates high risk behaviors or the potential for such;

(iv) explores options for alternative or additional services that may better meet the client's needs;

(v) establishes specific criteria for discharge to a less restrictive setting; and

(vi) establishes a projected discharge date, which is updated as clinically indicated.

(4) For residential treatment services and group home services, the comprehensive treatment plan also includes the following elements: a statement of the least restrictive conditions necessary to achieve the purposes of treatment, and an evaluation of the client's cultural needs and provision for access to cultural practices, including culturally traditional treatment.

(5) For case management services, a service plan is developed and written within 30 days of the initiation of services (see 26.F.1).

(6) For behavior management skills development services, a service plan is developed within 14 days of initiation of services (see 28.C (1) (c).

F. The treatment plan is reviewed by the treatment team at intervals not to exceed 30 days and is revised as indicated by changes in the child's behavior or situation, the child's progress, or lack thereof.

(1) Each treatment plan review documents assessment of the following, in measurable terms:

(a) progress, or lack thereof, toward each treatment goal and objective;

(b) progress toward and/or identification of barriers to discharge;

(c) the client's response to all interventions, including specific behavioral interventions;

(d) the client's response to medications;

(e) consideration of significant events, incidents, and/or safety issues occurring in the period under review;

(f) revisions of goals, objectives, and interventions, if applicable;

(g) any change(s) or updates in diagnosis, mental status or level of functioning;

(h) the results of any referrals and/or the need for additional consultation;

(i) the effectiveness of behavior-management techniques used in the period under review.

(2) Some or all of the required elements of a treatment planning document may be recorded in a document other than the treatment plan/review, such as a clinical review form or format provided by, or to a payor, when the following conditions are met:

(a) all required elements are performed and documented in a timely manner by qualified clinical personnel;

(b) the client's record contains evidence of participation of treatment team members in each phase of the treatment planning process.

G. When aftercare is indicated at the time of non-emergency discharge, the agency involves the client, case manager (if applicable), the parent, legal guardian, or guardian ad litem, if applicable; and assists the client, family, or guardian in arranging appointments, obtaining medication (if applicable), transportation and meeting other identified needs as documented in the treatment/discharge plan.

H. Prevention, planning, and processing of emergency discharge:

(1) The agency establishes policies and procedures for management of a child who is a danger to him/herself or others or presents a likelihood of serious harm to him/herself or others. The agency acts immediately to prevent such harm. At a

minimum, the policies and procedures provide that the following be documented in the client's file:

(a) that the agency makes all appropriate efforts to manage the child's behavior prior to proposing emergency discharge;

(b) that the agency takes all appropriate action to protect the health and safety of other children and staff who are endangered.

(2) In the event of a proposed emergency discharge, the agency provides, at a minimum, procedural due process including written notice to the family/legal guardian, guardian ad litem and department, if applicable, and provision to stop the discharge action until the parent/legal guardian, guardian ad litem and/or the department exhausts any other legal remedy they wish to pursue. The agency documents the following in the client record:

(a) provision for participation of the parent/legal guardian, and guardian ad litem in the discharge process, whenever possible; and

(b) arrangement for a conference to be held including all interested persons or parties to discuss the proposed discharge, whenever possible.

(3) If the child's parent/legal guardian is unavailable to take custody of the child and immediate discharge of the child endangers the child, the agency does not discharge the child until a safe and orderly discharge is effected. If the child's family refuses to take physical custody of the child, the agency refers the case to the department.

I. Discharge: Non-emergency discharge occurs in accordance with the client's discharge plan, unless precipitated by a client's or guardian's refusal to consent to further treatment, or other unforeseen circumstances. Prior to discharge, the agency:

(1) evaluates the appropriateness of release of the client to the parent/legal guardian;

(2) provides that any discharge of the client occurs in a manner that provides for a safe and orderly transition; and

(3) provides for adequate pre-discharge notice, including specific reason for discharge.

[7.20.11.23 NMAC - Rp 7 NMAC 20.11.23, 03/29/02]

7.20.11.24 BEHAVIOR MANAGEMENT, PERSONAL RESTRAINT, AND SECLUSION PRACTICES:

Certain provisions of this section are included to implement regulations of the federal centers for medicare and medicaid services (CMS) and may be amended when appropriate to reflect subsequent changes in the federal CMS regulations. These provisions are intended to implement, and to be consistent with the Child Health Act of 2000 and the CMS Interim Final Rule issued May 22, 2001, and are subject to further modifications as dictated by CMS.

A. The agency protects and promotes the rights of each client in the program, including the right to be free from physical or mental abuse, corporal punishment, and any personal restraint or seclusion imposed for purposes of discipline or convenience. The agency establishes and follows policies and procedures governing the use of behavior management practices including therapeutic hold, personal restraint and seclusion (when allowed as delineated below). This will include documentation of each therapeutic hold, personal restraint and seclusion in the client's record.

B. For those behavior management practices that are allowed for each type of program and are described above, the program supports their limited and justified use through:

(1) staff orientation and education that create a culture emphasizing prevention of the need for therapeutic hold, personal restraint and seclusion and their appropriate use;

(2) assessment processes that identify and prevent potential behavioral risk factors; and

(3) the development and promotion of preventive strategies and use of less restrictive alternatives.

C. Agency policy and procedures identify qualified staff authorized to approve the protocols and apply the criteria for use of therapeutic hold, personal restraint and seclusion.

D. Performance-improvement processes identify opportunities to reduce or eliminate the use of personal restraint or seclusion.

E. The agency establishes and follows policies and procedures for the safe, effective, limited, and least restrictive use of behavior management practices. The policies and procedures include measures to ensure that treatment planning includes regular review of the necessity for, type and frequency of behavior management practices used in individual cases.

F. When behavior management practices are used, the agency protects the safety, dignity, and privacy of clients to the maximum extent possible at all times during each procedure.

G. Treatment plans document the use of seclusion, personal restraint and therapeutic holds and include: consideration of the client's medical condition(s); the role of the client's history of trauma in his/her behavioral patterns; the treatment team's solicitation and consideration of specific suggestions from the client regarding prevention of future physical interventions.

H. Seclusion, personal restraint and therapeutic holds are implemented only by staff who have been trained and certified by a state recognized body in the prevention and use of therapeutic holds, personal restraint and seclusion. This training emphasizes de-escalation techniques and alternatives to physical contact with clients as a means of managing behavior. Clients do not participate in the therapeutic holding, personal restraint or seclusion of other clients.

I. Mechanical and chemical restraints are prohibited in all programs except the program created under the Adolescent Treatment Hospital Act, which has been mandated by NMSA 1978 Sections 23-9-1 et.seq., to serve adolescents who are violent or have a history of violence, and which provides 24-hour on-site professional medical services in accordance with Section 3207 of the Children's Health Act of 2000.

J. Personal restraint and seclusion, as defined in these certification requirements, are used in JCAHO-accredited or non-JCAHO-accredited residential treatment centers and group homes; in emergency circumstances to ensure the immediate physical safety of the client, other clients, staff member(s) or others; and when less restrictive interventions have been determined to be ineffective. Personal restraint and seclusion are used in accordance with these provisions and with federal law, rule or regulation which may supersede state or accreditation regulations. Personal restraint and seclusion are imposed only by an individual trained and certified by a state-recognized body in the prevention and use of personal restraint and seclusion and in the curriculum that may be set forth in federal regulations to be promulgated under Title V of the Public Health Service Act (42 U.S.C. 290aa et seq. as amended by section 3208, Part I, section 595). When federal regulations are promulgated under Title V as described above, the curriculum set forth there shall be included in the training.

K. Physical escort is allowed as a safe means of moving a client to a safe location.

L. Personal restraint or seclusion are not to be used for staff convenience and/or as coercion, discipline, or retaliation by staff.

M. This sub-section (M) applies, for personal restraint, to facilities accredited by JCAHO, and to all residential treatment centers for seclusion. These entities require orders that are consistent with Department regulation, agency policy, and regulations of the centers for medicare and medicaid services (CMS) 42 CFR, Parts 441 and 483. These orders are issued by a restraint/seclusion clinician within one hour of initiation of personal restraint or seclusion, and include documented clinical justification for the use of personal restraint or seclusion.

(1) If the client has a treatment team physician and he or she is available, only he or she can order personal restraint or seclusion.

(2) If personal restraint or seclusion is ordered by someone other than the client's treatment team physician, the restraint/seclusion clinician will consult with the client's treatment team physician as soon as possible and inform him or her of the situation requiring the client to be restrained or placed in seclusion and document in the client's record the date and time the treatment team physician was consulted and the information imparted.

(3) The restraint/seclusion clinician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the situation.

(4) If the order for personal restraint is verbal, the verbal order must be received by a restraint/seclusion clinician or a New Mexico licensed registered nurse (RN) or practical nurse (LPN). The restraint/seclusion clinician must verify the verbal order in a signed, written form placed in the client's record within 24 hours after the order is issued.

(5) A restraint/seclusion clinician's order must be obtained by a restraint/seclusion clinician or New Mexico licensed RN or LPN prior to or while the personal restraint or seclusion is being initiated by staff, or immediately after the situation ends.

(6) Each order for personal restraint or seclusion must be documented in the client's record and will include:

(a) the name of the restraint/seclusion clinician ordering the personal restraint or seclusion;

(b) the date and time the order was obtained;

(c) the emergency safety intervention ordered, including the length of time;

(d) the time the emergency safety intervention actually began and ended;

(e) the time and results of any one-hour assessment(s) required; and

(f) the emergency safety situation that required the client to be restrained or put in seclusion; and

(g) the name, title, and credentials of staff involved in the emergency safety intervention.

(7) Supervision and assessment of personal restraint or seclusion

(a) The restraint/seclusion clinician must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(b) A New Mexico registered nurse or a restraint/seclusion clinician other than a doctoral level psychologist, must conduct a face-to-face assessment of the physical well being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. A restraint/seclusion clinician or a New Mexico registered nurse must conduct a face-to-face assessment of the psychological well being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, but in no case later than one hour after its initiation.

(c) If the situation requiring emergency safety intervention continues beyond the time limit of the order for the use of personal restraint or seclusion, the New Mexico RN or LPN must immediately contact the ordering restraint/seclusion clinician or the client's treatment team physician to receive further instructions. If clinical circumstances justify renewal of personal restraint or seclusion, then the renewal order must be obtained within the time frames outlined in 24.O (1) below.

N. This sub-section (N) applies to personal restraint in residential treatment services not accredited by JCAHO. In these residential treatment services, personal restraint requires the following, which is consistent with department regulation and agency policy.

(1) A New Mexico licensed independent practitioner, licensed professional mental health counselor (LPC), licensed master social worker (LMSW), or registered nurse must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention.

(2) A New Mexico licensed independent practitioner, or a licensed professional mental health counselor (LPC), licensed master social worker (LMSW), in consultation with a licensed independent practitioner, or a registered nurse trained in the use of emergency safety interventions must conduct a face-to-face assessment of the well-being of the client within one hour of the initiation of the emergency safety intervention and immediately after the personal restraint is removed or the client is removed from seclusion. When the personal restraint or seclusion is less than one hour in duration, and the restraint/seclusion clinician is not immediately available at the end of the period of restraint or seclusion, the restraint/seclusion clinician will evaluate the client's well-being as soon as possible after the conclusion of the restraint/seclusion, bu in no case later than one hour after its initiation.

O. The following sub-section (O) applies to all residential treatment centers and group homes.

(1) The personal restraint or seclusion is limited to a maximum of two hours for clients age of 17 and one hour for clients under nine years of age.

(2) Post-intervention debriefings with the client will take place after each emergency safety intervention and the staff will document in the client's record that the debriefing sessions took place.

(3) The agency will have affiliations or written transfer agreements in effect with one or more hospitals approved for participation under the medicaid program that reasonably ensure that:

(a) A client will be transferred from the facility to the hospital and admitted in a timely manner when a transfer is medically necessary for medical care or acute psychiatric care;

(b) Medical and other information needed for care of the client in light of such transfer will be exchanged between the organizations in accordance with state medical privacy law, including any information needed to determine whether the appropriate care can be provided in a less restrictive setting; and

(c) Services will be available to each client 24 hours a day, seven days a week.

(4) The agency will document in the client's record all client injuries that occur as a result of an emergency safety intervention.

(5) All agencies will attest in writing that the facility is in compliance with CMS standards governing the use of personal restraint and seclusion. This attestation will be signed by the agency director.

(6) If the client is a minor, the agency will notify the parent(s) or legal guardian(s) that personal restraint or seclusion has been ordered as soon as possible after the initiation of each emergency safety intervention. This will be documented in the client's record, including the date and time of notification, the name of the staff person providing the notification, and who was notified.

(7) Agencies will provide for client health and safety by requiring direct service staff to demonstrate competencies related to the use of emergency safety interventions on a semiannual basis. Direct service staff will demonstrate, on an annual basis, their competency in the use of cardiopulmonary resuscitation. The agency will document in the staff personnel records that the training required was successfully completed.

(8) The agency must maintain an aggregate record of all situations requiring emergency safety intervention, the interventions used and their outcomes.

(9) Programs must report the death of any client to the CMS regional office by no later than close of business the next business day after the client's death. The report must include the name of the client and the name, street address and telephone number of the agency. The parent or legal guardian will also be notified. Staff must document in the client's record that the death was reported to the CMS regional office.

[7.20.11.24 NMAC - N, 03/29/02]

7.20.11.25 MEDICATIONS:

A The agency establishes and follows policies and procedures governing the storage, handling, use, administration and disposal of all medications that are consistent with applicable laws, regulations, and accepted professional practices.

B. Prescription orders are verified and individuals are identified before medications are administered or self-administered.

C. Medications are administered only by qualified, licensed medical staff, or are self-administered by the client with supervision of staff who have been trained in assisting with self-administration.

D. Policies and procedures support self-administration of medications. Staff trained in these procedures provide supervision of self-administration of medications and document the time the medications are taken, the side effects observed, and client response**,** as well as any medications refused or held. When medications are self-administered by clients, a staff member may hold the container for the client and/or assist with opening the container, but may not place the medication in the client's hand or mouth.

E. The agency has controls in place for locked storage of medication and for access by authorized personnel.

F. The agency has controls in place to ensure that medications are properly labeled with name of person served, dosage, name of medication, name of prescribing physician, and number or code identifying the written order.

G. The agency has controls in place for the destruction of out-of-date medications and proper disposal of unused medication and syringes.

H. When adverse or unusual conditions are observed, appropriate consultation and/or medical response must be sought in a timely manner.

I. Medication monitoring may include input from various disciplines and the client and family. This information is used to maintain and improve the outcomes of medication therapy while minimizing any drug-related problems or adverse effects.

J. When medications that require periodic testing of drug levels are used, such laboratory test results are accurately recorded in the client record, as applicable.

K. The physician documents in the client record the indication for, response to, and the potential and observed side effects of any prescription medication(s).

[7.20.11.25 NMAC - Rp 7 NMAC 20.11.30.2, 03/29/02]

7.20.11.26 COMPREHENSIVE COMMUNITY SUPPORT SERVICES:

A. Comprehensive community support services (CCSS) shall coordinate and provide necessary services and resources to eligible clients and families to promote recovery, rehabilitation and resiliency.

B. These culturally sensitive services shall identify and address the barriers that impede the development of skills necessary for independent functioning in the community as well as strengths, goals and measurable objectives, which may aid the client or family in the recovery or resiliency process.

C. CCSS shall address goals as identified by the client or family specifically to meet recovery and resilience based outcomes in the areas of independent living, learning, working, socializing and recreation.

D. CCSS shall be provided to children, youth and adults with significant behavioral health disorders and who meet other criteria as identified by the collaborative.

E. CCSS shall be provided in compliance with the medical assistance division (MAD) definition of medical necessity and shall be furnished within the MAD benefits.

F. CCSS shall be furnished within the scope and practice of the provider's respective profession as defined by state law, and in accordance with applicable federal, state and local laws and regulations.

G. An assessment of baseline functioning shall be performed within 10 working days of the client's admission into CCSS services. The assessment shall evaluate and document the client's specific functional effectiveness in multiple skill domains based on the desired outcomes of the client or family.

(1) Functional level determination shall identify domains in which functional limitations precipitated by the behavioral health disorder are present. The diagnoses and assessments shall be the basis for the comprehensive client or family driven goal directed, measurable service plan

(2) CCSS eligible clients shall have one designated agency that will have the primary responsibility of partnering with the client and family for the purpose of implementing the comprehensive service plan.

H. Within the CCSS agency, a primary community support worker (CSW), under the documented supervision of the CCSS supervisor, shall be identified on the comprehensive service plan and shall partner with the client and family for the purpose of coordinating and facilitating recovery and resiliency directed team meetings. The CCSS supervisor shall sign, with name, credentials, and date, the initial service plan indicating that he has reviewed and approved the comprehensive service plan and each revision as it occurs.

I. Community support activities and relevant providers shall be clearly identified in the comprehensive service plan. The primary CSW shall coordinate the service plan without duplication by the other service providers. The CCSS comprehensive service plan shall be completed no later than 30 calendar days of the client's admission into CCSS services and specify recovery and resiliency strategies to include:

(1) the community support(s) and any other rehabilitative and treatment interventions needed for the client to achieve his specified service goals and to meet recovery and resiliency outcomes;

(2) the CCSS staff responsible for each recovery and resiliency intervention and the frequency of the planned interventions;

(3) the client's relevant diagnoses and other risk factors that place him at risk of further diagnoses;

(4) measurable goals and objectives identified by the client and family as their comprehensive service plan priorities to meet desired recovery and resiliency outcomes;

(5) a recovery/ resiliency management plan;

(6) a crisis management plan to address after-hours crisis situations including actions to be taken by client, family and natural supports;

(7) potential service plan barriers and applicable strategies; and

(8) if requested, advanced directives related to client's behavioral healthcare.

J. CCSS shall include the development of crisis plan interventions, as defined in an individual crisis plan, as a component of overall CCSS comprehensive service plan. If the client has or requests an advance directive, the crisis plan may be incorporated into the advance directive. The individualized crisis plan shall support the client and family in

the management of crisis situations outside of regular business hours to develop or enhance the client's ability to make informed and independent choices.

(1) the crisis plan shall include the following requirements, which shall be formulated on admission to CCSS by the CCSS team, client, family, legal guardian and other interested parties.

(a) Risk assessment: Specify a process to assess potential risk and specify an algorithm of community resources to address by risk level that ranges from immediate (i.e. 911 or first responders) to intermediate (e.g. call to crisis line) to moderate (call for a clinic appointment).Specify a process to identify benchmarks that indicate when a crisis is appropriate reconciled.

(b) Client/family education: Provide the client and family education on community resources to be accessed during crisis situations. Each family and client shall be provided basic verbal communication techniques to help de-escalate a potential crisis situation.

(c) Internal communication: Crisis events are discussed in the CCSS team meeting to ensure all risk factors are identified and known by all team members.

(d) Face-to-face assessment: CCSS team member shall make a face-to-face visit as soon as possible, but no more than 48 hours after notification of a crisis, and complete an updated assessment for presentation to the team.

(e) Research past crisis situations for antecedent, precipitant, and consequent behaviors and discuss with the client or family to identify strategies or objectives likely to prevent crises.

(f) Identify alternative interventions that may be initiated during crisis situations, including pre-crisis or crisis instructions identified by the client or family.

(g) Incorporate client and family outcomes as benchmarks or measures of when the crisis is over.

(h) Revise crisis plan over time based on newly identified triggers and what is known to be effective.

(i) Document behavioral benchmarks (e.g., number of runs, self-injury, assaults, etc., and what worked).

(2) The negotiated crisis plan shall triage for differing levels of intensity and severity of crisis events and may identify other types of interventions that may include:

(a) residential services for stabilization;

(b) crisis respite services;

(c) wrap around services;

(d) increased family and community support specialist capacity to manage crisis situations;

(e) activation of advance directive instruction; and

(f) utilization of emergency room (ER) and other emergency response supports.

K. Every 90 days after implementation of the comprehensive service plan, the CCSS team, in partnership with the client and family, shall track and provide detailed documentation demonstrating progress made over time relating to the CCSS service goals, objectives and client/family designated recovery or resiliency outcomes. These shall be documented in the service plan updates with modifications made based upon barriers identified or redefined goals and objectives and future needs.

L. The follow up assessment shall document the current status of the client and family designated measurable recovery or resiliency functional outcomes.

M. Individualized CCSS interventions shall address the following objectives, as indicated in the assessment and comprehensive service plan:

(1) community services and resources available to support the client's achievement of his functional CCSS service goals and objectives;

(2) assistance in the development of interpersonal, community coping and functional skills (i.e., adaptation to home, school and work environments), utilizing evidence-based practices to support the skills development in the following domains:

(a) socialization skills;

(b) developmental issues as identified in the assessment;

(c) daily living skills;

(d) school and work readiness activities; and

(e) education and management of co-occurring illness;

(3) facilitating the development and eventual succession of natural supports in the workplace, housing/home, and social and school environments;

(4) provision of client and family education as appropriate regarding:

(a) self-management of symptom monitoring, illness management, and recovery and resiliency skills;

(b) relapse prevention skills;

(c) knowledge of medication and potential side effects;

(d) motivational and skill development in taking medication as prescribed;

(e) ability to identify and minimize the negative effects of symptoms which potentially interfere with the client's activities of daily living; and

(f) as indicated, supports to the client to maintain employment and school or community tenure;

(5) facilitating the client's abilities to obtain and maintain stable housing;

(6) any necessary follow-up by the CSW to determine if the services accessed have adequately met the client's needs.

N. Cultural competence shall be demonstrated by the CCSS provider through the agency's policies, procedures, training, outreach and advocacy efforts, and throughout the array of service delivery framework.

O. The CCSS provider shall demonstrate through a documented internal quality monitoring process that on average (60% or more) of CCSS services are delivered face-to-face and in vivo (where client is in the community).

P. The CSW shall provide routine follow-up to determine if the services accessed have adequately met the client's rehabilitative, recovery, resiliency, and treatment needs and document findings.

Q. CCSS shall be offered at convenient times and locations to meet the needs of the client and family; the CCSS provider will actively work to eliminate language, financial, and other barriers to service.

R. For clients and their families: The CSW shall make every effort to engage and partner with the client and family in achieving rehabilitative, recovery, and resiliency goals. Barriers to engaging the client or achievement of the service goals will be identified and utilized to amend the service plan interventions.

S. When CCSS is provided by a certified peer or family specialist, CCSS functions shall be performed with a special emphasis on recovery and resiliency values and process, such as:

(1) empowering the client to have hope for, and participate in, his own recovery;

(2) assisting the client to identify strengths and needs related to attainment of independence in terms of skills, resources and supports, and to use available strengths, resources and supports to achieve independence;

(3) assisting the client to identify and achieve his personalized recovery and resiliency goals; and

(4) promoting the client's responsibility related to illness self-management.

T. CCSS shall be subject to the limitations and coverage restrictions as defined by 8.315.6 NMAC, Comprehensive Community Support Services.

U. Behavior management skills development service (BMS) interventions are distinct and different from CCSS and shall not be considered to be CCSS.

V. **Eligible providers:** CCSS shall be delivered by a certified mental health agency.

(1) The agency shall be a legally recognized entity in the United States, qualified to do business in New Mexico, and shall meet standards established by the state of New Mexico or its designee, and requirements of the funding source.

(2) CCSS shall be provided in the following type of entities:

(a) federally qualified health center (FQHC);

(b) Indian health service (IHS) hospital or clinic;

(c) tribal-638 hospital or clinic;

(d) community mental health center

(e) core service agency (CSA); or

(f) an agency otherwise certified as a CCSS agency by New Mexico children, youth and families department (CYFD) or New Mexico department of health (DOH)

(3) Eligible clients who are 18 through 20 years of age may be served by an agency certified for CCSS by CYFD or DOH, as indicated.

W. **Staff qualifications:** Clinical services and supervision by licensed behavioral health practitioners shall be in accordance with their respective licensing board regulations.

(1) Minimum staff qualifications for the CSW:

(a) shall be a minimum of 18 years of age; and

(b) shall hold a bachelor's degree in a human service field from an accredited university and one (1) year relevant experience working with the target population; or

(c) shall hold an associate's degree in a human service field from an accredited college and have a minimum of two (2) years of experience working with the target population; or

(d) shall be a high school graduate or have a general education development (GED) and shall have a minimum of three years of experience working with the target population; or

(e) shall be certified as a certified peer specialist (CPS) or certified family specialist (CFS).

(2) Minimum staff qualifications for the CCSS program supervisor:

(a) shall hold a bachelor's degree in human services field from an a accredited university;

(b) shall have a four (4) years relevant experience working with the target population; and

(c) shall have one year demonstrated supervisory experience.

(3) Minimum staff qualifications for the clinical supervisor (The clinical supervisor and the CCSS program supervisor may be the same individual):

(a) shall be a licensed independent practitioner (i.e., psychiatrist, psychologist, LISW LPCC, LMFT, psychiatrically certified CNS) practicing within the scope of their New Mexico licensure;

(b) shall have one year documented supervisory experience; and

(c) shall provide documented clinical supervision on a regular basis to the CSW, CPS and CFS.

(4) Minimum staff qualifications for CPS:

(a) shall be a minimum of 18 years of age;

(b) shall have a minimum of high school diploma or GED;

(c) shall be self-identified as a current or former consumer of mental health or substance abuse services and have at least one year of mental health or substance abuse recovery; and

(d) shall have received certification as CPS.

(5) Minimum staff qualifications for CFS:

(a) shall be a minimum of 18 years of age;

(b) shall have a minimum of high school diploma or GED;

(c) shall have personal experience navigating any of the child-family-serving systems or advocating for family members who are involved with the behavioral health systems; shall have an understanding of how these systems operate in New Mexico;

(d) if the individual is a current or former consumer, he shall be well-grounded in his symptom self-management; and

(e) shall have received certification as a CFS.

X. **Staff training requirements:**

(1) The minimum CCSS staff training completed for all CSWs shall be documented in the personnel record and include:

(a) an initial training comprised of 20 hours of documented training or education drawn from an array of the following areas, to be completed within the first 90 days of employment as a CSW:

(i) clinical and psychosocial needs of the target population, including cultural competency with regard to race, religion, national origin, sex, physical disability and other community- specific characteristics;

(ii) psychotropic medications and possible side effects;

(iii) drugs of abuse and related symptoms;

(iv) crisis management;

(v) principles of recovery, resiliency and empowerment;

(vi) ethical and cultural considerations;

(vii) community resources and services, including pertinent referral criteria;

(viii) client and family support networking;

(ix) mental health or developmental disabilities code;

(x) children's code;

(xi) client and family centered practice;

(xii) behavioral management;

(xiii) treatment and discharge planning with an emphasis on recovery and crisis planning.

(b) documentation of ongoing training is required and maintained in the personnel record and comprised of 20 hours per year, commencing after the first year of hire, with content of the education based upon agency assessment of staff's needs. Such assessment shall be monitored and documented through the agency's continuous quality improvement program and annual plan.

(2) Minimum staff training requirements for supervisors shall be documented in the personnel record and include:

(a) the same 20 hours of documented training or continued education as required for the CCSS CSW;

(b) a minimum of eight hours of training specific to supervisory activities; and

(c) documentation of ongoing training comprised of 20 hours is required of a CCSS supervisor every year, commencing after the first year of hire, with content of the education based upon agency assessment of staff's needs. Such assessment shall be monitored and documented through the agency's continuous quality improvement functions.

Y. **Case loads:**

(1) Caseloads, on average, shall not exceed a ratio of 1:20 (one CSW to 20 clients receiving CCSS).

(2) Clients participating in medication management as the primary focus of service are not subject to the client- staff ratio.

(3) CSW caseloads, of client to staff ratio of 1:20 on average, shall be monitored and documented through the agency's internal continuous quality improvement program through defined periodic review activities such as peer chart reviews to ensure the agency is in caseload compliance. The agency will implement

timely corrective action when it is identified that staff ratio averages are not in compliance.

(4) Detailed case notes document all CCSS service intervention activities and locations of services provided for each service span delivered and include the CCSS worker's name, credential and date of the service delivery.

Z. **Documentation requirement:**

(1) The CCSS provider shall be responsible for consistent documentation of all service delivery. Each service delivery case note shall include but not be limited to:

(a) date of service;

(b) service location;

(c) duration of service span (e.g., 1:00-2:00pm);

(d) description of the service provided with reference to the comprehensive service plan and related service goal and objective; and

(e) the client's name, and signature and credential of the individual delivering the service.

(i) All CCSS file documentation shall be legible.

(ii) All CCSS service delivery shall be consistent with the service definition requirements.

(2) CCSS comprehensive service plan and service delivery documentation shall be internally monitored through the agency's continuous quality improvement functions at least quarterly to ensure compliance with all of the certification requirements.

[7.20.11.26 NMAC - Rp 7 NMAC 20.11.25, 03/29/02; A, 12/31/08]

7.20.11.27 DAY TREATMENT SERVICES:

A. Day treatment services as defined herein are provided in a school or other community setting and are distinct from partial hospitalization services provided in a psychiatric hospital. Education services are provided through the public school system or through a New Mexico accredited private school in coordination with the day treatment services.

B. Personnel:

(1) Direct service staff may be unlicensed or uncertified paraprofessionals such as teacher aides, mental health workers, psychiatric technicians or similar direct service workers. At least one staff member who has received all training required in 27.B (a) through (f) is present during program hours. The direct service staff receives documented clinical supervision for a minimum of two hours per month. The agency's direct service staff must have at least a high school education or GED and 20 hours of documented pre-service training, including, but not limited to crisis management/intervention, behavior management, and emergency procedures, that include current CPR and first aid certificates. Within 90 days of hire, the staff will receive an additional 20 hours of documented training, including but not be limited to:

(a) etiology and symptoms of emotional disturbances and neurobiological disorders;

(b) family systems;

(c) basic communication and problem solving skills;

(d) child and adolescent development;

(e) issues related to ethnic and cultural considerations of the clients served; and

(f) action and potential side effects of medications.

(2) Clinical director:

(a) Clinical director qualifications: The clinical director possesses one of the following New Mexico licenses; physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, licensed independent social worker (LISW), licensed master social worker (LMSW), clinical nurse specialist in child psychiatric nursing, registered nurse (RN) with a master's degree in psychiatric nursing, licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), or licensed independent school psychologist.

(b) In addition to having one of the above licenses, the clinical director is required to have a minimum of two years of experience in clinical practice with children, adolescents and families.

(c) Clinical director responsibilities: The responsibilities of the clinical director are to provide clinical oversight of the services, as well as to provide supervision, support, and consultation to all agency direct service staff.

(3) Clinical supervisor:

(a) Clinical supervisor qualifications: The clinical supervisor possesses one of the following New Mexico licenses: physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, licensed independent social worker (LISW), clinical nurse specialist in child psychiatric nursing, registered nurse (RN) with a master's degree in psychiatric nursing, licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), or licensed independent school psychologist.

(b) In addition to having one of the above licenses, the clinical supervisor is required to have a minimum of two years of experience in clinical practice with children, adolescents and families.

(4) Therapist: Therapist qualifications: The therapist possesses one of the following New Mexico licenses: Physician (physicians must be board-certified in psychiatry or eligible to attain such certification), psychologist, licensed independent social worker (LISW), licensed master social worker (LMSW), clinical nurse specialist in child psychiatric nursing, registered nurse (RN) with a master's degree in psychiatric nursing, licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT), licensed independent school psychologist, licensed professional mental health counselor (LPC), licensed professional art therapist (LPAT), licensed entry level school psychologist, or licensed mental health counselor (LMHC).

C. Services:

(1) Assessment and treatment planning conform to Section 23 of these certification requirements.

(2) The agency provides adequate care and continuous supervision of the client at all times in accordance with the client's developmental and clinical needs.

(3) The structured program of care is scheduled for a minimum of four hours per day, two to five days per week based on the acuity and the clinical needs of the client and family. The agency provides the following, pursuant to the client's treatment plan:

(a) individual, family, group or other therapy, in whatever combination is appropriate to meet the needs of the client;

(b) other services as provided in the treatment plan;

(c) development of life skills activities;

(d) crisis intervention;

(e) therapeutic recreation, when indicated by the child's needs;

(f) documentation of services provided, and of the client's progress or lack thereof on each day that service is provided.

(4) The agency documents that:

(a) the child has access to the appropriate educational services;

(b) the child has opportunities for involvement in community, social, athletic and recreational programs;

(c) the child has opportunities to pursue personal, ethnic or cultural interests; and

(d) advance schedules are posted for structured and supervised activities which include individual, group and family therapy, and other planned activities appropriate to the age, behavioral and emotional needs of the client pursuant to the treatment plan.

(5) The agency maintains a written agreement with the public school district or private school so that appropriate educational services are provided to clients in the day treatment services program.

[7.20.11.27 NMAC - Rp 7 NMAC 20.11.26, 03/29/02]

7.20.11.28 BEHAVIOR MANAGEMENT SKILLS DEVELOPMENT SERVICES:

A. Behavior management skill development services are delivered through an individualized behavior management skills development service plan designed to develop, restore, or maintain skills and behaviors that result in improved function or which prevent deterioration of function. Behavior management skills development services are delivered to clients up to age 21 who:

(1) are in need of behavior management skills development intervention to avoid inpatient hospitalization, residential treatment or separation from his/her family; or

(2) require continued intensive or supportive services following hospitalization or out-of-home placement as a transition to maintain the client in the least restrictive environment possible.

B. Personnel

(1) The behavior management skills development specialist meets the following criteria:

(a) is at least 21 years of age; and

(b) demonstrates the ability to independently implement and document the outcome of the goals, measurable objectives and interventions as defined in a behavioral management skills development service plan.

(2) The behavior management skills development specialist receives 20 hours of documented pre-service training, to include, but not limited to:

(a) crisis management/intervention;

(b) behavior management;

(c) emergency procedures, which include current CPR and first aid certificates.

(3) Within 90 days of hire, the behavior management skills development specialist receives an additional 20 documented hours of training, including but not limited to:

(a) etiology and symptoms of emotional disturbances and neurobiological disorders;

(b) family systems;

(c) basic communication and problem solving skills;

(d) child and adolescent development;

(e) issues related to ethnic and cultural interests of the clients served;

(f) action and potential side effects of medications.

(4) Behavior management skills development specialists receive supervision by a New Mexico licensed practitioner with a doctoral or master's degree from an accredited institution in a human service related field who has at least two years experience working with children, adolescents and families. Exception: If a supervisor with the above qualifications cannot be recruited, the supervisor must possess, at a minimum, a B.S.W., B.A., B.S., or B.U.S. in a human service related field plus four years experience working with seriously emotionally disturbed or neurobiological disordered children and adolescents.

(5) Supervision is provided for a minimum of two hours per month depending upon the complexity of the needs presented by clients and the supervisory needs of the behavior management skills development specialist. Supervision is documented with dates, times, and content of contacts.

C. Services:

(1) Behavior management skills development services focus on acquisition of skills and improvement of the client and/or family's performance related to targeted behaviors. The agency:

(a) conducts a clinical assessment, or acquires clinical information that guides the development of the behavior management skills development services plan;

(b) documents clinical review of information that enables the agency to complete the behavior management skills development service plan;

(c) develops a behavior management skills development service plan, including: client needs, measurable goals, interventions, discharge criteria, and a discharge plan, within 14 days of admission to the service;

(d) reviews the behavior management skills development service plan every 30 days and revises as necessary; and

(e) works in partnership with other agencies or individuals involved in the client's care to implement the discharge plan and link the client to aftercare, as indicated;

(f) provides services to one or more child(ren) from the same or different home(s), provided that a staff-to-client ratio of 1:1 is maintained at all times.

(2) The behavior management skills development specialist provides the following services:

(a) participation in the development, review and revision of the behavior management service plan;

(b) implementation of the behavior management skills development service plan to include teaching of behavior enhancing skills;

(c) documentation of each client contact, including date, time, duration, and the client's progress and/or response to the interventions each day service is provided, stated in terms of service plan goals and objectives; and

(d) coordinating with the family and school personnel, if appropriate, to assist the client to achieve and/or to maintain appropriate behavior management.

[7.20.11.28 NMAC - Rp 7 NMAC 20.11.27, 03/29/02]

7.20.11.29 TREATMENT FOSTER CARE SERVICES:

A. Treatment foster care services, Level I and Level II, are specifically designed to accommodate the needs of psychologically or emotionally disturbed and/or behaviorally

disordered clients. Eligible clients are those who are at risk for failure or have failed in regular foster homes, are unable to live with their own families, or are going through a transitional period from residential care as part of the process of return to family and community.

(1) Treatment foster care services, level I and II, are targeted to children who meet the following criteria:

(a) are at risk for placement in a higher level of care or are returning from a higher level of care and are appropriate for a lower level of care; or

(b) have complex and difficult psychiatric, psychological, neurobiological, behavioral, psychosocial problems; and

(c) require, and would optimally benefit from, the behavioral health services and supervision provided in a treatment foster home setting.

(2) Treatment foster care services level II (TFC II) Services are targeted to children who, besides, meeting the criteria in 29.A.1. (A). (c), also meet one of the following criteria:

(a) have successfully completed treatment foster care services level I (TFC I), as indicated by the treatment team; or

(b) require the initiation or continuity of the treatment and support of the treatment foster family to secure or maintain therapeutic gains; or

(c) require this treatment modality as an appropriate entry level service from which the client will optimally benefit.

(3) A client eligible for treatment foster care services, level I or level II, may change treatment foster homes only under the following circumstances:

(a) an effort is being made to reunite siblings; or

(b) a change of treatment foster home is clinically indicated, as documented in the client's record by the treatment team.

B. Personnel qualifications and responsibilities:

(1) Treatment coordinator qualifications: The treatment coordinator possesses one of the following: a master's degree from an accredited program in social work or another human-services field; or a bachelor's degree in social work or another related human-service field and two years experience with this population.

(2) Treatment coordinator responsibilities:

(a) Treatment planning: Under supervision, and in coordination with the rest of the treatment team, the treatment coordinator:

(i) prepares the initial and comprehensive treatment plans in accordance with the timelines established in these certification requirements;

(ii) coordinates the implementation of the treatment plan;

(iii) monitors the client and his/her situation for events related to the treatment plan or otherwise significant to provision of treatment;

(iv) documents revisions to the treatment plan;

(v) assures that all members of the treatment team, including the client as clinically indicated, participate in the treatment planning process, as documented by the signatures of treatment team members on the treatment planning documents; and

(vi) involves the client's parents or legal guardians in treatment team meetings and in all plans and decisions affecting the client and keeps them informed of the client's progress in the program unless prohibited by the court or otherwise contraindicated according to documentation in the client's record.

(b) Contact with client: The treatment coordinator has a private face-to-face visit with the client within the first two weeks of placement, and at least twice monthly thereafter for TFC I clients and once monthly for TFC II clients. These contacts are conducted both in-home and out-of-home.

(c) Contact with treatment foster parent(s): The treatment coordinator has a face-to-face interview with the client's treatment foster parents within the first two weeks of placement and at least twice monthly thereafter TFC I clients and once monthly for TFC II clients. The treatment coordinator has a minimum of one phone contact with the treatment foster parent(s) weekly. Phone contact is not necessary in the same week that face-to-face contact has been made.

(d) All contacts are documented in the client's record and include a summary related to the treatment plan, significant events and the communications between treatment coordinator, client, treatment parent(s) and the biological/adoptive family. All documentation includes the date, time, location of the contact, and names of persons present.

(e) Support of the client's relationship with his or her biological/adoptive family: The treatment coordinator supports and enhances the client's relationship with his or her family to the extent determined by the treatment team. The treatment team reviews any restrictions at the time of the writing of the comprehensive treatment plan or at the time the restriction is imposed. The treatment coordinator documents in the client's case record the reason(s) for any restriction, and the treatment team's

involvement. Thereafter, the restriction is reviewed at least every 30 days and documented in the treatment plan review.

(f) Assistance to treatment foster parents: The treatment coordinator assists the treatment foster parents in the implementation and development of treatment strategies, including goal-setting and planned interventions. This assistance is done through the following:

(i) the provision of ongoing client-specific training and problem solving;

(ii) facilitation of professional development training for the treatment foster parents as described in Section 29.B(10) of these certification requirements*;*

(iii) observation/assessment of family interactions;

(iv) assessment of safety issues involving the client(s) in the home.

(g) Community liaison and advocacy: Based upon an assessment of the client's and biological/adaptive family's needs, the treatment coordinator advocates for and coordinates the provision of community-based services*,* as related to identified goals*,* and provides technical assistance to community providers as needed to maximize the utilization of services by the client and family.

(h) A treatment coordinator is physically available within 60 minutes of a treatment foster home so that quality of care, appropriate supervision and timely responsiveness to the treatment foster family are possible.

(3) Clinical supervisor qualifications: An individual providing supervision to the treatment coordinator possesses one of the following New Mexico licenses: Physician (physicians must be board-certified in psychiatry or eligible to attain such certification)*,* psychologist, registered nurse (RN) with a masters degree in psychiatric nursing, clinical nurse specialist in a related field, licensed independent social worker (LISW), licensed professional clinical mental health counselor (LPCC), licensed marriage and family therapist (LMFT) or other licensed independent practitioner in a related field. In addition to having one of the above licenses, the clinical supervisor is required to have a minimum of three years experience in clinical practice with children, adolescents and families.

(4) Clinical supervisor responsibilities: The role of the clinical supervisor is to provide support, consultation and oversight to the treatment coordinator(s) and therapist(s) through a minimum of four hours of supervision each month.

(a) The clinical supervisor is responsible for supervising ongoing treatment planning and implementation of the treatment plan for each client. The clinical supervisor evaluates progress in treatment and signs the treatment plan documents.

(b) The clinical supervisor provides coordination and back up coverage allowing for 24-hour on-call crisis intervention services for treatment parents, clients and their families.

(c) The clinical supervisor monitors the caseload of each treatment coordinator, and monitors each treatment coordinator in fulfilling his/her responsibilities. The maximum number of treatment foster care Services client(s) that maybe assigned to a single treatment coordinator shall not exceed eight. Caseloads are reduced based on case complexity, travel times and non-direct service times. The actual number of clients in a single caseload is based upon the ability of the treatment coordinator and/or agency to meet all applicable regulations as well as on the following considerations:

(i) the difficulty of the total client caseload; including the amount of time needed for support of, contact with, and assistance to the treatment foster parent(s) based on the complexity of client needs;

(ii) the availability of paraprofessional support and assistance;

(iii) the skills and abilities of the treatment foster parent(s);

(iv) geographical areas to be served; and

(v) additional duties assigned to the treatment coordinator.

(5) Therapist qualifications: Therapists providing individual, family, and/or group therapy meet either the necessary licensing qualifications as listed for clinical supervisor or possess one of the following New Mexico licenses: Licensed master social worker (LMSW), licensed professional mental health counselor (LPC), licensed art therapist (LAT) or licensed mental health counselor (LMHC).

(6) Therapist responsibilities: The therapist provides individual, family and/or group psychotherapy to clients as described in the treatment plan. The therapist documents all therapeutic contacts in the client’s record. Therapy notes will be kept current and submitted to the treatment coordinator for inclusion in the client’s record within one week of the session date. The therapist is an active treatment team member and participates fully in the treatment planning process.

(7) Supervision/consultation: An independently-licensed therapist consults with the supervisor for a minimum of two times per month. A non-independently licensed therapist receives supervision from the supervisor at a minimum of two times per month. All consultation/supervision is documented with the date, time, duration, and topics discussed.

(8) Staff training:

(a) Therapists, treatment coordinators, and other professional staff participate in knowledge/skill based pre-service training relevant to the services provided including:

(i) child and adolescent development;

(ii) prevention and de-escalation of aggressive behavior and the use of therapeutic holds;

(iii) crisis management, and intervention;

(iv) grief and loss issues for client(s) in foster care;

(v) cultural competence and knowledge of the means for obtaining and providing culturally responsive services;

(vi) specific agency policies and procedures including documentation;

(vii) recognition of abuse/neglect symptoms and state abuse/neglect/exploitation reporting requirements;

(viii) actions and potential side-effects of medications;

(ix) certification in emergency first aid and CPR; and

(x) behavior management.

(b) Professional staff who can provide verifiable documentation of previous training in one or more of the above areas are not required to repeat the training if the staff and the clinical supervisor agree in writing as to which specific training is equivalent and therefore not required. This exception does not apply to training regarding an agency's policies and procedures.

(c) All professional staff attend annual, ongoing professional development/ training relevant to the agency's treatment foster care model and to their individual job responsibilities.

(9) Treatment parent qualifications/requirements: Prior to hiring or contracting with prospective treatment foster parents, the agency documents that each prospective treatment foster parent, including those who provide therapeutic leave, meets and conforms to the certification requirements set forth in 8.27.3 NMAC (Licensing Requirements for Treatment Foster Care Services), as well as the following qualifications and requirements:

(a) hold a current and valid license as treatment foster parent issued by an agency licensed by the department as a child placement agency. No home can be

licensed for treatment foster care services until any previous foster care license is surrendered to the issuing agency;

(b) have signed a release of information that permits the department to share with the treatment foster care services agency a summary of any substantiated complaints involving abuse/neglect pertaining to the prospective treatment foster family;

(c) have signed a release to allow the agency to read prior foster home and prior treatment foster home records that exist through any previous foster home licensure or certification;

(d) understand the placement in treatment foster care services as temporary, except when adoption by the treatment foster parents has become the permanency plan;

(e) have access to reliable transportation, and when driving a car have a valid New Mexico driver's license and liability insurance;

(f) have read, expressed understanding of, and agreed in writing to fulfill the requirements and responsibilities of a treatment foster parent;

(g) prior to hiring or contracting with prospective treatment foster parent(s), the agency documents that it has requested and reviewed the prospective parent(s)' substantiated reports of abuse/neglect, if any, and previous foster-parent records, if any, and determined that such history does not disqualify the prospective parent(s) from becoming treatment foster parent(s); the agency will inquire about any previous treatment foster care services or regular foster care experience applicant families may have had.

(10) Treatment parent training: The training of treatment foster parents is systematic, planned, documented and may include modalities other than didactic instruction. Training is consistent with the program's treatment philosophy and methods and equips treatment foster parents with the skills to carry out their responsibilities as agents of the treatment process. Prospective treatment foster parents are provided with a written list of duties clearly detailing their responsibilities prior to their approval by the program. The written professional development plan is placed in the treatment foster parent(s) record.

(a) All treatment foster parents receive 40 hours of training, at least 30 hours of which are completed prior to placement of client(s). Any remaining hours are completed within two months of first placement. The training, at a minimum, includes:

(i) first aid and CPR training, provided by a certified instructor before receiving a client for placement;

(ii) child and adolescent development;

(iii) behavioral management;

(iv) prevention and de-escalation of aggressive behavior and the use of therapeutic holds;

(v) crisis management/intervention;

(vi) grief and loss issues for client(s) in foster care;

(vii) cultural competence and culturally responsive services;

(viii) specific agency policies and procedures including documentation,

(ix) recognition of abuse/neglect symptoms, and State abuse/neglect/exploitation reporting requirements;

(x) side-effects of psychotropic medication; and

(xi) role of treatment foster parent in treatment planning.

(b) Treatment foster parents who can provide verifiable documentation of previous training in one or more of the above areas are not required to repeat the training if the staff and the clinical supervisor agree in writing which specific training is equivalent and therefore not required. This exception does not apply to training regarding an agency's policies and procedures.

(c) Twenty-four hours of inservice training is required annually after receiving a client for placement. The 24 hours may include:

(i) up to four hours of video when supplemented by discussion in a classroom or clinical training setting;

(ii) up to four hours of supplemental reading may be part of the 24-hour annual inservice training when supplemented by by discussion in a classroom or clinical training setting.

(11) Treatment foster parent responsibilities: The treatment foster parents works with the treatment team and with agency supervision to develop and implement the treatment plan. Treatment foster parents provide front-line treatment interventions. The family living experience is the basic service to which individualized treatment interventions are added. Treatment foster parents are responsible for meeting the client's basic needs, and providing daily care and supervision. In addition to their basic foster parenting responsibilities, treatment foster parents perform the following tasks and functions:

(a) Treatment planning: Treatment foster parents actively participate in the treatment planning process and implement specified provisions of the treatment plan.

(b) Treatment foster parents work with the treatment team to maximize the likelihood that all services are provided in a culturally competent and culturally proficient manner.

(c) Contact with the client's family: Unless contraindicated in the client's treatment plan, or by court order, treatment foster parents assist the client in maintaining contact with his or her family, and actively work to support and enhance those relationships. When reunification with the client's family is planned, the treatment foster parents work in conjunction with the treatment team toward the accomplishment of the reunification objectives outlined in the treatment plan.

(d) Permanency planning assistance: The treatment foster parents assist with efforts specified in the treatment plan to meet the client's permanency planning goal(s).

(e) Record keeping: The treatment foster parents systematically record information and document client behaviors/activities and significant events related to the treatment plan. Documentation occurs on a weekly basis at a minimum, and more often in response to the occurrence of significant events. Daily logging is preferable.

(f) Agency contact: The treatment foster parents keep the agency informed of the occurrence of significant events. Daily logging is preferable.

(g) Confidentiality: Treatment foster parents maintain agency standards of confidentiality.

(h) Incident reporting: Treatment foster parents report all serious incidents to the agency, consistent with agency policy and certification requirements.

(i) Availability: At least one treatment foster parent is readily accessible at all times and is able to be physically present, if necessary, to meet the client's emotional and behavioral needs; e.g., a treatment foster parents responds if the school requires immediate parental attention. A single treatment foster parent may not schedule work hours when a client is normally at home.

(j) Care and supervision: Treatment foster parents ensure that proper and adequate supervision is provided at all times. Guardians ad litem, court-appointed special advocates, and CYFD employees may meet privately with clients as necessary. Clients are not left in the care or unsupervised presence of friends, relatives, neighbors, or others who have not received both criminal records clearance and training. Treatment teams determine that all out-of-home activities are appropriate for the client's level of need, including the need for supervision.

(k) Community-based resources: The treatment foster parents work with all appropriate and available community-based resources to secure services for and/or advocate for the client(s).

B. Assessment, pre-placement, and placement: Prior to placement of any treatment foster care client in any home, including therapeutic leave or interim placement, the agency will determine that the placement is therapeutically appropriate. The placement process includes documented consideration of the home and all residents.

(1) The comprehensive assessment includes face-to-face interviews with the client; with the client's biological or adoptive family whenever possible and when not contraindicated; and contact with any previous care providers. The comprehensive assessment meets the following requirements, in addition to those listed in the general provisions:

(a) the client's and his/her family's priorities and concerns, as appropriate, are documented; and

(b) if the client is in department custody**,** the agency requests information from the client's social worker, including the permanency plan, collateral assessment(s), and any known or suspected history of abuse/neglect.

(2) Placement does not occur until after a comprehensive assessment of how the prospective treatment foster family can meet the client's needs and preferences, and a documented determination by the agency that the prospective placement is a reasonable "match" for the client.

(3) A documented match assessment includes, but is not limited to:

(a) the identified needs of the client;

(b) the strengths of the treatment foster parents to implement the client's specific services and treatment plan;

(c) composition of the treatment foster family; including the name, age, and gender of each person residing in the home or visiting on a regular basis;

(d) treatment foster parents' specific knowledge, skills, abilities and attitudes as related to the specific needs of each client including high risk behaviors or the potential for such;

(e) treatment foster family's ability to speak the primary language of the client;

(f) treatment foster family's willingness and ability to work with the client's family;

(g) proximity of the treatment foster parent to the client's family, friends and school. If the client is placed more than an hour's driving time from the family, the justification is documented in the client's record;

(h) client and client's family's (if applicable) preference for placement;

(i) availability of, and access to, community resources required to meet the client's needs; and

(j) a summary/rationale of the client's placement in the particular treatment foster home chosen; the clinical rationale includes consideration of all residents of the home, including anticipated effects of the placement on all clients present and potential health and safety risks, and is documented in each client record prior to the placement.

(4) Pre-placement processes:

(a) Prior to placement**,** the client's family of origin meets with his or her child's prospective treatment foster parent(s) unless clinically contraindicated, prohibited by court order, or prevented by refusal or unavailability**.** If a pre-placement meeting does not occur, the reasons are documented in the client's record.

(b) Following completion of the match assessment, the client visits with the treatment foster family for a full 72 hours. The dates and times of the visit are documented in the client's record. At the end of the 72 hours, the treatment coordinator documents an assessment of the visit and the therapeutic appropriateness of the match, including the client's reaction and the treatment foster parent(s) response. When it is clinically indicated, the client may remain in the placement at the end of the 72-hour visitation, provided that the clinically-based reasons are documented in the client's record.

(c) All information that the treatment foster care services agency receives concerning a client waiting for placement is explained to the prospective treatment foster family prior to placement. Prospective treatment foster parents are responsible for maintaining agency standards of confidentiality regarding such information.

(d) For all clients in the custody of the department, the treatment foster care services agency shares the home study of a prospective licensed treatment foster family with the client's department social worker and invites the social worker to meetings in which the prospective placement is discussed.

(e) The treatment foster parent(s) can refuse placement of any treatment foster client whom they consider inappropriate for the home or to protect the safety of any children currently in the home.

(f) Treatment home composition and capacity, including capacity for therapeutic leave: Prior to any placement, the agency determines that the match is consistent with the following limits:

(i) A Treatment foster family is eligible to care for level I and level II treatment foster clients, non-treatment siblings of treatment clients, and/or children who were previously treatment foster clients in the same home, but are no longer qualified for TFC. Non-treatment regular foster or shelter care children may be temporarily placed in the home for therapeutic leave or shelter care for up to 30 days, after the agency assesses and documents that such a temporary placement will not compromise the treatment of any current client. Regular foster care children who were in the home previously or foster children who are siblings or children of treatment foster clients currently in the treatment foster home may be placed without the 30 day limit pertaining to therapeutic leave or shelter care clients. Arrangements pertaining to placement of regular foster children are made with the department social worker.

(ii) The total number of children in a treatment foster care services home, including treatment foster care clients, therapeutic leave children, and any other children, may not exceed six, except in rare circumstances such as placing sibling groups together. Such exceptions are approved in advance by the treatment teams, guardians of all children, and by the agency's clinical director. The clinical rationale for the exception is documented in each client's record.

(iii) The total number of treatment foster clients placed in a two-parent treatment foster care home is limited to three. At no time may more than two TFC I children be placed in the same home, except when they are siblings. In the case of multiple treatment foster care children placements, at least one treatment foster care parent will not be employed outside the home.

(iv) The total number of treatment foster care clients placed in a single-parent treatment foster care home cannot exceed two. No more than one level I treatment foster care client may be placed in a single-parent treatment foster care home, unless both are siblings.

(g) The agency obtains written agreement of the treatment team, including Guardians ad Litem (GALs), and legal guardians, for all placements.

(h) A client with a history of more than one incident of substantiated sexual aggression may not be placed in a home with any other client, including client(s) temporarily present for therapeutic leave or shelter purposes, without prior written approval by the treatment teams of all treatment clients in the home. In the case of non-treatment minors, written permission must be obtained from the legal guardian(s) prior to such placement. The rationale for such placement will distinguish the sexually reactive from the sexually aggressive client. The sexually reactive child may have presented with a history of symptoms such as public masturbation, sex play and/or developmentally incongruent preoccupation with sexual matters or topics. This behavior

by itself should not present a barrier to the placement of other children. The sexually aggressive child has had more than one incident of using force or intimidation to make another child comply with a sexual activity. The treatment team is responsible for evaluating all collateral information, evaluating any high risk behaviors or the potential for such, regardless of when it occurred or when an evaluation was performed, and the severity of the force or intimidation, regardless of how recently it occurred, prior to placing the child in a home where there are other children.

(i) The agency trains the treatment foster family in cultural and physical care issues related to the client's race and culture prior to the client's placement.

(5) Therapeutic leave: Agency policy and practice provide for treatment foster parent(s)' access to therapeutic leave, both planned and crisis-based.

(a) Treatment foster parents providing therapeutic leave placements are licensed and trained by the agency, are given a copy of the client's treatment plan, and are supervised by the treatment coordinator in the implementation of the in-home strategies.

(b) Therapeutic leave placements may be provided by a licensed and appropriately trained treatment foster family from another licensed and certified treatment foster care services agency, provided that the placing agency ensures the client's treatment plan is implemented appropriately.

(c) It is the treatment foster care services agency's responsibility to determine that treatment foster parents into whose home a therapeutic leave client has been placed are sufficiently skilled to work with the mix of treatment clients in their home, and document this determination in their records prior to placement.

(d) If a treatment foster care services agency cannot secure a trained and licensed treatment foster care family to provide therapeutic leave for a client, the agency may place the client in a licensed residential treatment services or licensed group home services, if clinically appropriate and documented, for a period not to exceed seven days. The residential treatment services or group home services program must adhere to the client's treatment plan and document the services provided and the client's behavior, consistent with these certification requirements for treatment foster parent documentation.

(e) Therapeutic leave placements comply with all certification requirements stated herein, including capacity limits. The agency documents assessment of treatment home/family composition, physical and sexual safety issues, and language(s) spoken, prior to therapeutic leave placement.

D. Service planning and provision:

(1) All treatment foster care services, as described in these certification requirements, are the responsibility of the treatment foster care services agency. Services are furnished either through agency staff or contracted persons.

(2) The treatment foster care services agency provides intensive support, technical assistance, and supervision of all treatment foster parents.

(3) The agency provides clinically appropriate therapy services to the client, and involves the treatment foster parents and the client's family to achieve the goals of the treatment plan. Each treatment client receives regularly scheduled therapy, including family therapy, as clinically indicated and specified in the client's treatment plan. Family involvement in treatment, including family therapy is not required when contraindicated by court order, or temporarily contraindicated by the clinical judgement of the department's legal guardian or treatment team.

(a) Therapy cannot be suspended or terminated unless there is concurrence by the treatment team that therapy is not presently indicated.

(b) All efforts are made to place a client in close enough proximity to biological/adoptive family so that family therapy will not be hindered.

(c) Family therapy is required when reunification is the goal.

(d) In cases where family involvement is contraindicated, the agency documents the clinical or legal basis for that determination and documents regular review of the determination.

(4) The professional/clinical staff provide or locate resources most suited to the individual needs of the client in treatment foster care services and helps the client, his or her parent(s) and the treatment foster families to make effective use of them.

(5) Client's access to agency staff: An agency staff person, who is a member of the client's treatment team, is designated as a contact person for each client. The client has direct access to that staff member. The client is informed of his or her designated staff person and how to reach that person. The means for such communication is available to the client for his or her use at all times. This is documented in the client's record at admission, and each time a change is made.

(6) Crisis on call: The treatment coordinator, or another professional clinical staff member or contractor who meets the qualifications for treatment coordinator, is on-call to treatment foster parents, client(s) and their families on a 24-hour, seven-day-per-week basis.

(7) The agency works with the local school district to access for the client the most appropriate educational services in the least restrictive setting.

(8) The agency facilitates the creation of formal and/or informal support networks for its treatment foster parents through coordination of parent support groups and/or other systems.

(9) Documentation:

(a) All contacts between agency staff and clients' biological/adoptive parents, and/or treatment foster parent(s) are documented in the client's records.

(b) All therapy notes are documented and placed in the client's record within one week of the session date.

(c) Therapy notes explicitly address the goals/objectives identified in the treatment plan.

(10) The treatment foster care services agency provides intensive support, technical assistance and supervision to all treatment foster parents. The agency trains the treatment foster family in cultural and physical care issues related to the client's race and culture prior to placement and throughout its duration, with the intention of the treatment foster family becoming culturally competent.

(11) The agency is responsible for determining that the treatment foster parent(s) effectively manage the individual treatment needs, acuity-based safety needs, and cultural needs of all clients placed in the home.

(12) The agency develops and implements a plan to connect the treatment foster client with other children and adults in the community who share the same culture, race and ethnicity.

(13) Services are provided to each client as determined by the treatment team. No one member of the treatment team has veto power except for those provision set forth in the Children's Code regarding change of placement notification. No services are terminated and/or suspended without the review and concurrence of the team. This certification requirement does not limit a managed care entity's right to determine, or the agency's or legal guardian's right to appeal, based on medical necessity criteria, the authorization of continued placement of a treatment foster care services client.

(14) The treatment plan is developed through a process that utilizes a treatment team comprised of the following individuals, as applicable and appropriate: the client, the client's family, treatment foster parent(s), treatment coordinator, department social worker, juvenile probation/parole officer, education agency, guardian ad litem and other significant individuals in the client's life.

(15) The agency ensures that all treatment plans adhere to the treatment planning requirements contained in the general provisions section of these certification requirements.

(16) The initial treatment plan includes specific tasks to be carried out by the treatment team within the first 14 days of placement.

(17) The initial and comprehensive treatment plans address strategies to ease the client's adjustment to the treatment home and to assess directly the client's strengths, skills, interests and needs for treatment within the home.

(18) The treatment plan reviews address discharge planning and strategies to prepare for the client's return to the biological, or adoptive, regular foster care home or independent living as appropriate.

(19) The treatment plan is reviewed every 30 days by the treatment team, in accordance with the general provisions, and revised when clinically indicated. The review occurs face-to-face, telephonically or through teleconference.

E. Agency oversight:

(1) Except in emergencies, a client is removed from a treatment foster care services home only after the treatment team has documented that the move is in the client's best interest. When such a move is necessary, the agency complies with pre-placement, placement and treatment planning requirements.

(2) In the event that the treatment foster parents request that a treatment foster client be removed from their home, a treatment team meeting is held and there is agreement that a move is in the best interest of the involved client. Any treatment foster parent(s) who demands removal of a treatment foster client from his or her home without first discussing with and obtaining consensus of the treatment team will have their license revoked.

(3) If treatment foster parent(s) wish to transfer between agencies, there must be written documentation from both agencies that the transfer is in the best interest of any client(s) currently in the home, including consideration of change of treatment team members, and a written statement from the previous agency that the transferring treatment foster family is in good standing.

(a) If any clients are currently placed in the transferring treatment home, the receiving agency will evaluate the appropriateness of the match and update the treatment plan.

(b) The receiving agency completes a new home study, or an addendum to the original home study reflecting any changes that have occurred in the composition of the home since the date of the client's admission.

(c) The receiving agency notifies the previous agency that the treatment foster parent(s) has been hired, and the previous agency, upon receipt of that notice, cancels its previous license.

(4) At the time of new licensure of a treatment foster care home, if non-treatment foster care client(s) placed through prior licensing arrangements must be removed, the process is conducted through an orderly and purposeful plan which is approved in writing by the previous licensing agency as meeting the best interests of the clients.

F. Property damage and liability:

(1) Written plan: The agency providing treatment foster care services has a written policy concerning compensation for damages to a treatment foster family's property by client(s) placed in their care. A copy of the written plan is provided and explained to the prospective treatment foster parents during the pre-service training.

(2) Liability insurance: Treatment foster parent(s) document and verify on a regular basis that they continuously maintain liability insurance for automobiles, home and persons, including owner and occupants of the home.

(3) Property damage caused by client(s) in CYFD custody may be reimbursed by the protective services division of the department, consistent with protective services "maintenance payments to substitute care providers" PR 8.10.22.10.9 Property Loss and Damage.

G. Transition to independent living:

(1) Older adolescents in treatment foster care are provided with a series of developmental activities and supportive services designed to enable them to prepare to lead self-sufficient adult lives, in accord with their treatment plan. For those clients 16-20 years old for whom family reunification, placement with extended family or with previous caretakers, or adoption has been found to be infeasible or inappropriate, the agency provides or arranges for a set of service components to be delivered which are designed to enable the client to prepare for a successful transition to independent living.

(2) The services provided or coordinated address the client's identified needs for:

(a) life skills training;

(b) education with regard to health concerns including human sexuality;

(c) vocational and technical training;

(d) housing needs during transition and after discharge;

(e) legal services;

(f) arrangements for support services, aftercare services and socialization, and

(g) cultural, religious and recreational activities, as appropriate to the client's needs.

[7.20.11.29 NMAC - Rp 7 NMAC 20.11.28, 03/29/02]

7.20.11.30 RESIDENTIAL TREATMENT SERVICES AND GROUP HOME SERVICES:

A. Residential treatment services are provided to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, who are in need of psychosocial rehabilitation in a residential setting. They require active residential psychotherapeutic intervention and a 24-hour therapeutic group living setting to meet their developmental, psychological, social, and emotional needs.

B. Group home services are provided to children/adolescents with moderate behavioral, psychological, neurobiological, or emotional problems, who are in need of active psychotherapeutic intervention, who require a twenty-four hour therapeutic group living setting to meet their developmental, social and emotional needs, and/or who are in transition from a higher level of care to a lower level of care.

C. The agency maintains and follows policies and procedures for emergency and non-emergency admissions. Admission policies and criteria are based on the client's identified need for residential treatment services or group home services.

D. At the time of admission or transfer to residential treatment services or group home services, the client is informed of the reasons for the placement/transfer and his/her treatment options. This discussion with the client is documented in the client's record by the admitting professional.

E. Personnel:

(1) Direct service staff providing residential treatment services and/or group home services receive a minimum of twenty hours of pre-service training, including training in:

(a) crisis management/intervention, behavioral management, personal restraint and seclusion;

(b) the agency's emergency procedures, which include CPR and first aid.

(2) The direct service staff possess a high school diploma or G.E.D and one or more of the following:

(a) two years experience working with clients and adolescents with severe psychological*/* emotional disturbances/neurobiological disorders; or

(b) two years of post-secondary education in a human service related field; or

(c) a minimum of 40 hours of documented training, including the twenty hours of pre-service training described in E above, and twenty additional hours including the following topics:

(i) etiology and symptoms of emotional disturbances and neurobiological disorders;

(ii) family systems;

(iii) basic communication and problem solving;

(iv) child and adolescent development;

(v) ethnic and cultural considerations related to the clients served; and

(vi) action and potential side effects of medications.

(3) The training in (c) (i) through (vi) above, when required, must be provided within three months of hire.

(4) Those direct service staff who, prior to beginning direct service work, can provide documentation of a current certificate of training in one or more of these specified areas are not required to repeat that training; their training requirements may be adjusted as justified and documented by the clinical director or designee.

(5) Clinical director:

(a) Clinical director qualifications: The clinical director possesses one of the following New Mexico licenses: physician (physicians must be board-certified in psychiatry or eligible to attain such certification); psychologist; licensed independent social worker (LISW); clinical nurse specialist in child psychiatric nursing; registered nurse (RN) with a master's in psychiatric nursing; licensed professional clinical mental health counselor (LPCC); and licensed marriage and family therapist (LMFT);

(b) In addition to having one of the above licenses, the clinical director is required to have a minimum of two years of experience in clinical practice with clients, adolescents, and families.

(c) Clinical director responsibilities: The responsibilities of the clinical director are to provide clinical oversight of the services, as well as to provide supervision, support, and consultation to all agency staff.

(6) Clinical supervisor qualifications: The clinical supervisor possesses one of the following New Mexico licenses: physician (physicians must be board-certified in psychiatry or eligible to obtain such certification); psychologist; licensed independent social worker (LISW) or other licensed independent practitioner in a related field; clinical nurse specialist in child psychiatric nursing; registered nurse (RN) with a master's in psychiatric nursing; licensed professional clinical mental health counselor (LPCC); or licensed marriage and family therapist (LMFT). In addition to having one of the above licenses, the clinical supervisor is required to have a minimum of two years of experience in clinical practice with clients, adolescents and families.

(7) Therapists qualifications: Therapists providing individual, family and/or group therapy must meet either the necessary licensed requirements as listed for clinical supervisor or possess one of the following New Mexico licenses: licensed professional mental health counselor (LPC); licensed master's social worker (LMSW); licensed art therapist (LAT); or licensed mental health counselor **(**LMHC).

F. Services:

(1) Residential treatment services are provided through a treatment team approach and the roles, responsibilities and leadership of the team are clearly defined.

(2) The agency provides a daily structured program that meets clients' needs as identified in the comprehensive assessment and as prescribed in the treatment plan. The following services are provided:

(a) individual, family, and group therapy, at the level of frequency documented in the treatment plan;

(b) access to timely and necessary medical care;

(c) supervision of self-administered medication, if appropriate;

(d) crisis intervention;

(e) educational services;

(f) activities of daily living;

(g) recreation, leisure time and other planned therapeutic activities; and

(h) planning of discharge and aftercare services; to facilitate timely and appropriate post discharge care, regular assessments are conducted to support discharge planning and effect successful discharge with clinically appropriate aftercare services; this discharge planning begins when the client is admitted to residential treatment services and is updated and documented in the client's record at every treatment plan review, or more frequently as needed.

(3) The agency provides services, care, and supervision at all times, including:

(a) the provision of, or access to, medical services on a 24-hour basis;

(b) maintenance of a staff-to-client ratio appropriate to the level of care and needs of the clients.

(i) for residential treatment services, the minimum ratios are one to six during the day and evening shifts and one awake staff to twelve clients during the night shift.

(ii) for group home services, the minimum ratios are one to eight during the day and evening shifts and one awake staff to twelve clients during the night shift.

(iii) additional staff must be provided if the clinical needs of the client population are high.

(iv) a written schedule must be maintained by the agency to document the staffing ratios.

(c) arrangements for, and provision of, supervision for off-grounds activities, including transportation, in accordance with minimum and need-based ratios; and

(d) arrangements for, and provision of responses to significant life events that may affect the client's treatment when out of the facility.

(4) Services and activities are appropriate to the age, behavioral, and emotional development level of the client.

(5) When not therapeutically or legally contraindicated, the agency encourages parent/client contact and makes efforts at family reunification. Such contacts and efforts are documented as they occur. If reunification is contraindicated, the reason is documented in the client's record at the time that determination is made, and the issue is reconsidered when indicated.

(6) The following factors will be considered in determining the appropriate level of services and supervision.

(a) risk of victimizing others;

(b) risk of inappropriate consensual activity;

(c) risk of being victimized by others;

(7) The treatment plans contain all the elements outlined in Section 23 of these certification requirements.

G. Residential treatment services and group home services may be provided in the same licensed facility when the agency ensures the health and safety of all clients present.

(1) A program certified for residential treatment services may provide group home services in accordance with these certification requirements without requesting or receiving a separate certification for group home services.

(2) When residential treatment services and group home services are provided in the same facility, the agency's policies and procedures specify clinically-based criteria under which the populations may be mixed.

(3) When residential treatment services and group home services populations are mixed, the agency documents that the clinically-based criteria have been met to address safety issues.

(4) When residential treatment services and group home services populations are mixed, the minimum staffing ratios for residential treatment services apply.

[7.20.11.30 NMAC - Rp 7 NMAC 20.11.29, 03/29/02]

7.20.11.31 JCAHO ACCREDITED RESIDENTIAL TREATMENT SERVICES:

Residential treatment services programs that are accredited by JCAHO comply with the general provisions and residential treatment services sections of these requirements, and the following standards:

A. The agency provides services, care, and supervision at all times, including maintenance of a minimum staff-to-child ratio of one to five during the day and evening shifts and one awake staff to ten clients during the night shift. Additional staff is provided when warranted by client acuity or other conditions.

B. A physical examination is completed by a licensed independent medical practitioner within one week of admission, and includes medical history, physical examination, assessment of pain, motor and sensorimotor functioning, speech, hearing, and language functioning, vision, immunizations, oral health, history of psychotropic medication use, and, when indicated an AIMS test. If a comprehensive medical history and physical examination have been completed within 30 days before admission, a durable, legible copy of this report may be used in the clinical record as a physical examination, but any subsequent changes must be recorded at the time of admission.

C. The agency evaluates the need for the following assessments, and when such assessments are indicated, they are completed in a thorough and timely manner:

psychological, psychiatric, educational, vocational, legal, nutritional, developmental disabilities, and substance abuse.

D. The agency has a written plan to provide all necessary medical histories, physical examinations, and laboratory tests that the agency does not directly provide.

E. Infection control

(1) The agency has a comprehensive and functioning infection-control program based on proven epidemiological methods for surveillance and prevention of adverse outcomes related to infection.

(2) The agency uses preventive processes such as universal precautions to reduce risks for endemic and epidemic infections in clients and staff.

(3) Infection control policies, procedures, and practices include surveillance, identification, and control of infection, and required reporting to staff and public health authorities.

(4) A current certification stating that the employee is free from tuberculosis in a transmissible form, obtained prior to the first date of direct service.

[7.20.11.31 NMAC - Rp 7 NMAC 20.11.30, 03/29/02; A, 10/29/04]

7.20.11.32 [RESERVED]

[7.20.11.32 NMAC - N, 03/29/02; Repealed 04/14/05]

7.20.11.33 COMPREHENSIVE COMMUNITY SUPPORT SERVICES:

A. Agencies certified for case management under these regulations or agencies receiving children's behavioral health contract funding for case management services as of 01/01/08 will receive provisional certification as a comprehensive community support services provider.

B. The provisional certification will be valid until the expiration of the agencies case management certification at which time a survey will be completed by the licensing and certification authority. Children's behavioral health contract agencies will have a survey completed within twelve (12) months of the issuance of the provisional certification.

C. All comprehensive community support services providers will have to meet the general provisions of these requirements and requirements in medicaid regulation Title 8, Chapter 315, Part 6.

[7.20.11.33 NMAC - N, 01/01/08]

PART 12: LICENSING REQUIREMENTS FOR CHILD AND ADOLESCENT MENTAL HEALTH FACILITIES

7.20.12.1 ISSUING AGENCY:

Children, Youth and Families Department.

[1/1/99; 7.20.12.1 NMAC - Rn, 7 NMAC 20.12.1, 02/28/05]

7.20.12.2 SCOPE:

All residential treatment services that provide children and adolescent mental health services as specified in these regulations.

A. These regulations apply to the following:

(1) public or private, profit or nonprofit residential facilities providing services as outlined by these regulations;

(2) any facility providing services as outlined by these regulations which by state or federal law or regulation must be licensed by the state of New Mexico.

B. These regulations do not apply to the following:

(1) offices and treatment room of licensed private practitioners;

(2) agencies providing treatment foster care services which are licensed by the protective services division of the department;

(3) room and board facilities in public or private schools accredited or supervised by the New Mexico state department of education and inspected for fire and safety by the New Mexico state fire marshals office;

(4) children/adolescent crisis shelters which provide short term emergency 24-hour-a-day, living accommodations to children, which are licensed by the child care bureau of the department;

(5) any facility licensed as a community home or a multi-service agency.

[1/1/99; 7.20.12.2 NMAC - Rn & A, 7 NMAC 20.12.2, 02/28/05]

7.20.12.3 STATUTORY AUTHORITY:

Sections 24-1-3, 24-1-5 and 9-2A-7(D) NMSA 1978

[1/1/99; 7.20.12.3 NMAC - Rn & A, 7 NMAC 20.12.3, 02/28/05]

7.20.12.4 DURATION:

Permanent.

[1/1/99; 7.20.12.4 NMAC - Rn, 7 NMAC 20.12.4, 02/28/05]

7.20.12.5 EFFECTIVE DATE:

January 1, 1999 unless a later date is cited at the end of a section.

[1/1/99; 7.20.12.5 NMAC - Rn & A, 7 NMAC 20.12.5, 02/28/05]

7.20.12.6 OBJECTIVE:

A. Establish minimum standards for licensing of health facilities that provide residential mental health services in order to promote the health, safety and welfare of children and adolescents in need of such services.

B. Provide for monitoring of facility compliance with these regulations through surveys to identify any factors that could affect the health, safety, and welfare of the clients or the staff.

C. Assure that the agency/ facility establishes and follows written policies and procedures which specify how this is met.

D. To assure that adequate supervision must be provided at all times. Failure to provide a child or adolescent with the care, supervision and services outlined in these regulations is a violation of these regulations which could result in suspension, revocation or denial of licensure.

[1/1/99; 7.20.12.6 NMAC - Rn & A, 7 NMAC 20.12.6, 02/28/05]

7.20.12.7 DEFINITIONS:

For the purpose of these regulations the following apply.

A. "Abuse" means any act or failure to act, performed intentionally, knowingly or negligently that causes or is likely to cause harm to a client, including:

(1) physical contact that harms or is likely to harm a client of a facility;

(2) inappropriate use of a physical restraint, isolation, or medication that harms or is likely to harm a client;

(3) inappropriate use of restraint, medication, or isolation as punishment or in conflict with a physician’s order;

(4) medically inappropriate conduct that causes or is likely to cause physical harm to a client;

(5) medically inappropriate conduct that causes or is likely to cause great psychological harm to a client;

(6) an unlawful act, a threat, or menacing conduct directed toward a client that results and might reasonably be expected to result in fear or emotional or mental distress to a client;

(7) abuse or neglect as defined in NMSA 32A-4-2 (1997), or as amended.

B. "Action plan" means a written document submitted by the provider(s) to the licensing and certification authority (LCA) for approval which states those actions that the facility will be implementing, with specific time frames and responsible parties for each, to correct the deficiencies identified in the previous on-site visit or review of documents.

C. "Administrator" means the person in charge of the day-to-day operation of a facility. The administrator, director, or operator may be the licensee or an authorized representative of the licensee. The administrator may also be referred to as the director or operator.

D. "Agency staff personnel" means current and prospective operators, staff, employees or volunteers of the agency.

E. "Ambulatory" means the ability of the child to walk without assistance.

F. "Applicant" means the individual who, or organization which, applies for a license.

G. "Bed" means the total assembly on which a child sleeps, including frame, springs, mattress, mattress cover/pad, sheets, pillow, blankets and bedspread.

H. "Capacity" means the maximum number of children who can be accommodated in rooms designated specifically for them in a facility pursuant to these regulations.

I. "Child/adolescent" means (for the purpose of these regulations), a person under the chronological age of 18 years. Those persons who, while a resident or client of a residential treatment services facility licensed pursuant to these regulations, reach the age of 18 for the purposes of these regulations be considered a child until they complete their course of treatment in the facility.

J. "Cleared staff member" means an individual who has received a state and federal criminal background clearance (meaning a negative criminal record check) as documented by the department clearance letter.

K. "Client" means any person who receives treatment from a residential agency.

L. "Corporal punishment" means touching a child's body with the intent of inducing pain and includes, but not limited to, shaking, spanking, hitting, hair pulling, ear pulling or forced exercise and is considered an abusive act.

M. "Criminal records check" means the process of fingerprinting on state and FBI approved cards and submission of the fingerprint cards for the purpose of obtaining the state and federal conviction records of an individual. The use of the services of an agency contracted by the department of public safety (DPS) who can access the DPS database in order to obtain state criminal background checks for those applicants who have resided in the state of New Mexico for five years or more may be utilized as a means of obtaining state criminal records checks prior to employment. Federal finger printing is still required. The use of an alternate method to obtain state criminal background checks do not replace the federal fingerprinting requirement.

N. "Cruelty (mental or physical) and indifference to the welfare of children" means a failure to provide a child with the care, supervision, and services to which the child is entitled. Examples of physical and mental cruelty include physical device/chemical restraints, striking, slapping or hitting, withholding food or bathroom privileges as punishment, swearing at or threatening a child, and indifference to the basic needs, including physical and psychosocial, of the child and including any abuse as defined in NMSA 1978 32-A-4-2.

O. [RESERVED]

P. "Deficiency" means a violation of or failure to comply with a provision(s) of these regulations.

Q. "Department" means the New Mexico children, youth and families department.

R. "Direct physical supervision" as it relates to criminal records checks means in the line of vision and/or live video observation by cleared agency staff member of non-cleared agency staff members who have direct contact with children.

S. "Direct service staff" means supervisors, therapists, child care workers, coordinators or other employees who work directly with children in their daily living activities in a facility.

T. "Directed action plan" means an action plan that the LCA writes and specifies that the facility must enforce within a specific time frame noted because of the serious nature of the deficiency.

U. "Discipline" means training that enables a child to develop self control and orderly conduct in relationship to peers and adults.

V. "Emergency sanction" means an immediate measure that is imposed on a facility for a violation(s) of applicable licensing laws and regulations, other than license revocation, suspension, denial of renewal of license or loss of certification, when a health and safety violation warrants prompt action.

W. "Emergency service" means unanticipated admission to a hospital or other psychiatric facility; or the provision of emergency services including, but not limited to, treatment for broken bones, cuts requiring sutures, poisoning, contagious diseases requiring quarantine, burns requiring specialized medical treatment, medication under-dose or overdose requiring treatment; or incidents between residents, or between residents and staff resulting in physical or psychological harm or which could result in physical or psychological harm; or other conditions requiring emergency medical services (EMS) specialized treatment at an urgent care center or an emergency room.

X. "Emergency suspension" means an immediate and temporary canceling of a license pending an appeal hearing and/or correction of deficiencies. During a period of suspension, the medicaid provider agreement is not in effect.

Y. "Employment history" means a written summary for the most recent three-year period of all periods of employment with names, addresses and telephone numbers of the employers and the individuals immediate supervisor; and all periods of nonemployment, stating the reason for leaving employment and explanation of periods of nonemployment, with documented verifying references.

Z. "Exploitation" means the act or process, performed intentionally, knowingly, or recklessly, of using a clients property for another persons profit, advantage or benefit without legal entitlement to do so.

AA. "Facility" means a building(s) in which residential mental health services are provided to the public and which is licensed pursuant to these regulations.

BB. "Governing body" means the governing authority of a facility which has the ultimate responsibility for all planning, direction, control, and management of the activities and functions of a facility licensed pursuant to these regulations.

CC. "Informal resolution conference" means an informal process between the department and facility to resolve any filed or potential appeal arising from the imposition of a sanction(s). The informal conference is an opportunity for the facility to present new evidence or arguments regarding the deficiencies cited by, or corrective action proposed by the department, in order to avoid a hearing. The informal conference does not postpone any deadlines for an appeal unless agreed to by the parties.

DD. "License" means the document issued by the LCA pursuant to these regulations granting the legal right to operate for a specified period of time.

EE. "Licensee" means the person(s) who, or organization which, has ownership, leasehold, or similar interest in the facility and in whose name a license for a facility has been issued and who is legally responsible for compliance with these regulations.

FF. "Licensing and certification authority" (LCA) means the childrens behavioral health services bureau, licensing and certification unit of the department.

GG. "Maintenance" means keeping the building(s) in a repaired and safe condition and the grounds in a safe, sanitary and presentable condition.

HH. "Mobile non-ambulatory" means unable to walk without assistance but able to move from place to place with the use of devices such as walkers, crutches, wheelchairs, etc.

II. "Moral turpitude" means conduct contrary to justice, honesty, modesty or good morals including such acts as domestic abuse, drunk driving or other similar convictions.

JJ. "Neglect" means subject to the client's right to refuse treatment and subject to the caregivers right to exercise sound medical discretion. The following apply:

(1) failure to provide any treatment, service, care, medication or item that is necessary to maintain the health or safety of a client; or

(2) failure to take any reasonable precaution that is necessary to prevent damage to the health or safety of a client; or

(3) failure to carry out a duty to supervise properly or control the provision of any treatment, care, good service or medication necessary to maintain the health or safety of a client; or

(4) any abuse as defined in NMSA 1978 32-A-4-2.

KK. "Non-mobile" means unable to move without assistance from place to place.

LL."Partial compliance" means that a facility has moderate and few deficiencies and that these do not threaten the health and safety of clients or staff, so that it is able to receive a temporary license with the implementation of certain corrective action(s) within a prescribed time period.

MM. "Physical harm" means harm of a type that causes physical injury resulting in physical trauma to a client (visible injury that requires treatment in excess of primary first aid); loss or functional loss of a bodily member or organ or of a major life activity for a prolonged period of time; or loss of consciousness for any amount of time.

NN. "Policy" means a statement of principle that guides and determines present and future decisions and actions.

OO. "Premises" means all parts of buildings, grounds, vehicles and equipment of a facility.

PP. "Procedure" means the action(s) that will be taken to implement a policy.

QQ. "Programmatic services" means services provided to children to meet special needs above and beyond living accommodations, meals, care, and routine supervision.

RR. "Psychological harm" means harm that causes mental or emotional trauma or that causes behavioral change or physical symptoms that require psychological or psychiatric care.

SS. "Punishment" means a penalty imposed on a child for wrongdoing.

TT. "Residential treatment facility" means a facility that provides 24-hour therapeutic care to children and adolescents and is licensed for no more than 16 children/adolescents. This includes residential treatment centers, group homes, residential substance abuse facilities and other similar facilities.

UU. "Residential treatment" means 24-hour structured therapeutic group living for children and/or adolescents with severe behavioral, neurobiological, or emotional problems when documented history and clinical opinion establish that the needs of the child cannot be met in a less restrictive environment. Children admitted to residential treatment services are either in need of either active psychotherapeutic intervention or require a 24-hour therapeutic group living setting to meet their developmental, social and emotional needs.

VV. "Reduction in licensed capacity" means the reduction of licensed capacity of a residential facility until deficiencies noted by the LCA are corrected.

WW. "Restraint" means a mechanical device used to involuntarily physically restrict a clients freedom of movement, performance of physical activity, or have normal access to his or her body. It is limited to those situations with adequate, appropriate clinical justification and requires policies and procedures with clear criteria. Exception: This standard does not apply to therapeutic holding or comforting of children or to a timeout when the individual to whom it is applied is physically prevented from leaving a room for 15 minutes or less and when its use is consistent with behavior-management protocol.

XX. "Restricted admissions or provision of services" means the restriction of an agency from providing designated services and/or from accepting any new clients until specified deficiencies noted by the LCA are corrected.

YY. "Revocation" means the act of making a license null and void through its cancellation.

ZZ. "Seclusion" means the involuntary confinement of a client alone in a room where the individual is physically prevented from leaving and is limited to those situations with adequate, appropriate clinical justification, requiring policies and procedures with clear criteria.

AAA. "Seclusion room" means a room designed and utilized to isolate and contain a child who poses an imminent threat of physical harm to self or others or serious disruption to the environment.

BBB. "Self-administration of medications" means assistance and supervision of the child in the self-administration of a drug, provided that the medication is in the original container, with a proper label and directions. A staff member may hold the container for the child, assist with opening of the container, and assist the child in self-administering the medication.

CCC. "Serious incident" means an environmental hazard, arrest or detention, or situation that requires emergency services. Environmental hazards include unsafe conditions which create an immediate threat to life or safety, including, but not limited, to fire or contagious diseases requiring quarantine.

DDD. "Staff member" means any person other than the owner, operator or director of a facility who has contact with children in care and includes volunteers, full-time and part-time employees.

EEE. "Stay of sanction" means the department’s receipt of the facility’s notice of appeal will operate as a stay of suspension, revocation, or sanction. In case of an emergency suspension or emergency sanction neither the immediate five-day hearing nor the facilitys request for a later hearing will stay the department’s action.

FFF. "Substantial compliance" means that a facility that is found to be without deficiencies, or with minor and few non-health and safety deficiencies, and is able to receive annual licensure.

GGG. "Substantiated complaint" means a complaint determined to be factual, based on an investigation of events.

HHH. "Supervision" means the monitoring of the children’s whereabouts and activities by the facility staff in order to ensure health, safety, and welfare.

III. "Survey" means an entry, by the LCA, into a facility licensed, or required to be licensed, pursuant to these regulations, for examination of the premises and records, and interviewing of staff and children.

JJJ. "Suspension" means a temporary cancellation of a license pending an appeal hearing and/or correction of deficiencies. During a period of suspension, the medicaid provider agreement is not in effect.

KKK. "Treatment plan" means a plan, based on data gathered during the assessment, that identifies the treatment needs of the client being served, lists the strategies to meet those needs, documents measurable treatment goals and objectives, outlines the criteria and time frame for terminating specified interventions, and, when reviewed, documents the clients progress in meeting the specified goals and objectives.

LLL. "U/L approved" means approved for safety by the national underwriters laboratory.

MMM. "Unsubstantiated complaint" means a complaint not determined to be factual based on an investigation of events.

NNN. "Variance" means an act taken, at the sole discretion of the LCA, to refrain from pressing or enforcing compliance with a portion(s) of these regulations for an unspecified period of time for facilities which were in existence at the time these regulations were promulgated, new facilities in existing construction, or for new services when the granting of a variance will not create a danger to the health and welfare of children and staff of a facility.

OOO. "Waive/waiver" means to refrain from pressing or enforcing compliance with a portion(s) of these regulations for a limited period of time provided the health, safety, or welfare of the clients and staff are not in danger. Waivers are issued at the sole discretion of the licensing authority.

[1/1/99; 7.20.12.7 NMAC - Rn & A, 7 NMAC 20.12.7, 02/28/05]

7.20.12.8 RELATED REGULATIONS, LAWS AND CODES:

These regulations supplement the following regulations, laws, codes and any future amendments to such regulations or superseding regulations.

A. New Mexico health department regulations governing the Control of Disease and Conditions of Public Health Significance 7.4.3 NMAC, effective August 15, 2003.

B. [RESERVED]

C. [RESERVED]

D. New Mexico health department regulations 7 NMAC 1.3, Health Records, effective October 31, 1996.

E. New Mexico health department 7 NMAC 26.6, Requirements for Developmental Disabilities Community Programs, effective January 15, 1997.

F. New Mexico health department 7 NMAC 20.2, Comprehensive Behavioral Health Standards, effective January 1, 2000.

G. New Mexico health department 7 NMAC 20.2, Comprehensive Behavioral Health Standards, effective January 1, 2000.

H. New Mexico health department regulations 7 NMAC 1.7, Health Facility Licensure Fees and Procedures, effective October 31, 1996.

I. New Mexico health department regulations 7 NMAC 1.2, Adjudicatory Hearings, effective February 1, 1996.

J. New Mexico health department regulations 8.8.3 NMAC, Governing Background Records Checks and Employment History Verification, effective October 30, 2003.

K. New Mexico health department 7.6.2 NMAC, Food Service and Food Processing, effective August 12, 2000.

L. New Mexico drug laws and board of pharmacy regulations, 16.19.1 NMAC through 16.19.29 NMAC.

M. The latest edition adopted by the New Mexico state fire board of the National Fire Protection Association Life Safety Code Handbook 101, June 9, 1997.

N. The latest edition of the building code adopted by the New Mexico construction industries division of the Uniform Building Code enacted by the international conference of building officials.

O. New Mexico health department regulations 7.5.2 NMAC, Immunization Requirement, effective September 1, 2000.

P. Health facility licensure fees and procedures, department of health, 7 NMAC 1.7, effective October 31, 1996.

Q. 7.20.11 NMAC, Certification Requirements for Child and Adolescent Mental Health Services, effective March 29, 2002.

R. Health facility sanctions and civil monetary penalties 7 NMAC 1.8, effective October 31, 1996.

S. 7 NMAC 1.2, Adjudicatory Hearings, effective February 1, 1996.

T. New Mexico Childrens Code NMSA 32A-1-1 et. seq. (2004).

[1/1/99; 7.20.12.8 NMAC - Rn & A, 7 NMAC 20.12.8, 02/28/05]

7.20.12.9 STANDARD OF COMPLIANCE:

A. The degree of compliance required throughout these regulations is designated by the use of the words, "must" or "may". "Must" means mandatory. "May" means permissive.

B. The use of the words "adequate", "proper", and other similar words mean the degree of compliance that is generally accepted throughout the professional field by those who provide residential or day-treatment services to the public in facilities governed by these regulations.

[1/1/99; 7.20.12.9 NMAC - Rn, 7 NMAC 20.12.9, 02/28/05]

7.20.12.10 [RESERVED]

[1/1/99; 7.20.12.10 NMAC - Rn, 7 NMAC 20.12.10, 2/28/05; Repealed, 02/28/05]

7.20.12.11 INITIAL LICENSURE PROCEDURES:

To apply for a license for a facility pursuant to these regulations the following procedures must be followed by the applicant.

A. These regulations must be used as a reference for design of a new building, renovation or addition to an existing building. The applicant of the proposed facility must advise the LCA of its intent to open a facility pursuant to these regulations.

B. Floor and site plans: All applications for initial licensure must be accompanied by a set of floor plans for the facility.

(1) Floor and site plans are of professional quality, on substantial paper of at least 18" x 24", and are drawn to an accurate scale of 1/4" to 1'.

(2) Floor plans include:

(a) proposed use of each room, e.g., staff’s bedroom, staff’s toilet, children’s bedrooms (include number of children intended to sleep in each room), living room, kitchen, laundry, etc.;

(b) interior dimensions of all rooms;

(c) one building or wall section showing exterior and interior wall construction; section includes floor, wall, ceiling, and the finishes, e.g., carpet, tile, gypsum board with paint, wood paneling;

(d) door types, swing, and sizes of all doors, e.g., solid core, hollow core, 3'0" x 6'8" x 1 3/4" thick;

(e) air conditioning, if applicable;

(f) all sinks, tubs, showers and toilets;

(g) windows including size, type, sill height, and openable area;

(h) any level changes within the building, e.g., sunken living room, ramps, steps;

(i) a site/plot plan must be provided to indicate surrounding conditions including all steps, ramps, parking, walks and any permanent structures;

(j) indicate if the building is new construction, remodeled or alteration addition; if remodeled or an addition, the plans indicate existing and new construction plans.

C. Floor and site plans are reviewed by the LCA for compliance with current building and fire codes, and comments will be sent to the applicant specifying any needed changes or requests for any additional information.

D. Licensing phase: Prior to completion of construction, renovation or addition to an existing building the applicant must submit to the LCA the following.

(1) The application form, which is obtained from LCA, completed by typing or printing all the information requested, and dated, signed and notarized by the applicant.

(2) Fees: All applications for licensure are accompanied by the required fee.

(a) Current fee schedules are available from the LCA.

(b) Fee payments must be in the form of a certified check, money order, personal, or business check is made payable to the state of New Mexico.

(c) Fee payments are non-refundable.

(3) Zoning and building approval:

(a) The agency provides an initial application accompanied with the written approval from the appropriate authority, such as city, county, or municipality.

(b) The agency provides an initial application accompanied with original written building approval (certificate of occupancy), from the appropriate authority, city, county, or municipality.

(4) Fire authority approval: All initial applications are accompanied with written approval from the fire authority having jurisdiction.

(5) New Mexico environment department approval:

(a) For private water supply, if applicable.

(b) For private waste or sewage disposal, if applicable.

(6) Copy of appropriate drug permit: Issued by the state board of pharmacy, if applicable.

E. Initial survey: Upon receipt of a properly completed application including all supporting documentation as outlined above, an initial survey of the proposed facility must be scheduled by the LCA.

F. Issuance of license: Upon completion of the initial survey and determination that the facility is in substantial or partial compliance with these regulations, the LCA may issue a license.

[1/1/99; 7.20.12.11 NMAC – Rn & A, 7 NMAC 20.12.11, 02/28/05]

7.20.12.12 LICENSES:

A. Annual license: The LCA may, at its sole discretion, issue a license for up to one year to a facility which is determined to be in substantial compliance with these regulations.

B. Temporary license: The LCA may, at its sole discretion, issue a temporary license prior to the initial on-site survey, or if upon an on-site survey if it determines the facility to be in partial compliance with these regulations.

(1) A temporary license may cover, depending upon the severity/chronicity of the deficiencies and at the discretion of the LCA, any period of time, not to exceed 180 calendar days, during which time the facility must correct all specified deficiencies. In order to be issued a temporary license, deficiencies may not be violations of health and safety standards.

(a) The facility must submit an action plan within the time frame the LCA determines. The LCA approves the action plan. The facility is then either inspected on-site again, or is required to submit proof of correction through submission of appropriate and relevant documentation within the time frame the LCA specifies.

(b) If the facility does not meet licensing requirements at the end of the temporary licensure period, a sanction is imposed along with a second temporary

license or the temporary license expires. Only two consecutive temporary licenses are granted.

(2) When a temporary license is issued, the previous license and its expiration date become null and void, and the temporary license effective dates are in effect.

C. Amended license: A licensee applies to the LCA for an amended license when there is a change of a licensee; a change of the facility name; or change of capacity.

(1) A request for an amended license is submitted in writing to the LCA.

(2) The request is accompanied by the required fee for the amended license.

(3) The request is submitted within ten business days of the changes listed in Subsection C of 7.20.12.12 NMAC.

(4) Upon receipt of the completed application and fee, an on-site survey is performed by the LCA prior to the issuance of the amended license.

[1/1/99; 7.20.12.12 NMAC - Rn, 7 NMAC 20.12.12, 02/28/05]

7.20.12.13 LICENSE RENEWAL:

A. The licensee submits a renewal application on the forms obtained from the LCA, along with the required fee, within 60 days prior to the expiration of the current license.

B. Upon receipt of the renewal application and required fee, and prior to the expiration of the current license, the LCA conducts an on-site survey and issues a new license effective the day following the date of expiration of the current license if the facility is in substantial compliance with these regulations.

C. NMSA 1978 24-l-5 (a) (1997) or as amended, provides that no health facility is operated without a license. If a licensee fails to submit a renewal application with the required fee and the current license lapses, the facility ceases operations until it obtains a new license through the initial licensure procedures.

D. If the licensee submits the required renewal application and the LCA does not survey a facility by the expiration date of the current license, the current license continues in effect until the LCA conducts a renewal survey and issues a new license.

[1/1/99; 7.20.12.13 NMAC - Rn, 7 NMAC 20.12.13, 02/28/05]

7.20.12.14 POSTING OF LICENSE:

The facility's license is posted on the licensed premises in an area visible to the public.

[1/1/99; 7.20.12.14 NMAC - Rn, 7 NMAC 20.12.14, 02/28/05]

7.20.12.15 NON-TRANSFERABLE RESTRICTIONS ON A LICENSE:

A license is nontransferable otherwise to other persons or locations.

A. The license is null and void and is returned to the LCA when any one of the following situations occur:

(1) ownership of the facility changes;

(2) the facility changes location;

(3) the licensee of the facility changes;

(4) the facility discontinues or suspends operations.

B. A facility wishing to continue operation as a licensed facility under the above-mentioned circumstances submits an application for an amended licensure in accordance with these regulations at least 30 calendar days prior to the anticipated change.

[1/1/99; 7.20.12.15 NMAC - Rn, 7 NMAC 20.12.15, 02/28/05]

7.20.12.16 AUTOMATIC EXPIRATIONS OF A LICENSE:

A. a license automatically expires at midnight on the day indicated on the license as the expiration date, unless renewed, suspended, or revoked; or

B. the day a facility discontinues or suspends operation; or

C. the day a facility is sold, leased, or otherwise changes ownership and/or licensee; or

D. the day a facility changes location.

[1/1/99; 7.20.12.16 NMAC - Rn, 7 NMAC 20.12.16, 02/28/05]

7.20.12.17 SUSPENSION OR REVOCATION OF A LICENSE OR IMPOSITION OF EMERGENCY SANCTIONS WITHOUT PRIOR HEARING:

In accordance with Section 24-1.5 (H) NMSA 1978, if immediate action is required to protect human health and safety, the LCA may immediately suspend or revoke a license or impose emergency sanctions pending a hearing, provided such hearing is held within five working days of such action, unless waived by the licensee.

[1/1/99; 7.20.12.17 NMAC - Rn, 7 NMAC 20.12.17, 02/28/05]

7.20.12.18 GROUNDS FOR REVOCATION, SUSPENSION OF LICENSE, DENIAL OF INITIAL OR RENEWAL APPLICATION FOR LICENSE, OR IMPOSITION OF SANCTIONS:

A license may be revoked or suspended; an initial or renewal application for license may be denied; or sanctions may be imposed after notice and opportunity for a hearing, for any of the following:

A. failure to comply with any provision(s) of these regulations;

B. failure to allow surveys by authorized representatives of the LCA;

C. employment of any person convicted of a felony or misdemeanor including a misdemeanor involving moral turpitude or presence at a facility of a staff member under the influence of alcohol or mood-altering drugs; if after employment, a staff member is charged and/or convicted of a felony or misdemeanor involving moral turpitude and it is known to the agency, it is immediately reported to the LCA;

D. purposeful or intentional misrepresentation(s) or falsification(s) of any information on application forms or other documents provided to the LCA;

E. discovery of repeat violations of these regulations or failure to correct deficiencies of survey findings in current or past contiguous or noncontiguous licensure periods;

F. presence of and/or a history of licensure revocation, suspension, denial, sanction or penalty or other similar disciplinary actions taken by regulatory bodies in other states regardless of whether any of these actions resulted in a settlement in lieu of a sanction;

G. failure to provide the required care and services as outlined by these regulations for the clients receiving care at the facility;

H. exceeding licensed capacity, except in an emergency.

[1/1/99; 7.20.12.18 NMAC - Rn, 7 NMAC 20.12.18, 02/28/05]

7.20.12.19 HEARINGS AND APPEALS:

A. Appeals of any sanction except revocation or suspension of a license or imposition of emergency sanction(s) without prior hearing as outlined in Section 17 above, are made in writing to the LCA within 10 business days of receipt of the official notice of revocation, suspension, denial of licensure or sanction.

B. When an appeal is filed the sanction is stayed until a hearing is held and final determination issued or an informal resolution reached, unless it is an emergency revocation or suspension of license or imposition of emergency sanctions. A hearing will be held within 30 calender days.

C. The entity filing the appeal may also request an informal resolution conference at that time. The purpose of the informal resolution conference is to allow the entity receiving the sanction an opportunity to present information on plans to remedy deficiencies and discuss possible pre-hearing dispositions. This does not apply to the emergency revocation or suspension of a license or to the imposition of emergency sanctions.

D. The LCA and the licensee may informally resolve any filed or potential appeal arising from the imposition of sanctions. However, in the case of an emergency revocation or suspension of licensure and/or the imposition of an emergency sanction, there is no stay available.

[1/1/99; 7.20.12.19 NMAC - Rn, 7 NMAC 20.12.19, 02/28/05]

7.20.12.20 SANCTIONS:

A. Action plan: The LCA directs a facility to correct deficiencies within the time frame specified by the LCA through the submission of an action plan. At the discretion of the LCA, the action plan can be written by the facility and approved by the LCA or it may be a directed action plan that the LCA writes and is enforced by the facility within the time frame specified by the LCA. The facility produces proof of correction through submission of appropriate and relevant documentation. The LCA may conduct an on-site visit to review the facility, with emphasis on the previously noted deficiencies. If another on-site visit reveals other deficiencies, the LCA may amend either the action plan or the directed action plan to require compliance with any other deficiencies noted.

B. Restricted admissions or provision of services: The LCA restricts the facility from accepting any new clients or expanding into additional services until such time the identified deficiencies are corrected.

C. Maintenance or reduction of capacity: The LCA directs the facility to maintain or reduce the capacity of the facility until deficiencies are corrected and the LCA approves the corrections.

D. Compliance monitor: The LCA may select a compliance monitor for a specified period of time to closely observe a facilitys compliance efforts. The compliance monitor has authority to review all applicable facility records, policies, procedures and financial records and the authority to interview facility staff and clients. The compliance monitor may also provide consultation to the facility management to correct violations. The facility pays all costs of the compliance monitor.

E. Temporary management: The LCA may appoint professional temporary management with expertise in the field of child and adolescent mental health services the facility provides. The management appointed is primarily responsible for overseeing the operation of the facility, to protect the health and safety of its clients, to assess the correction of deficiencies, or to facilitate an orderly closure. The facility pays all costs of temporary management.

F. Suspension: The LCA suspends licensure for a specified period of time pending correction of deficiencies. During a period of suspension, the medicaid provider agreement terminates on the date of suspension.

G. Denial or revocation of license: The LCA denies initial licensure or renewal of licensure based upon deficiencies related to:

(1) abuse, neglect or exploitation of a client(s); or

(2) presence of, and/or a history of health and safety deficiencies found in current or previous surveys or on-site visits; or

(3) presence of, and/or a history of, licensure revocation, suspension or denial or sanctions or penalties or other similar disciplinary actions taken by the regulatory bodies in other states; or

(4) noncompliance with health and safety related regulations.

H. In such circumstances the medicaid provider agreement terminates on the date of such denial or revocation.

[1/1/99; 7.20.12.20 NMAC - Rn, 7 NMAC 20.12.20, 02/28/05]

7.20.12.21 CURRENTLY LICENSED FACILITIES:

A. Any facility currently licensed on the date these regulations are promulgated and which provides the services prescribed under these regulations, but which fails to meet all building requirements, may, at the discretion of the LCA, continue to be licensed as a residential facility.

B. Variances may be granted for those building requirements the facility cannot meet, provided:

(1) the variances granted will not create a hazard to the health, safety and welfare of the clients and staff or otherwise deny access to any disabled person who is otherwise qualified to receive services from the facility; and

(2) the building requirements for which variances are granted cannot be corrected without an unreasonable expense to the facility; and

(3) variances are not in conflict with existing building and fire codes; and

(4) variances granted are recorded and made a permanent part of the facility file; and

(5) variances granted continue to be in effect as long as the facility continues to provide services pursuant to these regulations and meet the criteria of Subsection A of 7.20.12.21 NMAC above; these variances are not transferred to a different facility or transferred/assigned upon the sale of the facility.

[1/1/99; 7.20.12.21 NMAC - Rn & A, 7 NMAC 20.12.21, 02/28/05]

7.20.12.22 NEW FACILITY:

A. If a facility is opened in an existing building, a variance may be granted for those building requirements the facility cannot meet under the same criteria outlined in Paragraphs (1), (2) and (3) of Subsection B of 7.20.12.21 NMAC of these regulations and if not in conflict with existing building and fire codes. Such a variance is granted at the sole discretion of the LCA.

B. A new facility opened in a newly constructed building must meet all requirements of these regulations.

[1/1/99; 7.20.12.22 NMAC - Rn, 7 NMAC 20.12.22, 02/28/05]

7.20.12.23 FACILITY SURVEYS:

A. A survey by the LCA is conducted at a minimum of once per year in each facility licensed pursuant to these regulations. Additional surveys or on-site visits may be made to provide the facility with technical assistance, and/or to assess/monitor progress with correction of violations found on previous surveys or to investigate complaints or allegations of abuse, neglect or exploitation.

B. The facility is provided with a written report of the findings within 20 business days of completion of the survey.

C. The facility may be required to submit an action plan, approved by the LCA, within 15 business days of receipt of the findings. The action plan may be a directed action plan due to the serious nature of the deficiencies and the LCA will expect health and safety deficiencies to be corrected immediately.

D. The LCA, at its sole discretion, may accept the action plan as written or require modifications of the action plan by the licensee.

E. Application for licensure, whether initial or renewal, constitutes permission for entry into, and surveys of, a facility by the authorized LCA representatives at reasonable times while the application is pending, and if licensed, during the licensure period.

F. LCA surveyors have the right to enter upon and into the premises of any facility which is licensed or required to be licensed, whether or not an application for licensure has been made, at any reasonable time for the purpose of determining the state of compliance with these regulations.

G. On-site surveys are announced or unannounced at the sole discretion of the LCA.

[1/1/99; 7.20.12.23 NMAC - Rn, 7 NMAC 20.12.23, 02/28/05]

7.20.12.24 REPORTING OF INCIDENTS:

All facilities licensed pursuant to these regulations must report to the LCA within 24 hours, any serious incident or unusual occurrence which has, or could threaten the health, safety, or welfare of the clients or staff of the facility. Such incidents may include, but are not limited to:

A. fire, flood, or other natural disaster which creates structural damages to the facility or poses health hazards;

B. any outbreak of contagious disease dangerous to the public health;

C. any human act(s) by staff members of the facility which presents or poses possible physical and/or psychological health hazards;

D. any human act(s) by staff member(s) of the facility which results in the serious illness, injury, or physical and/ or psychological impairment of a client;

E. any death of a client;

F. any suspected client abuse, neglect or exploitation of a client, as defined in these regulations;

G. incidents that include acts of physical harm to a client or by staff or other clients;

H. absence of clients without permission, including not returning from a pass, for longer than 24 hours past the designated return time;

I. any non-informational call made to poison control involving potential harm to a client or resulting in treatment of a client.

[1/1/99; 7.20.12.24 NMAC - Rn, 7 NMAC 20.12.24, 02/28/05]

7.20.12.25 COMPLAINT AND INVESTIGATION PROCEDURES:

A. Submission of complaints: Complaints regarding any facility licensed pursuant to these regulations are submitted to the LCA.

(1) Complaints are submitted in writing and may be signed by the complainant.

(2) Complainants who telephone the LCA are able to provide necessary information needed by the LCA in order to document the complaint.

B. Initiation of investigation: The department screens, and if it deems appropriate, will initiate an investigation within 30 business days from receipt of a complaint. If it is probable that the health, safety, or welfare of a child is in jeopardy, the complaint is investigated as soon as possible after the complaint is made.

C. Results of investigation: The licensee of the facility is notified of the results of the investigation.

D. Anonymity may be requested by the complainant, but cannot be guaranteed.

E. Action by the LCA in response to a complaint:

(1) Unsubstantiated complaint: A complaint which is unsubstantiated by the LCA is not made part of the facility file and the LCA takes no further action.

(2) Substantiated complaint: The LCA may take the following actions if a complaint is substantiated:

(a) require the facility to submit a written action plan to the LCA;

(b) impose other sanctions that may include, but not be limited to, the denial, suspension or revocation of a license, or the filing of criminal charges, or a civil action which may be initiated by the LCA.

[1/1/99; 7.20.12.25 NMAC - Rn, 7 NMAC 20.12.25, 02/28/05]

7.20.12.26 CAPACITY OF A FACILITY:

The capacity of a facility licensed pursuant to these regulations is determined by the following.

A. All residential treatment facilities are limited to a total capacity of 16 children in a single residential building.

B. By square footage of childrens sleeping rooms as specified by these regulations.

C. The capacity as reflected on the license issued to a facility licensed pursuant to these regulations must not be exceeded at any time. Exception: The facility may exceed its licensed capacity for a period not to exceed 72 hours due to emergency placements by families, juvenile probation and parole officers, sheriff, police, court or protective services. The facility notifies the LCA within one business day of the event.

[1/1/99; 7.20.12.26 NMAC - Rn, 7 NMAC 20.12.26, 02/28/05]

7.20.12.27 REPORTS AND RECORDS REQUIRED TO BE ON FILE IN THE FACILITY:

Each facility licensed pursuant to these regulations maintains the following reports and records on file and makes them available for review upon request by the LCA.

A. Exception: Agencies having multiple facilities in the same city or town may keep reports and records on file in a central location. For such facilities the information is made readily available to the LCA and includes:

(1) a copy of the latest fire inspection report by the fire authority having jurisdiction; and

(2) a copy of the last survey conducted by the LCA including any variances granted; and

(3) records of monthly fire and emergency evacuation drills conducted by the facility; and

(4) health certificates of staff; and

(5) agreements or contracts with other health care providers to provide services that are not available in the facility, if applicable; and

(6) a copy of a current pharmacy license, if applicable; and

(7) latest inspection of drug room by state board of pharmacy, if applicable; and

(8) New Mexico environment department approval of private waste or sewage disposal, if applicable.

B. New Mexico environment department approval of kitchen and food management and, if applicable, survey reports of private water supply, private waste and/or sewage disposal. Exception: Those facilities which have been exempted by the environmental improvement division or recognized local authority from meeting the requirements for kitchens and food service [because of the program], have the exemption on file.

C. One month of menus of meals served in the facility.

D. Documentation of staff criminal record checks and verification of employment history as required by these regulations.

E. A valid drug permit issued by the state board of pharmacy for those facilities licensed pursuant to these regulations who as a regular part of their program supervise the administration and/or clients self-administration of medication and safeguard medications for the children in care.

F. A copy of staff members current American red cross, or other recognized organizations, standard first aid certificate, for all direct care staff within 90 days of employment.

[1/1/99; 7.20.12.27 NMAC - Rn, 7 NMAC 20.12.27, 02/28/05]

7.20.12.28 FACILITY RULES:

A. Each facility has written rules which are age appropriate and clear and understandable to the children in care. The rules include but are not limited to the following:

(1) the use of tobacco or alcohol;

(2) the use of the telephone;

(3) visitors and visiting hours;

(4) daily routine of the facility such as bed times, free time, study hours, use of personal possessions, playing of radios and watching television; and

(5) leaving the premises of the facility.

B. Facility rules are posted in an area of the facility readily available to the children.

C. Prior to placement in, or admission to, a facility, the rules are explained to the child, parents, or legal guardian in a language they can understand.

[1/1/99; 7.20.12.28 NMAC - Rn, 7 NMAC 20.12.28, 02/28/05]

7.20.12.29 STAFF RECORDS:

Each facility licensed pursuant to these regulations maintains a complete record on file for each staff member or volunteer. Staff records are made available for review upon request of the LCA.

A. Staff records contain at a minimum the following:

(1) name;

(2) address and telephone number;

(3) position for which employed;

(4) date first employed;

(5) documentation of a minimum of three references checked

(6) a person(s) to contact in case of an emergency;

(7) a copy of the employees first aid certificate;

(8) health certificate stating that the employee is free from tuberculosis in a transmissible form as required by the New Mexico department of health regulations, Control of Communicable Disease in Health Facility Personnel, 7.4.4 NMAC.

(9) A clearance letter from the department stating the criminal records check has been conducted with negative results or; a signed statement by the administrator, director, or operator attesting to direct supervision of an uncleared employee by a cleared employee until official clearance is received.

(a) Each uncleared employee is identified on the staff schedule.

(b) The staff schedule reflects changes as they occur.

B. A daily attendance record of all staff is kept in the facility.

C. The facility keeps daily, weekly and monthly schedules of all staff. These schedules are kept on file for at least 12 months.

[1/1/99; 7.20.12.29 NMAC - Rn, 7 NMAC 20.12.29, 02/28/05]

7.20.12.30 POLICIES AND PROCEDURES:

All facilities licensed pursuant to these regulations have written policies and procedures for the following:

A. reporting of suspected child abuse, neglect or exploitation, pursuant to these regulations;

B. actions to be taken in case of accidents or emergencies involving a child, including death;

C. disciplinary methods utilized by the facility;

D. actions to be taken when a child is found to be absent without authorization for longer than 24 hours;

E. the administration of medication;

F. confidentiality of the childrens records;

G. the use of seclusion rooms and/or restraints, if used by the facility;

H. maintenance of building(s) and equipment;

I. fire and evacuation;

J. administration and preparation of drugs;

K. the handling of complaints received from clients, parents, guardians or any other person;

L. adequate staff coverage to meet the acuity needs of the treatment population which are reassessed and adjusted when clinically indicated.

[1/1/99; 7.20.12.30 NMAC - Rn, 7 NMAC 20.12.30, 02/28/05]

7.20.12.31 CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES PERSONNEL AND STAFF REQUIREMENTS:

A. Criminal record checks: The agency conducts appropriate, legally permissible and mandated state and federal criminal records inquiries into the background of agency personnel, including employees and volunteers, and prospective employees and volunteers. Agency personnel means current and prospective operators, staff, employees and volunteers.

B. All requests for a federal background check will be submitted within one week after commencement of employment or volunteer service of those persons who, following receipt of a background check clearance, have direct, unsupervised contact with children. The agency verifies that the fingerprints were submitted to the state of New Mexico department of public safety and the federal bureau of investigation.

(1) An agency staff member who has not received a background check clearance works under the direct continuous physical supervision of a staff member who has received the mandated federal criminal records check clearance until a clearance is obtained.

(a) Exception: A new employee or volunteer who has been a resident of the state of New Mexico for no less than five continuous years immediately preceding the commencement of employment or volunteer service with the agency and has received a background clearance (meaning a negative criminal record check), from the state of New Mexico and local law enforcement agencies pursuant to a request from the employing agency. This exception applies only for 180 days following the original request for a federal background clearance check, and is subject to the following requirements:

(b) The use of the services of an agency contracted by the department of public safety (DPS) who can access the DPS database in order to obtain state criminal background checks for those applicants who have resided in the state of New Mexico for five years or more may be utilized as a means of obtaining state criminal records checks prior to employment. Federal finger printing is still required. The use of an alternate method to obtain state criminal background checks does not replace the federal fingerprinting requirement.

(2) An individual is not eligible for continued employment or service as a volunteer after being notified that the federal background check reveals information that would disqualify the individual from employment or work as a volunteer in the agency. The agency is on violation of this standard if it retains the individual in employment or volunteer service.

(a) If the agency has not received a federal background check clearance within 180 calendar days after the original request, the employee or volunteer remains under the direct physical supervision of a cleared staff until the federal background check is received and known to the agency.

(b) The department may extend the 180 calendar day period up to an additional 120 days, if the agency is able to verify, to the satisfaction of the department, that the agency has done everything required to obtain a completed federal background check within the required time frame and the report has not been received due to circumstances beyond the control of the agency.

(c) In those instances where extensions of time are granted, the employee or volunteer remains within line of sight of a cleared staff member until such time the results of the federal background check are received and known to the agency.

(3) Any employee or volunteer who has received state and federal background clearance while employed by, or providing services at, another agency within 180 calendar days of commencement of employment of service with the agency, is not required to undergo an additional federal background check unless the agency itself requires or requests it or the department believes it has cause to request it.

(4) If the prospective employee is not a United States citizen, a criminal records clearance or its equivalent from the persons country of origin is required if the individual has not lived in the United States for five continuous years.

(5) Non-compliance with these criminal records checks standards may result in sanction or loss of licensure.

C. Staff members who work directly with children and who are counted in the staff-to-child ratio are 18 years of age or older.

D. The director and all staff having direct contact with the children including volunteers, administrative, clerical, maintenance or other support staff, comply with the regulations governing criminal record checks and employment history verification.

E. Persons under the age of 18 at all times work directly under the supervision of a staff member who is physically present. Such persons are not counted in the staff coverage.

F. Persons employed solely for clerical, cooking, maintenance or other support activities who are not left with children unsupervised, are not included in the staff coverage.

G. Student trainees in psychiatry, psychology, social work and /or nursing, who are officially enrolled in a clinical training program of a New Mexico accredited institution of higher learning, and who are under the supervision of a cleared New Mexico licensed practitioner as defined by the certification requirements for child and adolescent mental health services and who are cleared by a state criminal records check, which may include clearance from DPS, or a department approved state clearance mechanism, may be allowed to work with children unsupervised during their enrolled student tenure if the trainee signs a sworn affidavit attesting that he or she has never been convicted of a crime which would disqualify him or her from providing direct services to children as provied by these regulations.

[1/1/99; 7.20.12.31 NMAC - Rn, 7 NMAC 20.12.31, 02/28/05]

7.20.12.32 OUTDOOR PLAY AREAS, EQUIPMENT, TOOLS, VEHICLES, AND OTHER LIKE ITEMS:

Facilities providing services to children 12 years of age and younger will have an outdoor play area.

A. The play area is provided with appropriate equipment to the age level of the children.

B. A facility play area located adjacent to a public street or highway will have the play area fenced with at least one latched gate available for emergency exits.

C. All stationary outdoor play equipment for children is positioned in a way which helps prevent accidents, permit freedom of action, and is securely fastened to the ground.

(1) Outdoor play equipment for children include energy-absorbing surfaces underneath and is maintained in good repair at all times.

(2) Power-driven tools and equipment, motor vehicles, chemicals, and like items of a dangerous nature are kept locked and secured from children. Any use of such items by the children is done only under the general supervision of a staff member.

[1/1/99; 7.20.12.32 NMAC - Rn, 7 NMAC 20.12.32, 02/28/05]

7.20.12.33 COUNSELING AREA:

A facility will provide a designated room or area to allow private discussions and counseling sessions, as appropriate, between individual children, families, staff and others as appropriate.

[1/1/99; 7.20.12.33 NMAC - Rn, 7 NMAC 20.12.33, 02/28/05]

7.20.12.34 EDUCATION:

Each facility licensed pursuant to these regulations ensures that every child in residence attend(s) an appropriate education program in accordance with New Mexico state law.

[1/1/99; 7.20.12.34 NMAC - Rn, 7 NMAC 20.12.34, 02/28/05]

7.20.12.35 TRANSPORTATION:

Each facility licensed pursuant to these regulations, which transports children as part of their program activities, meets the following requirements:

A. Any vehicle used for transporting children must carry vehicle liability insurance. The amount of coverage is not to be less than the basic limits set by the financial responsibility law.

B. Each vehicle used for transportation of children is licensed, registered and meet(s) all applicable laws of the state of New Mexico.

C. Occupancy in a vehicle cannot exceed the capacity recommended by the manufacturer and as appropriate, restraints are used during transportation.

D. Drivers of vehicles used to transport children are licensed and abide by state and local laws.

E. Seat belt restraint laws of the state of New Mexico are adhered to at all time.

F. Children must not be transported in the back of open trucks.

G. Each vehicle used for transportation of children are equipped with a fire extinguisher and first aid kit.

H. Children are loaded and unloaded at the curb side of the vehicle.

I. Each child remains seated while the vehicle is in motion and age-appropriate restraints are used during transportation.

[1/1/99; 7.20.12.35 NMAC - Rn, 7 NMAC 20.12.35, 02/28/05]

7.20.12.36 IMMUNIZATIONS:

A. Every child in the facility is immunized according to the immunization schedule of the New Mexico health department, public health division, immunization schedule.

B. When an immunization record cannot be obtained for the child at the time of admission or within 30 days after admission, the facility arranges for all immunizations required by the department of health.

C. Exemptions from immunizations for religious or other grounds are only accepted if approved by the public health division of the department of health.

[1/1/99; 7.20.12.36 NMAC - Rn, 7 NMAC 20.12.36, 02/28/05]

7.20.12.37 NOTIFIABLE DISEASES:

A. While in a facility, any child who becomes ill from a suspected notifiable disease, as defined by the New Mexico department of health is immediately referred to a physician or medical facility.

B. Each facility reports any notifiable disease occurring to a child to the local public health field office. A current list of notifiable diseases published by the public health (health services) division of the department of health, can be obtained from the public health division upon request.

[1/1/99; 7.20.12.37 NMAC - Rn, 7 NMAC 20.12.37, 02/28/05]

7.20.12.38 MANAGEMENT OF DRUGS AND PHARMACEUTICALS:

A. Other than over-the-counter medication, a facility does not acquire, store or dispense medications.

(1) Exception: Medication for a particular child prescribed by a licensed physician, licensed doctoral level psychologist, nurse practitioner, or dentist, such as may be needed for the child's health care.

(2) Exception: Facilities providing services which require regular use of controlled and/or prescription medication for the children under care must hold and display an appropriate drug permit as determined by the state board of pharmacy.

B. All medications and poisonous substances must be kept in a locked cabinet or other container inaccessible to the children. The key to the medication storage container is only available to the authorized staff.

C. Poisonous substances and medications labeled for external use only are not accessible to children and are kept separate from other medication.

D. Medications prescribed for one child are not provided to any other child.

E. All prescribed medications are kept in their original prescription containers.

F. Only medications which can be self-administered by the child or with assistance and supervision in self-administration are kept in the facility. Exception: Facilities which require regular use of controlled or prescription medication administered by a physician, dentist, or nurse are kept by a facility and administered in accordance with the appropriate drug permit issued by the state board of pharmacy.

G. Medication prepared for self-administration or administration by staff are not prepared in advance.

H. All medication given to a child is entered in the child's record with the date, time and dosage and initials of the staff member assisting with the self-administration of the medication.

I. Medications which require refrigeration are kept in a separate locked box within a refrigerator, a locked refrigerator, or a refrigerator in a locked room.

J. All outdated medications are disposed of in a manner approved by the state board of pharmacy.

K. The staff member assisting is self administration of medication may hold the container, assist the child in opening the container and assist the child in self-administering the medication. Exception: When a facility has a nurse registered in the state of New Mexico on the staff who prepares dosages and administers the medication to the children, the nurse may administer the medication.

[1/1/99; 7.20.12.38 NMAC - Rn, 7 NMAC 20.12.38, 02/28/05]

7.20.12.39 SERVICES AND CARE OF CHILDREN IN RESIDENTIAL TREATMENT SERVICES:

A. A facility licensed pursuant to these regulations makes every effort to achieve a normal homelike environment for the children in care.

B. The health, safety and welfare of children must be the primary concern in all activities and services provided by facilities licensed pursuant to these regulations.

[1/1/99; 7.20.12.39 NMAC - Rn, 7 NMAC 20.12.39, 02/28/05]

7.20.12.40 CHILDREN'S ROOMS:

Each child's room is provided with, but not limited to, the following:

A. a bed as defined in Subsections A - F of 7.20.12.41 NMAC;

B. a dresser or other adequate storage space for private use;

C. an individual closet or closet areas with a clothes rack and a shelves accessible to the child;

D. a table or desk with a reading lamp and chair, or a well-lighted area within the facility with desk or table for a study area;

E. window shades, drapes, or blinds in good repair;

F. exception: any item other than the bed may be removed from a child's room if it is documented in the child's record that such items would be a danger to the health or safety of the child.

[1/1/99; 7.20.12.40 NMAC - Rn, 7 NMAC 20.12.40, 02/28/05]

7.20.12.41 CHILDREN'S BEDS:

A. Children's beds are at least 30 inches wide, of sturdy construction and in good repair.

B. If bunk beds are used, the vertical distance between the mattresses is sufficient to allow each occupant to sit up comfortably in bed.

C. Each bed has a clean, comfortable, nontoxic mattress which is waterproof or has a waterproof covering and a comfortable mattress pad.

D. Each bed is provided with a clean, comfortable pillow and pillow case.

E. Each bed is provided with two clean sheets and bedding that is appropriate for weather and climate.

F. Beds are spaced at least 36 inches apart.

[1/1/99; 7.20.12.41 NMAC - Rn, 7 NMAC 20.12.41, 02/28/05]

7.20.12.42 LIVING AND/OR MULTI PURPOSE ROOMS:

Each facility includes a living and/or multi purpose room for the children's use. Such rooms are provided with reading lamps, tables, chairs, couches, or settees. These furnishings are well constructed, comfortable and kept in good repair.

[1/1/99; 7.20.12.42 NMAC - Rn, 7 NMAC 20.12.42, 02/28/05]

7.20.12.43 DINING AREA:

A dining room is provided for meals.

A. Tables and chairs for the dining room accommodate the number of children for whom the facility is licensed.

B. The living and/or multi purpose room may be used as a dining area if the dining area portion does not exceed 50 percent of the available floor space and still allows comfortable arrangement of necessary furnishings for a living area.

[1/1/99; 7.20.12.43 NMAC - Rn, 7 NMAC 20.12.43, 02/28/05]

7.20.12.44 LAUNDRY AND LINEN SERVICES:

A. The facility provides laundry services to the children either on the premises or by use of a commercial laundry or linen service. The following minimum requirements for clean linen and clothing are:

(1) the sheets and pillow case are changed at least one time per week and/or when there is a change of occupant;

(2) the mattress pad, blankets and bedspread are laundered at least one time per month and/or when there is a change of an occupant; the mattress is turned at least one time per month;

(3) a face towel, bath towel, and washcloth are changed at least every other day.

B. If laundry services are provided on the premises, each laundry room or area is equipped with a washer and dryer.

C. Children may do their own laundry if they are capable and wish to do so, or if it is part of their training or rehabilitation program.

D. Soiled linen and clothing are stored in bags or containers until washed.

E. Under no circumstance is collection, sorting, storage, or washing of soiled clothing or linens done in a food preparation, food storage, or food service area.

F. A separate, dry, well-ventilated storage area for clean linen is provided.

[1/1/99; 7.20.12.44 NMAC - Rn, 7 NMAC 20.12.44, 02/28/05]

7.20.12.45 CLOTHING:

A. Each child has his or her own clothing which is clean, neat, in good repair and appropriate to the season.

B. If necessary, children's clothing is inconspicuously marked with his or her name.

C. The use of a common clothing pool is strictly prohibited.

[1/1/99; 7.20.12.45 NMAC - Rn, 7 NMAC 20.12.45, 02/28/05]

7.20.12.46 PERSONAL POSSESSIONS:

A. A facility allows a child in care to bring his or her personal belongings to the facility and to acquire belongings of their own while living in the facility.

B. The facility may, within reason, and because of the child's program or treatment plan, limit or supervise the use of these items while the child is in residence.

C. Where extraordinary limitations are imposed, the child is informed by the facility of the reasons, and the reasons are recorded in the child's record.

D. The facility makes provisions for the protection of the children's property.

[1/1/99; 7.20.12.46 NMAC - Rn, 7 NMAC 20.12.46, 02/28/05]

7.20.12.47 PETS:

A. Pets are permitted and encouraged in a facility licensed pursuant to these regulations for the enjoyment of the children.

B. Pets are not permitted in the kitchen or food preparation areas.

C. Pets are inoculated as required by state or local law and records of inoculation kept on file in the facility.

[1/1/99; 7.20.12.47 NMAC - Rn, 7 NMAC 20.12.47, 02/28/05]

7.20.12.48 PERSONAL HYGIENE:

Each child is provided with his or her own clearly identified toothbrush, comb, hair brush and other items for personal hygiene.

[1/1/99; 7.20.12.48 NMAC - Rn, 7 NMAC 20.12.48, 02/28/05]

7.20.12.49 MEDICAL CARE:

A. A residential facility licensed pursuant to these regulations arranges for a general medical examination by a physician for each child in care within 30 calendar days of admission unless the child has received such an examination within 12 months before admission and the results of the examination are available to the facility. These examinations conform to the requirements of the EPSDT screen.

(1) The facility arranges to secure timely and medically appropriate treatment for any condition discovered by the medical examination.

(2) The facility arranges periodic medical examination of all children at intervals recommended by the physician.

(3) The facility ensures that children receive timely, competent medical care when they are ill and that they continue to receive necessary follow-up medical care.

B. The residential facility arranges to secure any necessary dental care.

C. Each child more than three years of age has an annual dental examination.

D. A facility licensed pursuant to these regulations has written procedures, approved by a physician, pharmacist or nurse regarding how staff should administer over-the-counter medications to children in care and such procedures conform to 38 and its subsections.

E. Each facility has a first aid kit and first aid manuals readily accessible to the staff and secure from the children.

(1) The first aid kit contains, at a minimum, band aids, gauze pads, adhesive tape, scissors, soap, and syrup of ipecac.

(2) In case of accidental poisoning, the facility immediately contacts the poison control center and its directions are followed.

(3) Syrup of ipecac is not given to any child without first contacting the poison control center.

[1/1/99; 7.20.12.49 NMAC - Rn, 7 NMAC 20.12.49, 02/28/05]

7.20.12.50 NUTRITION:

Each residential treatment service facility licensed pursuant to these regulations provides to the children a planned, nutritionally adequate diet.

A. When the food service of the facility is not directed by a nutritionist or dietitian, regular, planned consultation with a nutritionist or dietitian is obtained by the facility. The nutritionist or dietitian approves the clients nutrition plan and reviews and revises when indicated.

B. A copy of the current week's menu is posted in the kitchen of the facility.

C. Posted menus are followed and any substitution is of equivalent nutritional value and is recorded on the posted menu.

D. The facility provides at least three meals a day served at regular times, as follows:

(1) normally not more than a 14-hour span between the evening meal and breakfast the following day;

(2) normally not less than 8 hours between breakfast and the evening meal of the same day;

(3) the same main dishes are not served within a week period; identical menus are not served on a one-week-cycle basis;

(4) time allowed for meals is sufficient to enable the children to eat at a leisurely rate, encourage socialization and to provide a pleasant mealtime experience.

[1/1/99; 7.20.12.50 NMAC - Rn, 7 NMAC 20.12.50, 02/28/05]

7.20.12.51 FOOD MANAGEMENT:

Each facility meets the requirements of all state and local regulations governing food service, posts inspection reports in a conspicuous place and maintains a file of any deficiencies noted in an inspection.

A. Exception: Those facilities which have a written exemption from the environmental improvement division or recognized local authority.

B. Each facility has a copy of the current applicable food service regulations as published by the environmental improvement division. Exception: Those facilities which have a written exemption from the environmental improvement division or recognized local authority.

C. Dry and evaporated milk may be reconstituted only if used for cooking purposes. All milk for drinking is grade-A pasteurized and served directly from its original container or from a dispenser approved by the environmental improvement division.

D. Potentially hazardous food such as meat, milk and custard are kept at 45 degrees F. or below. Hot food is kept at 140 degrees F. or above during preparation and service.

E. Each refrigerator and freezer contains an accurate thermometer reading within 2 degrees F., located in the warmest part of the appliance in which food is stored. The temperature of the refrigerator is 45 degrees F. or below. The temperature for the freezer is 0 degrees or below.

F. Refrigerators, freezers, cupboards and other food storage areas are kept clean and sanitary at all times.

G. Drugs, biologicals, poisons, stimulants, detergents, and cleaning supplies are not kept in the same storage area used for storage of foods.

H. Dishes and utensils are properly washed, sanitized, and stored in accordance with food service regulations.

I. All garbage and rubbish are stored in containers which are waterproof, easily cleaned, and have tight- fitting lids.

[1/1/99; 7.20.12.51 NMAC - Rn, 7 NMAC 20.12.51, 02/28/05]

7.20.12.52 CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES:

GENERAL BUILDING REQUIREMENTS FOR RESIDENTIAL TREATMENT SERVICES: The following standards apply to residential treatment services: Building requirements:

A. Access to the disabled: All facilities licensed pursuant to these regulations are accessible to, and usable by, disabled employees, staff, visitors, and clients.

B. Prohibition of mobile homes: Trailers and mobile homes are not used for living or activity areas for children.

C. Design and selection of building(s) for the special needs of children: In the design or selection of a building, attention is given to the special needs of the children and staff.

Conditions which are detrimental to health, safety, and welfare of the children are avoided.

D. Extent of a facility: All buildings on the premises providing services are considered part of the facility and meet all requirements of these regulations. Children living in any building on the premises are counted in the capacity of the facility. Where a part of the facility's services is contained in another facility, separation and access are maintained as described in current building and fire codes.

E. Additional requirements: A facility applying for licensure pursuant to these regulations may be subject to additional requirements not contained herein. The complexity of building and fire codes and other applicable standards of city, county, or municipal governments establishes such additional requirements. Applicable standards may be incorporated by the LCA in its licensing process.

[1/1/99; 7.20.12.52 NMAC - Rn, 7 NMAC 20.12.52, 02/28/05]

7.20.12.53 MAINTENANCE OF BUILDING AND GROUNDS FOR RESIDENTIAL TREATMENT SERVICES:

Facilities maintain the building(s) in good repair at all times. Such maintenance includes, but is not limited to, the following.

A. All electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems are maintained in a safe and functioning condition, including regular inspections of these systems.

B. All equipment used for client care is kept clean and in good repair.

C. All furniture and furnishings are kept clean and in good repair.

D. The grounds of the facility are maintained in a safe and sanitary condition at all times.

[1/1/99; 7.20.12.53 NMAC - Rn, 7 NMAC 20.12.53, 02/28/05]

7.20.12.54 HOUSEKEEPING:

A. The facility is kept free from offensive odors and accumulations of dirt, rubbish, dust, and safety hazards.

B. Children's rooms, examination rooms, meeting rooms, waiting rooms and other areas of daily usage are cleaned daily.

C. Floors and walls are constructed of a finish that can be easily cleaned. The floor polishes will provide a slip resistant finish.

D. Bathrooms, lavatories, and drinking fountains are cleaned daily and as often as necessary to maintain a clean and sanitary condition.

E. Deodorizers are not used to mask odors caused by unsanitary conditions or poor housekeeping practices.

F. Combustibles such as cleaning rags and compounds are kept in closed metal containers in areas providing adequate ventilation and away from clients rooms and common areas.

G. Poisonous or flammable substances are not stored in residential sleeping areas, food preparation areas, or food storage areas. All poisonous substances must be kept in a locked cabinet or other container inaccessible to the children and away from living and common areas.

H. Storage areas are kept free from accumulations of refuse, discarded equipment, furniture, paper, and the like.

[1/1/99; 7.20.12.54 NMAC - Rn, 7 NMAC 20.12.54, 02/28/05]

7.20.12.55 WATER:

A. A facility licensed pursuant to these regulations is provided with an adequate supply of water which is of a safe and sanitary quality suitable for domestic use.

B. If the water supply is not obtained from an approved public system, the private water system is inspected, tested, and approved by the New Mexico environment department prior to licensure. It is the facility's responsibility to ensure that subsequent periodic testing or inspection of such private water system is made at intervals prescribed by the New Mexico environment department or other recognized authority. The facility maintains copies of all inspection reports and certificates pertaining to its water supply.

C. Hot and cold running water are distributed at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

D. Back flow preventors (vacuum breakers), are installed on hose bibbs, laboratory sinks, janitor's sinks, and on all other water fixtures to which hoses or tubing can be attached.

E. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water provided to hand washing facilities does not exceed 120 degrees F.

[1/1/99; 7.20.12.55 NMAC - Rn, 7 NMAC 20.12.55, 02/28/05]

7.20.12.56 SEWAGE AND WASTE DISPOSAL:

A. All sewage and liquid wastes are disposed of into a municipal sewage system where such facilities are available.

B. Where a municipal sewage system is not available, the system used is inspected and approved by the New Mexico environment department or recognized local authority. The facility maintains copies of all inspection reports and certificates issued pertaining to its waste disposed system(s).

C. Where municipal or community garbage collection and disposal service are not available, the method of collection and disposal of solid wastes generated by the facility is inspected and approved by the New Mexico environment department or recognized local authority.

D. Infectious waste: Facilities licensed pursuant to these regulations which generate infectious waste ensure that the method of disposal of such wastes meets the requirements of the New Mexico environment department or recognized local authority.

E. All garbage and refuse receptacles are durable, have tight fitting-lids, are insect/rodent proof, washable, leakproof and constructed of materials which do not absorb liquids. Receptacles are kept clean.

[1/1/99; 7.20.12.56 NMAC - Rn, 7 NMAC 20.12.56, 02/28/05]

7.20.12.57 FIRE SAFETY COMPLIANCE:

All current applicable requirements of state and local codes for fire prevention and safety must be met by the facility. The facility maintains a copy of all applicable inspection reports and certifications.

[1/1/99; 7.20.12.57 NMAC - Rn, 7 NMAC 20.12.57, 02/28/05]

7.20.12.58 FIRE CLEARANCE AND INSPECTIONS:

A. Each facility requests from the fire authority having jurisdiction an annual inspection of the facility. If the policy of the fire authority having jurisdiction does not provide for an annual inspection of the facility, the facility documents the date the request was made and to whom. If the fire authority does conduct annual inspections, a copy of the latest inspection is kept on file in the facility.

B. Written documentation from the state fire marshals office or fire authority having jurisdiction evidencing a facility’s compliance with applicable fire prevention codes is submitted to the LCA prior to issuance of an initial license.

[1/1/99; 7.20.12.58 NMAC - Rn, 7 NMAC 20.12.58, 02/28/05]

7.20.12.59 STAFF FIRE AND SAFETY TRAINING:

A. All staff of the facility knows the location of, and is instructed in, proper use of fire extinguishers procedures to be observed in case of fire or other emergency. The facility requests the fire authority having jurisdiction to give periodic instruction in fire prevention and techniques of evaluation.

B. Facility staff is instructed as part of their duties to constantly strive to detect and eliminate potential safety hazards, such as loose handrails, frayed electrical cords, faulty equipment, blocked exits or exit ways, and any other condition which could cause burns, falls, or other personal injury to the clients or staff.

C. Each child is, upon being accepted into the facility, given an orientation tour of the facility to include, but not be limited to, the location of the exits, fire extinguishers, and telephones, and is instructed in accordance with their abilities on actions to be taken in case of fire or other emergencies.

D. Fire and evacuation drills: The facility conducts a least one fire and evacuation drill each month.

(1) Logs are maintained by the facility showing the date, time, names of staff participating in the drill and outlining any problems noted in the conduct of the drill.

(2) Fire drills are held at different times of the day.

(3) In the conduct of fire drills, emphasis is placed upon orderly evacuation, under proper discipline, rather than upon speed.

[1/1/99; 7.20.12.59 NMAC - Rn, 7 NMAC 20.12.59, 02/28/05]

7.20.12.60 EVACUATION PLAN:

Each facility has an evacuation plan conspicuously posted in each separate area of the building showing routes of evacuation in case of fire or other emergency.

[1/1/99; 7.20.12.60 NMAC - Rn, 7 NMAC 20.12.60, 02/28/05]

7.20.12.61 PROVISIONS FOR EMERGENCY CALLS:

A. An easily accessible telephone for summoning help in case of an emergency is available in the facility.

B. A list of emergency numbers, including, but not limited to, fire department, police department, ambulance services, and poison control center are prominently posted by each telephone.

[1/1/99; 7.20.12.61 NMAC - Rn, 7 NMAC 20.12.61, 02/28/05]

7.20.12.62 FIRE EXTINGUISHERS:

A. Fire extinguishers, as approved by the state fire marshal or fire prevention authority having jurisdiction, are located in the facility.

B. Fire extinguishers and other firefighting equipment are properly maintained as recommended by the manufacturer, state fire marshal or fire authority having jurisdiction.

C. All fire extinguishers are inspected annually and recharged as specified by the manufacturer, state fire marshal, or fire authority having jurisdiction. All fire extinguishers are tagged, noting the date of inspection.

[1/1/99; 7.20.12.62 NMAC - Rn, 7 NMAC 20.12.62, 02/28/05]

7.20.12.63 FIRE ALARM SYSTEM:

A manually-operated, electrically monitored fire alarm system is installed in each facility as required by the national fire protection association 101 (Life Safety Code). Multiple-story facilities require manual alarm systems.

[1/1/99; 7.20.12.63 NMAC - Rn, 7 NMAC 20.12.63, 02/28/05]

7.20.12.64 FIRE DETECTION SYSTEM:

The facility is equipped with smoke detectors as required by the NFPA 101 (Life Safety Code) and approved in writing by the fire authority having jurisdiction as to number, type and placement.

[1/1/99; 7.20.12.64 NMAC - Rn, 7 NMAC 20.12.64, 02/28/05]

7.20.12.65 CARPETS:

Carpeting, if used in new facilities is of at least class II rating. Existing facilities, as they replace carpeting, replace it with carpet having a class II rating.

[1/1/99; 7.20.12.65 NMAC - Rn, 7 NMAC 20.12.65, 02/28/05]

7.20.12.66 SMOKING:

Smoking, if permitted in a facility, is done only in areas designated by the facility and approved by the state fire marshal or fire authority having jurisdiction. Smoking is not allowed in a kitchen or food preparation area.

[1/1/99; 7.20.12.66 NMAC - Rn, 7 NMAC 20.12.66, 02/28/05]

7.20.12.67 LIGHTING AND LIGHTING FIXTURES:

The facility meets the following requirements for lighting:

A. All areas of the facility including storerooms, stairways, hallways, and entrances are lighted sufficiently to make all parts of each area clearly visible.

B. Exits, exit-access ways, and other areas used by children and staff are illuminated.

C. All spaces occupied by people, machinery, or equipment within buildings, approaches to buildings, and parking lots are lighted.

D. Lighting is sufficient to make all parts of each area clearly visible.

E. All lighting fixtures are shielded.

[1/1/99; 7.20.12.67 NMAC - Rn, 7 NMAC 20.12.67, 02/28/05]

7.20.12.68 EMERGENCY LIGHTING:

A. A facility provides emergency lighting which activates automatically upon disruption of electrical service.

B. The emergency lighting is sufficient to illuminate paths of egress and exits of the facility.

[1/1/99; 7.20.12.68 NMAC - Rn, 7 NMAC 20.12.68, 02/28/05]

7.20.12.69 EXITS:

A. Each facility and each floor of a facility has exits as required/permitted by the national fire protection association 101 (Life Safety Code).

B. Each facility has at least two approved exits, remote from each other.

C. Each exit is clearly marked with signs having letters at least six inches high whose principal strokes are at least 3/4 of an inch wide. Exit signs are visible at all times.

D. Exits, exit paths, or means of egress do not pass through hazardous areas, storerooms, closets, bedrooms, or spaces subject to locking.

E. Sliding doors are not acceptable as a required exit.

F. When illuminated exit signs are present, they are maintained in operable condition.

G. Exit ways are kept free from obstructions at all times.

H. Exit doors are at least 36" wide.

[1/1/99; 7.20.12.69 NMAC - Rn, 7 NMAC 20.12.69, 02/28/05]

7.20.12.70 ELECTRICAL STANDARDS:

A. All electrical installation and equipment must comply with all current state and local codes.

B. Circuit breakers or fused switches that provide electrical disconnection and overcurrent protection must be:

(1) enclosed or guarded to provide a dead front assembly;

(2) readily accessible for use and maintenance;

(3) set apart from traffic lanes;

(4) located in a dry, ventilated space, free of corrosive fumes or gases;

(5) able to operate properly in all temperature conditions;

(6) located on the same floor and in the same facility area as the circuits they serve;

(7) marked showing the area each circuit breaker or fused switch services.

C. The use of jumpers or devices to bypass circuit breakers or fused switches is prohibited.

[1/1/99; 7.20.12.70 NMAC - Rn, 7 NMAC 20.12.70, 02/28/05]

7.20.12.71 ELECTRICAL CORDS AND ELECTRICAL RECEPTACLES:

A. Electrical and extension cords:

(1) Electrical cords and extension cords must be U/L approved.

(2) Electrical cords and extension cords must be replaced as soon as they show wear.

(3) Under no circumstances are extension cords used as a general wiring method.

(4) Extension cords are plugged into an electrical receptacle within the room where used and are not connected in one room and extended to another room.

(5) Extension cords must not be used in series.

B. Electrical receptacles:

(1) Duplex grounded type electrical receptacles (convenience outlets), are installed in all areas in sufficient quantities for tasks to be performed as needed.

(2) The use of multiple sockets (gang plugs), in electrical receptacles is strictly prohibited.

(3) The main electrical service line has a readily available disconnect switch. All staff personnel of the facility know the location of the electrical disconnect switch and how to operate it in case of an emergency.

(4) Facilities who care for children less than six years of age are either provided with safety electrical outlets or have all electrical outlets not in use provided with protective covers.

[1/1/99; 7.20.12.71 NMAC - Rn, 7 NMAC 20.12.71, 02/28/05]

7.20.12.72 HEATING, VENTILATION, AND AIR-CONDITIONING:

A. Heating, air-conditioning, piping, boilers, and ventilation equipment are furnished, installed and maintained to meet all requirements of current state and local mechanical, electrical, and construction codes.

B. The heating method used by the facility has a minimum indoor winter design capacity of 70 degrees F. with controls provided for adjusting the temperature as appropriate for client and staff comfort.

C. The use of unvented heaters, open flame heaters or portable heaters is prohibited.

D. A supply of outside air sufficient to assure proper combustion must be provided in all spaces where fuel fired boilers, furnaces, or heaters are located to assure proper combustion.

E. All fuel fired boilers, furnaces, or heaters are connected to an approved venting system to take the products of combustion directly to the outside air.

F. Each facility is adequately ventilated at all times to provide fresh air and the control of unpleasant odors by either mechanical or natural means.

G. All gas-fired heating equipment is provided with a 100 percent automatic cutoff control valve that operates in the event of pilot failure.

H. The facility is provided with a system for maintaining clients and staffs comfort during periods of hot weather.

I. All boilers, furnaces or heater rooms are protected from other parts of the building by construction having a fire resistance rating of not less than one hour. The doors are self-closing with a three- quarters hour fire resistance.

J. All central ventilation and air condition systems are provided filters having efficiencies greater than 25 percent.

K. All gas-burning heating and cooking equipment are connected to an approved venting system to take the products of combustion directly to the outside air.

L. All openings to the outer air used for ventilation are screened with screening material of not less than 16 meshes per lineal inch.

M. Screen doors are equipped with self-closing devices.

[1/1/99; 7.20.12.72 NMAC - Rn, 7 NMAC 20.12.72, 02/28/05]

7.20.12.73 WATER HEATERS:

A. Fuel-fired hot water heaters are enclosed and separated from other parts of the building by construction as required by current state and local building codes. Any inspection report or certificate is maintained by the facility.

B. All water heaters are equipped with a pressure relief valve (pop-off-valve) vented to the outside or a drain in the building.

[1/1/99; 7.20.12.73 NMAC - Rn, 7 NMAC 20.12.73, 02/28/05]

7.20.12.74 TOILETS, LAVATORIES AND BATHING FACILITIES:

A. All fixture and plumbing are installed in accordance with current state and local plumbing codes.

B. All toilets are enclosed and vented.

C. All toilet rooms are provided with a lavatory for hand washing.

D. All toilet rooms are kept supplied with toilet paper.

E. All lavatories for hand washing are kept supplied with disposable towels for hand drying or provided with a mechanical blower. The use of a common towel is prohibited.

F. The location, type and minimum number of toilets, lavatories and bathing facilities are as follows.

(1) Toilets and sinks for children in a residential facility are provided in a ratio of at least one toilet and one sink for every six children in care.

(2) If a residential treatment facility provides service to both sexes, separate facilities are provided for each sex in the same ratio as stated in Paragraph (1) of Subsection F of 7.20.12.74 NMAC of these regulations.

(3) Showers or tubs in a residential facility are provided for the children's use in the same ratio as stated in Paragraphs (1) and (2) of Subsection F of 7.20.12.74 NMAC.

G. A combination of a tub and shower is permitted.

H. Residential facilities for developmentally disabled children have grab bars in tubs and showers.

I. Tubs or showers have a slip resistant surface.

J. Toilet room doors in residential treatment services facilities serving developmentally disabled children swing out.

K. If a facility has live-in staff, a separate toilet, hand washing, and bathing facilities for staff are provided and are not counted in the ratios in Paragraphs (1) or (2) of Subsection F of 7.20.12.74 NMAC.

L. Toilet, hand washing, and bathing facilities are readily available to the children. No passage through a child's room by another child to reach a toilet, bath, or hand washing facility is permitted.

M. New facilities have a minimum of one toilet and bathing facility which meet the requirements for the disabled.

[1/1/99; 7.20.12.74 NMAC - Rn, 7 NMAC 20.12.74, 02/28/05]

7.20.12.75 CORRIDORS:

A. Corridors in each facility have a minimum width of 36 inches. Corridors in newly constructed facilities have a minimum width of 44 inches.

B. Corridors have a clear ceiling height of not less than 7 feet measured to the lowest projection from the ceiling.

C. Corridors remain clear and free of obstructions at all times.

D. In facilities contained within existing commercial or residential buildings, less stringent corridor widths are allowed if not in conflict with the building or fire codes and approved by the LCA prior to occupying the facility.

[1/1/99; 7.20.12.75 NMAC - Rn, 7 NMAC 20.12.75, 02/28/05]

7.20.12.76 DOORS:

A. All exit doors must have a minimum width of 36 inches.

B. All sleeping room doors are at least one and three quarter inches bonded solid core, with a minimum width of 30 inches.

C. All doors to toilet and bathing facilities have a minimum width of 24 inches.

D. Locks on doors to toilets are of such type that the lock can be released from the outside.

E. Exit doors leading to the outside of a facility with a capacity of ten or more children open outward.

F. Exit doors leading to the outside of a facility are provided with a night latch, dead bolt or security chain, provided such devices open from the inside without the use of a key or tool and are mounted at a height not to exceed 48 inches above the finished floor.

G. Sleeping room doors for non-mobile children are at least one and three quarter inches bonded solid core, with a minimum width of 44 inches.

H. Each sleeping room housing non-mobile children must have a 44-inch exit door directly to the outside.

[1/1/99; 7.20.12.76 NMAC - Rn, 7 NMAC 20.12.76, 02/28/05]

7.20.12.77 MINIMUM ROOM DIMENSIONS:

A. All habitable rooms in a facility must have a ceiling height of not less than seven feet, six inches. Kitchens, halls, bathrooms and toilet compartments must have a ceiling height of not less than seven feet.

B. All habitable rooms other than a kitchen are not less than seven feet in any dimension.

C. Any room with a sloped ceiling is subject to review and approval or disapproval by the LCA, based upon Uniform Building Code computation of minimum area.

[1/1/99; 7.20.12.77 NMAC - Rn, 7 NMAC 20.12.77, 02/28/05]

7.20.12.78 CHILDREN'S ROOMS:

A. Each child's room is an outside room.

B. There is no through traffic in the children's rooms.

C. Single rooms have at least 80 square feet of floor area. Closet and locker areas are not counted as part of the floor area.

D. Not more than four children more than two years of age occupy a designated bedroom space.

E. Children's rooms have beds spaced at least three feet apart.

F. Residential treatment services facilities for developmentally disabled children which provide care and services to non-mobile children have at least 100 square feet of floor area for each non-mobile resident.

G. Rooms having more than one child must have at least 60 square feet for each bed or if double bunks are used at least 90 square feet of floor area for each bunk. Closet and locker area must not be counted as part of the available follow space.

[1/1/99; 7.20.12.78 NMAC - Rn, 7 NMAC 20.12.78, 02/28/05]

7.20.12.79 WINDOWS:

A. Children's sleeping rooms and activity rooms have window area of at least one-tenth the floor area with a minimum of at least 10 square feet.

B. Sleeping rooms provide at least one window for egress or rescue with a minimum net clear opening of 5.7 square feet. The minimum net clear opening for height dimensions is 24 inches. The minimum net clear opening width dimension is 20 inches.

C. Egress and rescue windows have a finished sill height of not more than forty-four inches above the floor.

D. Exception: If the sleeping room has a door directly to the outside, an egress/rescue window is not required.

E. Bars, grills, and grates or similar devices may be installed on emergency escape or rescue windows or doors only if equipped with release mechanisms which can be opened from the inside without the use of a key, knowledge or effort.

[1/1/99; 7.20.12.79 NMAC - Rn, 7 NMAC 20.12.79, 02/28/05]

7.20.12.80 ADMINISTRATION AND PUBLIC AREAS:

A. Entrances are able to accommodate wheelchairs.

B. Public areas include:

(1) conveniently accessible wheelchair storage; and

(2) reception and information counter or desk; and

(3) conveniently accessible public toilets; and

(4) conveniently accessible drinking fountains.

C. Interview space(s) for private interviews related to social services, obtaining medical and/or psychological information, etc., are provided.

D. General or individual office(s) for business transactions, records, administrative, and professional staff are provided.

E. Clerical space or rooms for typing, clerical work, and filing, separated from public areas for confidentiality, are provided.

F. Special storage for staff personal effects with locking drawers or cabinets (may be individual desks or cabinets), are provided. Such storage is near individual work stations and is staff controlled.

G. General storage facilities for supplies and equipment are provided.

H. When indicated, the nurses station(s) has a work counter, communication system, space for supplies, and provisions for charting.

I. A drug distribution station, is provided and includes a work counter, sink, refrigerator, and locked storage for biologicals and drugs, and may be part of the nurses station.

[1/1/99; 7.20.12.80 NMAC - Rn, 7 NMAC 20.12.80, 02/28/05]

7.20.12.81 FLOORS AND WALLS:

A. Floor material is readily cleanable and wear resistant.

B. In all areas subject to wet cleaning, floor materials are not physically degradable by liquid germicidal or cleaning solution.

C. Floors subject to traffic while wet have a slip resistant surface.

D. Wall finishes are washable and in the proximity of plumbing fixtures, are smooth and moisture resistant.

E. Wall bases in areas subject to wet cleaning are covered with flooring and baseboards tightly sealed within the wall, and constructed without voids.

F. Floor and wall areas penetrated by pipes, ducts, and conduits are tightly sealed to minimize entry of rodents and insects. Joints of structural elements are similarly sealed.

G. Threshold and expansion joint covers are flush with the floor surface to facilitate use of wheelchairs and carts.

[1/1/99; 7.20.12.81 NMAC - Rn, 7 NMAC 20.12.81, 02/28/05]

7.20.12.82 ACCESS REQUIREMENTS FOR DISABLED IN NEW FACILITIES:

A. Accessibility to the disabled is provided in all new facilities and will include the following:

(1) main entry into the facility is level or has a ramp to allow for wheelchair access;

(2) building layout allows for access to main living area and dining area;

(3) access to at least one bedroom is required to have a door clearance of 32 inches; the toilet/bathing unit also provides a 60-inch diameter clear space (turning radius);

(4) if ramps are provided to the building, the slope of each ramp is at least a 12-inch horizontal run for each inch of vertical rise;

(5) ramps exceeding a six-inch rise are provided with handrails.

B. Requirements contained herein are minimum and additional disability requirements apply depending on the size and complexity of the facility.

[1/1/99; 7.20.12.82 NMAC - Rn, 7 NMAC 20.12.82, 02/28/05]

7.20.12.83 SPECIAL REQUIREMENTS FOR SECLUSION OR SECURITY ROOMS:

Any facility licensed pursuant to these regulations and that uses a seclusion or security room in its program complies with all of the following:

A. the room has no less than 80 square feet of floor area;

B. the door is of substantial construction either one and three-quarter inches, bonded solid core or metal able to withstand unusual stress;

C. the door is at least 32 inches wide, preferably 36 inches;

D. the door swings outward to prevent children from barricading themselves in the room;

E. the door has a fixed wired glass vision panel not to exceed 1,296 square inches, and mounted in steel or other approved metal frame;

F. a dual lock system that is simple to operate is on the door; it has a quickly operated throw bolt and key lock;

G. the floor is of substantial construction with a smooth surface so that it presents no danger in terms of materials that peel, splinter, or cause burns;

H. walls are of high impact resistance with nothing protruding from the walls that would allow for climbing by children;

I. the ceiling is of monolithic construction and unreachable to children;

J. light fixtures are security rated and recessed so children cannot break the lens, bulbs, etc.;

K. windows in the room have security-rated screens with locks that cannot be picked;

L. there is nothing else in the room, including electrical outlets, switches, holes, hardware, or places to hook things; all heating and air-conditioning registers are out of reach; there are no sharp edges in the room such as window sills, baseboards, or wainscots;

M. rooms are approved in writing from the state fire marshal or fire authority having jurisdiction; these records are maintained by the facility;

N. the observation room is convenient to a staff’s station to permit continuous close observation of clients;

O. a toilet room with a lavatory is immediately accessible.

[1/1/99; 7.20.12.83 NMAC - Rn, 7 NMAC 20.12.83, 02/28/05]

CHAPTER 21: BEHAVIORAL HEALTH

PART 1: GENERAL PROVISIONS

7.21.1.1 ISSUING AGENCY:

Human Services Department.

[7.21.1.1 NMAC - N, 9-1-11]

7.21.1.2 SCOPE:

This rule applies to the general public.

[7.21.1.2 NMAC - N, 9-1-11]

7.21.1.3 STATUTORY AUTHORITY:

Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the human services department. The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; human services; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees.

[7.21.1.3 NMAC - N, 9-1-11]

7.21.1.4 DURATION:

Permanent

[7.21.1.4 NMAC - N, 9-1-11]

7.21.1.5 EFFECTIVE DATE:

September 1, 2011, unless a later date is cited at the end of a section.

[7.21.1.5 NMAC - N, 9-1-11]

7.21.1.6 OBJECTIVE:

The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.

[7.21.1.6 NMAC - N, 9-1-11]

7.21.1.7 DEFINITIONS:

This section contains the glossary for the New Mexico behavioral health system. The following definitions apply to terms used in this chapter and shall guide any rules promulgated by collaborative members regarding behavioral health.

A. Definitions beginning with letter "A":

(1) **Abuse, individual:** Any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with 30- 47-1 NMSA 1978.

(2) **Abuse, provider:** Provider practices that are inconsistent with sound fiscal, business, medical or service related practices and result in an unnecessary cost to the program, or in reimbursement for services that are not medically, clinically, or psychosocially necessary or in services that fail to meet professionally recognized standards for behavioral health care.

(3) **Adult behavioral health procedures manual:** The procedures manual that includes the psychiatric rehabilitation program requirements and comprehensive community support services requirements.

(4) **Advance directive:** Written instructions such as a mental healthcare advance directive, psychiatric advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive, relating to the provision of health care when an adult is incapacitated. (See generally, 27-7A-1 - 27-7A-18 NMSA, 1978, and 24-7B-1 – 24-7B-16 NMSA 1978.)

(5) **Adverse determination:** A determination by the BHE that the behavioral health services furnished, or proposed to be furnished to a consumer, are not medically, clinically or psychosocially necessary or not appropriate.

(6) **American society of addiction medicine (ASAM):** An organization of professionals in addiction services that developed, in the early 1990s or a set of criteria and tools to identify the level of care best suited to an individual in need of addiction services.

B. Definitions beginning with letter "B":

(1) **Behavioral health (BH):** The umbrella term for mental health and substance abuse. It includes both mental health (MH) , including psychiatric illnesses and emotional disorders, and substance abuse (SA), including addictive and chemical dependency disorders, and includes co-occurring MH and SA disorders and the prevention of those disorders.

(2) **Behavioral health entity (BHE):** One or more managed care organizations selected by HSD and the collaborative to provide all defined behavioral health service responsibilities, including medicaid behavioral health.

(3) **Behavioral health planning council (BHPC):** The body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico, and with which the BHE will be expected to interact with as an advisory council. (See 24-1-28 NMSA, 1978)

C. Definitions beginning with letter "C":

(1) **Chair or co-chairs:** The secretary of human services shall serve as the chair of the collaborative. The secretary of health and the secretary of children youth and families shall alternate each state fiscal year as the co-chair of the collaborative.

(2) **Clinical necessity:** The determination made by a behavioral health professional exercising prudent clinical judgment as to whether a behavioral health service would promote growth and development, prevent, diagnose, detect, treat, ameliorate, or palliate the effects of a behavioral health condition, injury, or disability for the consumer.

(3) **Collaborative:** The interagency behavioral health purchasing collaborative, responsible for planning, designing and directing a statewide behavioral health system. The collaborative, established under Section 9-7-6.4 NMSA 1978, by its statutory member agencies collectively, operates under by-laws adopted by the collaborative.

(4) **Collaborative members or member agencies:** The statutory and *ex officio* agency representatives who sit on the collaborative or their agency designees.

(5) **Comprehensive community support services (CCSS):** CCSS is a recovery and resiliency oriented service which is provided in the community, primarily face-to-face, using natural supports to the maximum extent possible to build on client and family strengths. These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a consumer or member’s service plan and include

therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community. (See, 8.315.6 NMAC, 8.305.1 NMAC and collaborative adult behavioral health procedural manual.)

(6) **Consumer:** For purposes of these rules, a person with a mental health or substance use disorder receiving or eligible to receive behavioral health services through collaborative or collaborative member contracts, or a past recipient of such services.

(7) **Consumer empowerment:** Activities that address the following areas:

(a) consumer choice

(b) consumer voice

(c) self-management

(d) community integration

(8) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

(9) **Core service agencies (CSAs):** Multi-service agencies that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for consumers with complex behavioral health service needs, ensure that community support services are integrated into treatment, and develop the capacity for consumers to have a single point of accountability for identifying and coordinating their behavioral health, health and other social services.

(10) **Credentialing:** A systematic process whereby the BHE or provider verifies and warrants that an employed, contracted or affiliated behavioral health professional or agency meets specified practice standards including education, experience, licensure and certification.

(11) **Cultural competence:** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural situations, including situations of diverse culture, race, ethnicity, national origin or disability. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs that match an individual’s culture to increase the quality and appropriateness of behavioral health care and outcomes. *See*, 8.305.1.7 NMAC.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which a BHE gives another entity the authority to perform certain functions on its behalf but for which the BHE retains full accountability for the delegated functions.

(2) **Designated representative:** A person designated under a valid mental health care treatment advance directive as an individual's authorized agent according to the provisions of the Mental Health Care Treatment Decisions Act (Section 24-7B NMSA 1978) and who has personal knowledge of the respondent and the facts as required in Subsection B of the act.

E. Definitions beginning with letter "E":

(1) **EPSDT:** Early and periodic screening, diagnostic and treatment.

(2**)** **Ex-officio members:** Non-voting members of the collaborative, who otherwise serve as full members (e.g. the secretary of higher education department, secretary of veteran's services department, New Mexico public defender, and the children's cabinet coordinator).

(3) **Executive committee**: A committee of the collaborative comprised of the secretaries of human services, health, and children youth and families. The executive committee is authorized to negotiate, approve and execute contracts and amendments on behalf of the collaborative.

F. Definitions beginning with letter "F":

(1) **Family-centered care:** When a child is the consumer, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and behavioral health professionals, builds on individual and family strengths and respects diversity of families.

(2) **Family specialist:** An approved provider who is certified as a family specialist through an approved state certification program. *(*See Subsection U of 7.20.11.7 NMAC)

G. Definitions beginning with letter "G":

(1) **Grievance (consumer):** Oral or written statement by a member expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

(2) **Grievance (provider):** Oral or written statement by a provider to the BHE expressing dissatisfaction with any aspect of the BHE or its operations that is not a BHE action.

H. Definitions beginning with letter "H": **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

I. Definitions beginning with letter "I": **Indicated prevention:** Interventions that identify individuals who are experiencing early signs of substance abuse, mental illness and other related problem behavior and target them with special programs.

J. – K. **[RESERVED]**

L. Definitions beginning with letter "L":

(1) **Letter of direction (LD):** Written instructions, detailed action steps, and guidelines to clarify the implementation of programs funded by new funding sources or changes to programs funded by funding sources identified in the BHE contract.

(2) **Local collaborative (LC):** An advisory body, delineated by either judicial district

or tribal grouping and recognized by the collaborative, that provides input on local and regional behavioral health issues to the collaborative, the BHPC and the BHE.

(3) **Logic model, prevention services:** A logical conceptual framework used to connect the prevention effort with its intended results and the goal of reducing substance abuse. The framework is based upon existing knowledge that is refined or revised with new research. The logic model specifically describes the changes expected within the target population(s), why it is likely that these changes would result from the proposed prevention services and activities, and how this logically relates to the needs assessment.

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization that contracts with the state of New Mexico to provide a variety of health care services to individuals who are enrolled.

(2) **Management letter:** A document signed by the co-chairs of the collaborative and a representative of the BHE authorized to bind the BHE that describes a certain task or activity to be pursued or conducted by the BHE, the specific approach to that task or activity, the expected result and the schedule to be followed to implement the task or activity. Such letters are not intended to be amendments to the BHE contract, but more specific directions for completing contract requirements.

(3) **Medicaid:** The medical assistance program authorized under Title XIX and Title XXI of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

(4) **Medically necessary services:** Clinical and rehabilitative physical, mental or behavioral health services that:

(a) are essential to prevent, diagnose or treat medical or behavioral health conditions or are essential to enable the consumer to attain, maintain or regain the consumer's optimal functional capacity;

(b) are delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the consumer;

(c) are provided within professionally accepted standards of practice and national guidelines; and

(d) are required to meet the physical, mental and behavioral health needs of the consumer and are not primarily for the convenience of the consumer, the provider or the BHE. (Subparagraphs (a) and (b) of Paragraph (7) of Subsection M of 8.305.1.7 NMAC)

N. Definitions beginning with letter "N":

(1) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with a BHE to furnish covered behavioral health services to consumers under the provisions of the BHE contract.

(2) **Non-network provider:** An individual provider, clinic, group, association or facility that provides covered services and does not have a contract with the BHE.

O. **[RESERVED]**

P. Definitions beginning with letter "P":

(1) **Peer specialist:** An approved provider who is certified as a peer specialist through a state approved certification program. (Paragraph (4) of Subsection A of 8.315.6.10 NMAC)

(2) **Performance measures:** A system of operational and tracking indicators specified by state or federal requirements or the collaborative, including but not limited to the federal national outcome measures (NOMS).

(3) **Prevention services:** Services that follow current national standards for prevention including both physical and behavioral health.

(4) **Prevention provider:** A provider under contract for the exclusive or primary purpose of providing services designed to prevent or reduce the prevalence of substance abuse, mental illness, or other specified behavioral health disorders.

(5) **Psychosocial necessity:** Services or products provided to a consumer with the goal of helping that individual develop to his/her fullest capacities through learning and environmental supports and reduce the risk of the consumer developing a behavioral health disorder or an increase in the severity of behavioral health symptoms. The consumer need not have a behavioral health diagnosis but rather have a need to improve psychosocial functioning.

Q. **[RESERVED]**

R. Definitions beginning with letter "R":

(1) **Recovery:** Behavioral health recovery is an individual's personal journey of healing and transformation enabling a person with a behavioral health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

(2) **Re-credentialing:** A systematic process whereby the BHE verifies and warrants that an employed or affiliated behavioral health professional who is currently credentialed, continues to meet specified practice standards, including education, experience, licensure and certification.

(3) **Resiliency:** A global term describing a dynamic process, whereby people overcome adversity and go on with their lives in a productive and self-satisfying manner.

(4) **Responsible offeror:** An offeror who submits a response proposal and who has furnished, when required, information and data to prove that the offeror’s financial resources, production or service facilities, personnel, service reputation and experience are adequate to make satisfactory delivery of the services or items of tangible personal property described in the proposal.

S. Definitions beginning with letter "S":

(1) **Selective prevention:** Prevention interventions targeted at a subgroup of the general population that is determined to be at risk for sexual assault, substance abuse or mental illness.

(2) **State:** The state of New Mexico, including any entity or agency of the state and including but not limited to the collaborative and member agencies.

(3) **Subcontract:** A written agreement between the BHE and a third party, or between a subcontractor and another subcontractor, to provide services, and where appropriate approved by the collaborative.

(4) **Subcontractor:** A third party who contracts with the BHE or a BHE subcontractor for the provision of services.

(5) **Supported employment:** Integrated work for not less than the federal minimum wage in a setting with ongoing support services for individuals with severe disabilities for whom competitive employment:

(a) has not traditionally occurred;

(b) has been interrupted or intermittent as a result of severe disability, and who,

(c) because of the nature and severity of their disabilities need intensive physical, educational, social or psychological support to perform work.

(6) **Supportive housing:** Permanent housing that is affordable to individuals with low or no incomes, is chosen by the individual, which a person retains even if their service needs change, and which is an essential ingredient to foster and support a person's journey towards recovery and resiliency.

T. **[RESERVED]**

U. Definitions beginning with letter "U": **Universal prevention:** Prevention interventions intended to reach the entire population or a large share of it, without regard to individual risk factors.

V - Z **[RESERVED]**

[7.21.1.7 NMAC - N, 9-1-11; A, 1-15-13]

7.21.1.8 MISSION STATEMENT:

The mission of the collaborative is to ensure that quality behavioral health services are provided to both medicaid and non-medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a single service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[7.21.1.8 NMAC - N, 9-1-11; A, 1-15-13]

PART 2: STANDARDS OF DELIVERY FOR BEHAVIORAL HEALTH SERVICES

7.21.2.1 ISSUING AGENCY:

Human Services Department.

[7.21.2.1 NMAC - N, 9-1-11]

7.21.2.2 SCOPE:

This rule applies to the general public.

[7.21.2.2 NMAC - N, 9-1-11]

7.21.2.3 STATUTORY AUTHORITY:

Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the human services department. The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; human services; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees.

[7.21.2.3 NMAC - N, 9-1-11]

7.21.2.4 DURATION:

Permanent

[7.21.2.4 NMAC - N, 9-1-11]

7.21.2.5 EFFECTIVE DATE:

September 1, 2011, unless a later date is cited at the end of a section.

[7.21.2.5 NMAC - N, 9-1-11]

7.21.2.6 OBJECTIVE:

The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities.

[7.21.2.6 NMAC - N, 9-1-11]

7.21.2.7 DEFINITIONS:

[RESERVED]

[See 7.21.1.7 NMAC.]

7.21.2.8 MISSION STATEMENT:

The mission of the interagency behavioral health collaborative (the collaborative) is to ensure quality behavioral health services are provided to medicaid and non-medicaid consumers; providers are reimbursed timely and accurately; data is collected, and services promote prevention, recovery, resilience, and efficient use of available resources. This mission serves the collaborative vision to establish a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[7.21.2.8 NMAC - N, 9-1-11]

7.21.2.9 QUALITY MANAGEMENT:

The collaborative recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner with better outcomes for consumers and families. Under the terms of the interagency behavioral health collaborative contracts, quality assurance and management programs are incorporated into behavioral health care delivery and administrative systems.

[7.21.2.9 NMAC - N, 9-1-11]

7.21.2.10 BROAD STANDARDS:

A. **Commitment to persons served:** The BHE and provider shall provide or ensure that:

(1) service delivery is individually centered and family-centered, and furthers an individual’s capacity for recovery and resiliency;

(2) all services are designed to enhance, promote and expand the recovery, resiliency, independence, self-sufficiency, self-esteem and quality of life of the persons served;

(3) individuals served are involved in the individual planning, decision-making, implementation and evaluation of services provided;

(4) agents under an advance directive, family members, guardians or treatment guardians, caregivers, or other persons critical to the consumer's life and well-being are involved in the individual planning, decision-making, implementation and evaluation of services provided, subject to requirements or principles of confidentiality and individual choice;

(5) the system offers a full range of appropriate behavioral health services for multi-diagnosed clients, including facilitating access to and coordinating care with appropriate medical care providers;

(6) services are based on evidence of effectiveness;

(7) services consider the individual consumer's and family's preferences;

(8) services and providers comply with Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

B. **Collaboration and system of care requirements:** The BHE shall be responsible for developing a system of care that offers acceptable access and appropriate, effective care to all individuals and families served. The BHE shall coordinate and collaborate with the collaborative in the implementation of the requirements of this or other rules and the requirements of any contracts between the BHE and the collaborative. The BHE shall work with the BHPC and, upon request, with LCs to seek advice and comment during the planning, implementation, and evaluation of services. The BHE shall consult with the BHPC to identify service gaps and needs, including provider training, coaching and supervision needs and opportunities.

C. **Reporting requirements:** The BHE shall provide to the collaborative such reports as may be required by the BHE contract. The BHE shall verify the accuracy and completeness of data and other information in reports submitted.

D. **Behavioral health data:** For reporting purposes, behavioral health data shall be collected and reported as required by contract for any consumer or family member receiving any behavioral health service provided by a behavioral health practitioner, regardless of setting or location as required by the collaborative, including behavioral health licensed professionals, practicing within the BHE. The BHE shall monitor and ensure the integrity of data. Findings shall be reported to the collaborative as required by the BHE contract.

E. **Emergency response requirements:** The BHE shall participate in disaster behavioral health planning and emergency response with the collaborative and in a manner consistent with the protocol of described in the New Mexico department of health emergency operations plan, psychosocial annex. The BHE shall ensure that its

network providers are likewise prepared to be responsive and appropriate to the specific needs of an event calling for emergency response and psychosocial support services.

F. **Sexual assault:** The BHE shall ensure that its providers have the capacity to provide comprehensive, confidential and sensitive services to victims of sexual assault as mandate by the Sexual Crimes and Prosecution and Treatment Act Sections 29-11-1 through 29-11-7, NMSA 1978.

G. **Advance directives:** The BHE shall have and implement policies and procedures for advance directives. The BHE shall require its providers to honor advance directives within its utilization management protocols.

H. **Forensic evaluations:** The BHE shall ensure that network and non-network providers providing forensic evaluations shall assure that such evaluations shall be performed pursuant to court authority and either the *Rules of Criminal Procedure for the District Courts,* 5-602.B, NMSA 1978, or other legal authority. Each evaluation file shall have a copy of the court order from the state district court.

I. **Special coordination requirements:** The BHE shall ensure effective coordination with other service systems and providers. Such coordination shall include at least the following:

(1) physical and behavioral health services;

(2) emergency services;

(3) pharmacy services;

(4) transportation;

(5) supportive housing;

(6) SCI MCOs;

(7) CYFD, including children in CYFD custody;

(8) New Mexico corrections department;

(9) court-ordered or parole board-ordered treatment;

(10) children in tribal custody or under tribal supervision;

(11) adolescents transitioning into the adult system;

(12) children with IEPs;

(13) medicaid eligibility outreach and assistance;

(14) medicaid waiver and non-medicaid disability programs;

(15) aging and long-term services department programs;

(16) HIV/AIDS treatment providers;

(17) individuals with special health care needs;

(18) supported employment.

J. The BHE shall ensure that consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders, receive covered services in a manner that meets their unique needs and in accordance with the specific requirements of the BHE contract.

K. The BHE shall comply with all applicable standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments.

L. The BHE shall hold subcontractors to all standards, procedure manuals, practice guidance, clinical protocols, orders or regulations issued by the collaborative or by collaborative member agencies or departments and shall monitor and assure compliance. Subcontracts of the BHE shall allow the BHE to observe or review administrative or clinical practices for contract compliance, quality management and outcomes.

[7.21.2.10 NMAC - N, 9-1-11]

7.21.2.11 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure and operations:** Quality management is an integrated approach that links knowledge, structure and processes together throughout a BHE's system to assess and improve quality. The BHE's quality management (QM) and improvement (QI) structures and processes shall be planned, systematic, clearly defined, and in full compliance with the BHE contract. The BHE shall comply with the provisions of 8.305.8.12 NMAC, regardless of the funding source of services. The BHE shall ensure that the QM/QI program is applied to the entire range of covered services and all major demographic population groups in accordance with the BHE contract. The BHE shall have an annual QM/QI work plan, prior approved by the collaborative, and as specified in its BHE contact with the collaborative.

B. **Continuous quality improvement/total quality management:** The BHE shall base its administrative operations and service delivery on principles of continuous

quality improvement/total quality management (QM/QI). Such an approach shall include at least the following:

(1) recognize that opportunities for improvement are unlimited;

(2) ensure that the QM/QI process shall be data driven;

(3) require the continual measurement of clinical and non-clinical effectiveness and programmatic improvements of clinical and non-clinical processes driven by such measurements;

(4) require the re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and

(5) rely on consumer and stakeholder input.

C. **Prevention and coordination of care:** The BHE shall institute QM/QI policies and procedures that emphasize and promote prevention and coordination across multiple providers and systems.

D. **Consumer/family satisfaction:** The BHE shall work with the collaborative in conducting the annual adult and child/family consumer satisfaction survey based on the national mental health statistics improvement project or successor projects. If the BHE conducts any other or separate satisfaction survey, such survey, including the survey instrument and methodology, shall be prior approved by the collaborative. The BHE shall comply with requirements of 8.305.8.11 and such other requirements as the BHE contract may require.

E. **Clinical practice guidelines:** The BHE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of services for acute and chronic behavioral health care conditions.

(1) The BHE shall select the clinical issues to be addressed with clinical guidelines based on the needs of consumers.

(2) The clinical practice guidelines shall be evidence-based.

(3) The BHE shall comply with the provisions of 8.305.8.12 NMAC regardless of the funding source for services. The BHE shall fully comply with all specifications of the BHE contract regarding clinical practice guidelines and evidence-based practices.

[7.21.2.11 NMAC - N, 9-1-11]

7.21.2.12 PERFORMANCE MEASURES:

A. BHE shall be accountable as specified in its contract for the achievement of any performance measure targets identified by the collaborative. The BHE shall measure and track performance measures, report on such measures at intervals defined by the collaborative, and incorporate performance measures as part of its QM/QI program. Performance measures include those required by the federal government or specified by the collaborative.

B. **Effectiveness of the QI program:** The BHE shall evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and non-clinical service to consumers. The BHE shall conduct data-driven evaluations of clinical practices to improve quality of care. The BHE shall demonstrate how it has influenced or changed provider practice patterns.

[7.21.2.12 NMAC - N, 9-1-11]

7.21.2.13 STANDARDS FOR UTILIZATION MANAGEMENT:

The collaborative requires appropriate utilization management (UM) standards to be implemented as well as activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under-utilization. The BHE shall manage the use of resources, maximize the effectiveness of care by evaluating clinical appropriateness, and authorize the type and volume of services through fair, consistent and culturally competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes. The consumer's service plan or treatment plan priorities, advance directives, and prolonged service authorizations for individuals with chronic conditions shall be considered in the decision-making process.

A. **Necessity requirement:** The BHE shall comply with 8.305.8.13 NMAC regarding standards for utilization management. References to "medical necessity" in 8.305.8.13 NMAC shall be read as "clinical and psychosocial necessity" as defined in these rules. References to "member" in 8.305.8.13 NMAC shall be read as "consumer" and shall include the consumer's family, legal guardian, and designated representative as appropriate. All requirements in 8.305.8.13 NMAC regarding providing notice to providers shall include notice to the consumer and consumer's family, legal guardian, and designated representative as appropriate.

B. **Use of qualified professionals:** The BHE shall ensure the involvement of representative practicing providers, consumers and family members in the development of its UM procedures. The BHE shall evaluate network provider satisfaction with the UM process as part of its annual provider satisfaction survey.

C. **Decisions:** The BHE shall make available UM decision criteria to providers, consumers, their families, and the public. The BHE shall ensure that consumers have an optimal choice of providers consistent with their treatment needs and available providers.

D. **Records:** The BHE shall maintain records (both hard and electronic) that verify its utilization management activities and compliance with UM requirements specified in this rule and the specific contractual requirements of the BHE contract.

[7.21.2.13 NMAC - N, 9-1-11]

7.21.2.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING:

The BHE shall have and implement policies and procedures that comply with 8.305.8.14 NMAC, as well as any other applicable credentialing or recredentialing requirements from collaborative member departments and agencies, including but not limited to any federal block grant or other collaborative practice protocols, rules or other requirements.

A. **Practitioner participation:** The BHE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. **Credentialing application:** The BHE shall use a collaborative-approved application for network participation.

C. **Evaluation of practitioner site:** The BHE shall perform an initial visit to the offices of potential high volume behavioral health care providers, as determined by the BHE with approval of the collaborative.

D. **Assessment of organizational providers:** For organizational providers, the BHE shall confirm that the provider is in good standing with state and federal regulatory bodies and has been certified by the appropriate state certification agency, when applicable.

E. **Performance evaluation:** The BHE shall ensure that all providers maintain the certification and training necessary to provide the services they offer. The BHE shall utilize QM/QI data in conducting provider recredentialing, recontracting or performance evaluations.

F. **Practices and programs:** The BHE shall ensure that credentialing and recredentialing requirements shall recognize and promote approaches to services such as consumer- and family-run programs, Native American healing practices and programs, traditional curanderismo, and other legally acceptable programs.

[7.21.2.14 NMAC - N, 9-1-11]

7.21.2.15 RIGHTS AND RESPONSIBILITIES:

The BHE and the provider shall have a written policy, approved by the collaborative as required, that states their commitment to treating clients in a manner that respects their rights, respecting and recognizing the consumer's dignity and need for privacy. This policy shall also address the BHE and the provider's expectations with regard to clients'

responsibilities. The BHE shall comply with 8.305.12 NMAC and 8.349.2 NMAC regarding grievances and appeals, regardless of funding source. The BHE shall be required to comply with NMAC 8.305.8.15 NMAC, member (consumer) bill of rights, any other collaborative member department or agency's rights' statements, and all consumer rights and responsibilities provisions of the BHE contract with the collaborative.

A. **Consumer handbook:** The BHE shall maintain a consumer handbook, prior approved by the collaborative, that includes but is not limited to information about consumer rights and responsibilities. The written information provided to consumers or clients of the BHE or provider shall be comprehensible, readable, easily understood and culturally sensitive.

B. **Complaints or grievances:**

(1) Consumers, their families or legal guardians, and designated representatives have a right and shall have the means to voice complaints or file grievances and appeals about the care provided by the BHE or provider in its network.

(2) The BHE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals.

(3) The BHE and the provider shall have written policies and procedures for the timely resolution of client or provider complaints or grievances.

(4) The BHE shall provide information specified in 42 CFR Section 438.10(g)(1) about its grievance system to all providers and subcontractors at the time they enter a contract.

(5) The BHE shall provide the collaborative regular reporting of all consumer and provider grievances, appeals, and fair hearings, and such other related data and information as specified in the BHE contract.

[7.21.2.15 NMAC - N, 9-1-11]

7.21.2.16 STANDARDS FOR CLINICAL RECORDS:

A. **Standards and policies:** The BHE shall require clinical records to be maintained in a format and manner that is timely, legible, current, and organized, and that permits effective and confidential consumer care and quality review. The BHE shall fully comply with all medical records, data, and confidentiality requirements of the BHE contract and any relevant state and federal law.

B. **Confidentiality:** The BHE shall have and implement clinical record confidentiality policies and procedures that implement the requirements of state and federal law and policy, this rule, and the BHE contract. These policies and procedures shall be

consistent with confidentiality requirements in 45 CFR parts 160 and 164 for all medical records and any other health and enrollment information that identifies a particular consumer. Medical record contents shall be consistent with the utilization control required in 42 CFR Part 456, 42 CFR 431.305(b) and 45 CFR 164.530(c).

C. **Evaluation and treatment or service records:**

(1) To promote effective service delivery and quality review, treatment or service records shall be maintained in a manner that is current, comprehensive, detailed, organized, and legible.

(2) The BHE and the provider shall ensure that consumers and family members participate in treatment or service planning, development, and implementation and maximize consumer and family recovery and resiliency. The BHE shall ensure that consumers and family members, where appropriate, are presented with opportunities to proactively engage and participate in the behavioral health service delivery system, with a focus on the family as a potential change agent where consistent with the consumer's preferences and wishes.

[7.21.2.16 NMAC - N, 9-1-11]

7.21.2.17 STANDARDS FOR ACCESS:

A. **Ensure access:** The BHE shall ensure the accessibility and availability of behavioral health providers for each medically, clinically or psychosocially necessary service. The BHE shall comply with 8.305.8.18 NMAC, regardless of the funding source and shall comply with such geo-access standards as the collaborative may require. The BHE shall maintain and update its service access plan, which shall describe the BHE's system for consumer access to services.

B. **Array of services:** The BHE shall ensure that in each region of the state there is an array of covered services that allow consumers to be served within the least restrictive setting and in close proximity to their places of residence, with preference given to in-state providers.

C. **Appointment standards:** The BHE shall ensure that appointment standards detailed in the BHE contract are met by the provider and shall report to the collaborative on the compliance of providers in meeting appointment standards.

D. **Access to transportation services:** The BHE shall assist consumers in accessing existing transportation benefits and resources to provide transportation to covered services, including transportation to address a behavioral health issue during non-business hours and transportation related to an emergency. The BHE shall coordinate behavioral health transportation services with the consumer's respective MCO, where applicable.

E. **Cultural competency:** The BHE and provider shall provide effective services to people of all cultures, races, ethnic backgrounds, religions in a manner that respects the worth of the individual and protects the dignity of each individual regardless of the circumstances under which services are sought.

(1) The BHE shall develop, implement, evaluate, and update a cultural competency plan for itself and for all network providers to ensure that consumers and their families, including individuals with disabilities, receive covered services that are culturally and linguistically appropriate to meet their needs.

(2) The BHE shall ensure that providers have access to specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of behavioral health care and outcomes. The BHE shall ensure compliance with 8.305.1.7 NMAC, regardless of funding source.

[7.21.2.17 NMAC - N, 9-1-11]

7.21.2.18 DELEGATION:

Delegation is a process whereby the BHE gives another entity the authority to perform certain functions on its behalf. The BHE shall be fully accountable for the quality of clinical care and services provided to consumers through its delivery system. The BHE may not delegate the accountability for the quality of services provided. The BHE will be responsible for the QM/QI program and not delegate this responsibility to subcontractors. The BHE shall not assign, transfer or delegate key management functions such as utilization review/utilization management or care coordination without the explicit written approval of the collaborative. The BHE shall ensure its full compliance with all delegation requirements of the BHE contract.

[7.21.2.18 NMAC - N, 9-1-11]

PART 3: BEHAVIORAL HEALTH ENTITY CONTRACTING

7.21.3.1 ISSUING AGENCY:

Human Services Department.

[7.21.3.1 NMAC - N, 9-1-11]

7.21.3.2 SCOPE:

This rule applies to collaborative member agencies.

[7.21.3.2 NMAC - N, 9-1-11]

7.21.3.3 STATUTORY AUTHORITY:

Subsection F of Section 9-7-6.4 NMSA 1978 requires the interagency behavioral health purchasing collaborative (the collaborative) to adopt rules through the human services department. The collaborative is created by statute and comprised of the secretaries of aging and long-term services; Indian affairs; human services; health; corrections; children, youth and families; finance and administration; workforce solutions; public education; and transportation; the directors of the administrative office of the courts; the New Mexico mortgage finance authority; the governor's commission on disability; the developmental disabilities planning council; the vocational rehabilitation division of the public education department; the New Mexico health policy commission; and the governor's health policy coordinator, or their designees.

[7.21.3.3 NMAC - N, 9-1-11]

7.21.3.4 DURATION:

Permanent

[7.21.3.4 NMAC - N, 9-1-11]

7.21.3.5 EFFECTIVE DATE:

September 1, 2011, unless a later date is cited at the end of a section.

[7.21.3.5 NMAC - N, 9-1-11]

7.21.3.6 OBJECTIVE:

The objective of this rule is to provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative.

[7.21.3.6 NMAC - N, 9-1-11]

7.21.3.7 DEFINITIONS:

[RESERVED]

[7.21.3.7 NMAC - N, 9-1-11; Repealed, 1-15-13]

7.21.3.8 MISSION STATEMENT:

The mission of the collaborative is to ensure that quality behavioral health services are provided to medicaid and non-medicaid consumers; that providers are reimbursed timely and accurately; that services promote prevention, recovery, resilience in

consumers, and that available resources are used in the most efficient and effective manner. This mission serves the collaborative's vision of establishing a behavioral health service delivery system in which consumers and family members are assisted in participating fully in the life of their communities; support of recovery and development of resiliency are expected; behavioral health is promoted; and the adverse effects of substance abuse and mental illness are prevented or reduced.

[7.21.3.8 NMAC - N, 9-1-11; A, 1-15-13]

7.21.3.9 ELIGIBLE BEHAVIORAL HEALTH ENTITY (BHE):

The collaborative shall award a contract to one or more behavioral health entities which meets applicable requirements and standards delineated under state and federal law including Title IV of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. The BHE contract shall, at a minimum, manage delivery of all covered behavioral health services (both medicaid and non-medicaid services), including network development and management, tracking funding and expenditures from various funding sources, conducting utilization management, ensuring coordination of services, ensuring quality management and improvement, and conducting various administrative functions.

A. **BHE contract procurement:** The collaborative may, in conjunction with human services department, jointly procure contractors to provide both BH and other medicaid services.

B. **BHE contract issuance:** Prior to execution of a contract with a BHE, the collaborative must meet and give approval as to the substance and form of the proposed contract. The executive committee is authorized to negotiate, sign and execute the contract with a BHE without further approval from the other members.

C. **BHE contract amendments:** The BHE contract shall not be altered, changed or amended other than by an instrument in writing executed by the contractor and the co-chairs of the collaborative. The executive committee is authorized to adopt and execute an amendment to a BHE contract on behalf of the collaborative without obtaining prior approval of the other members.

D. **Other contracts:** The chair and co-chairs are authorized to negotiate any additional contracts, memoranda of understanding or other agreements, and any amendments or modifications thereto, on behalf of the collaborative without obtaining the prior approval of the members.

[7.21.3.9 NMAC - N, 9-1-11; A, 1-15-13]

7.21.3.10 [RESERVED]

[7.21.3.10 NMAC - N, 9-1-11; Repealed, 1-15-13]

7.21.3.11 READINESS REVIEW:

Following full execution and prior to the effective date of the BHE contract, the contractor shall demonstrate to the satisfaction of the collaborative that it is able to meet the requirements of the RFP. The readiness review may include, but is not limited to, desk and on-site reviews, system demonstrations, interviews with the contractor's staff and such other review of any and all requirements of the RFP as determined by the collaborative.

[7.21.3.11 NMAC - N, 9-1-11]

7.21.3.12 CONTRACT MANAGEMENT:

The collaborative or its designee shall provide collective and coordinated oversight and administrative functions to ensure BHE compliance with the terms of its contract, assuring each member agency with fiduciary responsibility for funds within the contract is involved and is able to meet its obligations to oversee state and federal funds for which it is responsible. Further, the provisions of 8.305.3.10 apply to all BHE contracts.

[7.21.3.12 NMAC - N, 9-1-11]

CHAPTER 22-24: [RESERVED]

CHAPTER 25: STATE HEALTH INSTITUTIONS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: DRUG AND ALCOHOL TESTING OF EMPLOYEES

7.25.2.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.25.2.1 NMAC - N, 10/15/2012]

7.25.2.2 SCOPE:

This rule applies to all employees providing direct health care services in state health facilities as defined in NMSA 1978, Section 9-7-18.

[7.25.2.2 NMAC - N, 10/15/2012]

7.25.2.3 STATUTORY AUTHORITY:

Section 9-7-18 of the Department of Health Act, NMSA 1978, Sections 9-7-1 through 9-7-18.

[7.25.2.3 NMAC - N, 10/15/2012]

7.25.2.4 DURATION:

Permanent.

[7.25.2.4 NMAC - N, 10/15/2012]

7.25.2.5 EFFECTIVE DATE:

October 15, 2012, unless a later date is cited at the end of a section.

[7.25.2.5 NMAC - N, 10/15/2012]

7.25.2.6 OBJECTIVE:

To protect the health and welfare of those served in state health care facilities operated by the department of health by ensuring that employees providing direct health care are not impaired by any illegal or prescription drug, or alcohol, while providing services.

[7.25.2.6 NMAC - N, 10/15/2012]

7.25.2.7 DEFINITIONS:

A. "Direct care" means health care providers authorized or permitted to offer health care services directly to a patient without another employee’s assistance or presence.

B. "Department" means the department of health.

C. "For cause" means upon reasonable suspicion of impairment as set forth in 1.7.8 NMAC.

D. "Health care provider" means any health care staff member who is licensed, certified or otherwise authorized or permitted by law to provide direct, unsupervised health care to a patient.

E. "Illegal or prescription drug" means a substance listed in any of Schedules I through V of the Controlled Substances Act.

F. "State health care facility" means a hospital, an entity providing services for the developmentally disabled, a shelter care home, a free-standing hospice or a home health agency operated by the department.

[7.25.2.7 NMAC - N, 10/15/2012]

7.25.2.8 TESTING REQUIREMENTS:

A. All direct care health care providers shall be deemed employed in safety-sensitive positions to be tested for drug or alcohol abuse prior to employment, and subject to both random and for cause drug and alcohol testing thereafter pursuant to the rules promulgated by the state personnel board set forth at 1.7.8 NMAC, which rules are hereby incorporated by reference.

B. Any safety-sensitive employee may be tested without prior notice for drug or alcohol abuse upon reasonable suspicion of impairment.

(1) All reports of suspected drug or alcohol impairment while working shall be investigated by the allegedly impaired employee's supervisor, and if believed credible based upon direct observation of the factors listed in Subsection C of 1.7.8.11 NMAC, the employee shall be tested immediately upon approval of the next level supervisor as set forth in that section.

(2) The immediate supervisor must provide a succinct memorandum of the factors which led him or her to conclude the allegation was credible to the department's substance abuse coordinator or designee within 24 hours of testing.

C. Drug or alcohol test results shall be reported in writing only to the department's substance abuse coordinator or designee. Positive test results will be provided in writing to the prospective new hire or employee along with a copy of this rule including 1.7.8 NMAC.

[7.25.2.8 NMAC - N, 10/15/2012]

PART 3-9: [RESERVED]

PART 10: NEW MEXICO VETERANS CENTER POLICY

7.25.10.1 ISSUING AGENCY:

Veterans Service Commission, New Mexico Veterans Center.

[Recompiled 10/31/01]

7.25.10.2 SCOPE:

[RESERVED]

[Recompiled 10/31/01]

7.25.10.3 STATUTORY AUTHORITY:

[RESERVED]

[Recompiled 10/31/01]

7.25.10.4 DURATION:

[RESERVED]

[Recompiled 10/31/01]

7.25.10.5 EFFECTIVE DATE:

[RESERVED]

[Recompiled 10/31/01]

7.25.10.6 OBJECTIVE:

[RESERVED]

[Recompiled 10/31/01]

7.25.10.7 DEFINITIONS:

[RESERVED]

[Recompiled 10/31/01]

7.25.10.8 MISSION STATEMENT:

A. It is the mission of the New Mexico veterans center to provide the highest quality of nursing and domiciliary services to veterans honorably discharged from the United States armed services and who are disabled by age, disease, or otherwise and by reason of such disability are incapable of earning a living. The center supports the principle of prohibiting discrimination based on race, religion, color or national origin.

B. The ultimate aim of the facility is to create and maintain an environment of friendliness, warmth and understanding between residents and staff and to provide a community where aging and disabled veterans can live out their lives in comfort and dignity. Service provided by the center includes medical and twenty-four hour nursing care; physical therapy; occupational therapy; social services; housekeeping services; dietary services; recreation services; and spiritual comfort.

C. The center recognizes that the needs of the disabled veterans are not static, and thus each person served must receive comprehensive recurring assessments as his or her needs change. A number of different staff specialists are employed to provide assessments and can furnish medical diagnosis; assessment of health status; nutritional assessment; rehabilitative assessment and social assessment.

D. Since the New Mexico veterans center is the only facility of its type in New Mexico, we must be aware of the needs of veterans throughout the state, and the resources that exist in each area. In addition, we can be looked upon as a resource center for assisting veterans and families of veterans. We will work closely with other providers in the public and private sector to achieve a continuum of appropriate services. We will continue to develop relationships with schools of higher education in New Mexico and support and participate in training and research activities that increase the body of knowledge in long-term care facilities.

[Recompiled 10/31/01]

7.25.10.9 GOVERNING BODY AND ADMINISTRATION:

A. Purpose: To define the ultimate responsibility of the veterans service commission in relationship to the administrator and the New Mexico veterans center.

B. Policy: It shall be the policy of the New Mexico veterans center, in accordance with New Mexico Statutes Annotated, 1978 Compilation, Section 23-4-1 through 23-4-2, that the center shall be under the control of the New Mexico veterans service commision which shall appoint an executive director for the center. The executive director shall appoint, subject to the provisions of the State Personnel Act, such personnel as may be necessary for the efficient performance of the duties prescribed in Sections 23-4-1 through 23-4-4.1, NMSA 1978 Compilation.

C. Governing body responsibilities:

(1) Appointing an executive director as the official representative of the governing body and formalizing responsibilities and authority of the administration.

(2) Adopting a statement of the facility's missions and objectives to include the types of services to be offered.

(3) Adopting, reviewing and revising policies describing the organization of the facility and establishing authority and responsibility.

(4) Adopting effective administrative and resident care policies designed to assure maintenance of professional standards.

(5) Designating veterans service commission officers and their duties. This will include scheduling of meetings, attendance requirements, and recording minutes.

(6) Providing for regular attendance at committee meetings by the administrator or his designee and providing for submission of regular reports to the governing body.

(7) Providing a physical plant, equipment, and staff appropriate to the needs of residents.

(8) Approving annual budgets that reflect and carry out the objectives of the facility.

(9) Assuring that the facility is licensed and certified by the appropriate agencies, and that all facility personnel meet the legal requirements of licensing, certification, or requisition of their occupations in accordance with federal, state, and local requirements.

D. Administrator's responsibilities:

(1) Adopting and enforcing rules, regulations, and procedures concerning the health care and safety of residents and the protection of their personal and property rights.

(2) Appointing a designee to act in his absence so that administrative direction is provided at all times.

(3) Establishing and implementing the resident care policies, personnel policies, and other policies of the facility.

(4) Maintaining a file of any incident report to include the time, date, and nature of the incident, the circumstances involved, the action taken, any other information considered essential, and insure that each report is dated and signed.

(5) Evaluating and implementing, if feasible, any recommendations from the facility's committees and consultants.

(6) Managing the on-going functions of the facility by employing adequate numbers of appropriately trained staff and auxiliary personnel and delegating duties appropriately.

(7) Providing that the volunteer program is planned and supervised by a designated individual, and that volunteers are given a thorough orientation to the facility and its objectives, services, staff, routines and limitations.

(8) Delegating responsibility for discharge planning to one or more individuals of the facility's staff.

(9) Maintaining on-going liaison with the governing body and with the medical, nursing, and other professional and supervisory staff through regularly scheduled meetings and periodic reports.

(10) Attending continuing education institutes and workshops are required by state licensing requirements.

[Recompiled 10/31/01]

7.25.10.10 ORGANIZATION:

A. Purpose: To outline the basic organization of the New Mexico veterans center; establish lines of authority and responsibility for all personnel; and define often used terms. See attached organizational chart and description of structure.

B. Definition:

(1) Administrator: Exercises overall supervision, responsibility, and direction of the facility. He is directly responsible to the veterans service commission.

(2) Assistant administrator: Assists the administrator in providing overall supervision, responsibility, and direction of the facility. He assumes the duties of the administrator in his absence.

(3) Division: Major organizational component comprising of one or more departments. The division head exercises overall supervision and is responsible for all activities within that division.

(4) Department: Lesser organization component comprised by major function or mission. The department head is responsible for the supervision and operation of his department and reports to his respective division head.

(5) Section: Next lower organizational element under a department. An area may also be considered a section. The section chief reports to the unit department head.

C. Organizational structure:

(1) The purpose of the attached organizational chart is to establish clear lines of authority and responsibility in order to achieve accountability for program and administrative services. The chart reflects the major divisions responsible to the administrator and the sections and departments reporting to the division heads.

(2) Individual division heads have sole responsibility for the operation of their respective divisions. Activities, functions and roles of personnel assigned, and the administration of the respective departments assigned will be the responsibility of the

division head. Problems which occur involving more than one division will first be defined by the respective heads, and a method of solving the problem arrived between them. On occasions where solutions cannot be reached, the administrator will determine the solution, and the division heads will implement such decisions.

(3) Division heads shall establish written numbered procedures for the individual functions under his/her direct supervision and will review and update such procedures annually. Division heads will establish methods of monitoring his/her division's functions according to regulations and standards of the joint commission on accreditation of hospitals (JCAH) and intermediate care facilities (ICF). Divisions who have responsibility for additional standards for compliance, i.e., Occupational Safety and Health Act (OSHA), Life Safety Code, American national standards institute (ANSI), etc., will establish guidelines and monitoring procedures for these responsibilities. In addition, each division head will establish and maintain organizational and functional role descriptions and supervisory relationships to be approved by the administrator.

D. Responsibilities: In accordance with this organizational concept, the following management practices apply:

(1) The director of medical services reports to the administrator and is fully responsible for maintaining the general health conditions and medical practices of the facility. He is responsible for assuring that the quality of medical services and health care is in comformity with all applicable federal, state, and local laws, regulations, codes, rules, and policies. He is responsible for assigning, directing, and evaluating the performance of the staff assigned to his division; for making appropriate medical services available at all times to the residents; for planning, preparing and controlling the division's inter-disciplinary team approach to active treatment; and for maintaining communication with the other divisions and with the administrator.

(2) The nursing services department reports to the director of medical services and is responsible for providing medical and health care needs for the residents on a twenty-four hour, seven-day per week basis. Training will be provided for staff on an on-going basis. The department will insure that residents are provided with rehabilitative nursing care, and that residents are kept comfortable, clean, neat, and well groomed.

(3) The rehabilitation services department reports to the medical services director and is responsible for providing a variety of activities, both inside and outside the facility, to provide recreational, social, educational, creative, and spiritual activities for all residents. Residents will be encouraged to participate in community activities, both independently and as planned activities. A full array of physical therapy, occupational therapy, and recreational services will be provided.

(4) The director of administrative services reports to the administrator and is responsible for the activities of the following departments: personnel, fiscal, maintenance, and food services. He is responsible for maintaining adequate, modern

administrative support to efficiently meet the needs of, and contribute to the program services for the residents. He is responsible for seeing that the division's practices are in comformity with all applicable federal, state, and local laws, rules, regulations, codes, and policies. He is responsible for maintaining clean and sanitary surroundings at all times.

(5) The director of administrative services is also responsible for maintaining an efficient system of laundry services to all of the resident and support areas. He is responsible for establishing and maintaining a program which fully meets the day-to-day nutritional needs of the resident. He is responsible for assuring adequate and modern accounting for all receipts and expenditures.

(6) The director of administrative services is also responsible for the overall preparation and monitoring of the institution's budget and for communicating orally and in written form to all divisions and sections regarding budget status. He is responsible for sound leave practices and for an on-going evaluation of staff leave status at all levels. He is responsible for all purchasing and property control procedures.

(7) The maintenance department head reports to the director of administrative services and is responsible for the general maintenance of the grounds and roadways, buildings, and structures, maintenance of vehicles and oversees the housekeeping operations. The director is charged with providing a safe and accessible environment for residents and staff and assuring that good maintenance practices are followed. Maintenance of the facility will include remodeling, replacement, repair or deletion of facility structures, materials and machinery as required, while assuring that such remodeling, repair or deletions are necessary for the benefit of the residents. The director will comply with the New Mexico Uniform Building Code, ANSI, Standards of ICF/MR, Fire Code, and all state, federal, local building requirements. All work performed at the facility will be based on 504 accessibility criteria and will conform to a high standard of product selection. In addition, the director of the division will prepare all necessary reports on energy usage; preventative maintenance, budget and inventory utilization as required by the administrator. Recruitment of staff will be based on the needs of the facility, availability of funds, and the specialties or trades required for the efficient operation of the facility.

(8) The personnel director reports to the director of administrative services and is responsible for the day-to-day operation of the personnel department and in-service training. The director will be responsible for the overall monitoring of the employees of the facility in terms of evaluation, promotion, and compliance with state personnel board rules and Title VI, Section 504, and applicable laws and contracts. The director will provide current and valid data on a day-to-day basis on the status of the employees of the facility in terms of vacancy, promotion, transfer, and termination and performance evaluation. In addition, he will initiate special studies periodically to determine absenteeism, educational achievement, turnover rates, and other areas related to personnel. The director will assure smooth and efficient handling of all personnel actions; constantly cooperating with other divisions, departments, and units of

the facility in defining and resolving personnel related problems. Each year in the preparation of budget requests, the director will provide a current and accurate listing of all positions in conjunction with, or as part of, the overall budget request. In-service training (basic orientation) will be provided to all new employees prior to the employee reporting to the work station. On-going training needs will be assessed and provided as needed, in cooperation with other facility staff and departments.

(9) The food services director reports directly to the director of administrator services and is responsible for the dietary, nutritional and food services operations. Dietetic services will meet the nutritional, therapeutic, psychosocial, and special dietary needs of the residents. Food will be served in an attractive manner, at the proper temperature, and will meet the individual needs of the residents.

(10) The fiscal director reports directly to the administrative services director and is responsible for the facility budget and expenditures, maintenance of accurate accounting procedures, payroll, supplies, and purchasing procedures. He will insure that accounts receivable and accounts payable are accurate and reflect the correct accounting procedures as directed by the state of New Mexico.

(11) The medical director will report directly to the administrator. His responsibilities will consist of assuring that all residents receive proper medical care by a licensed physician, developing procedures for handling medical emergencies and transfers to other health care facilities as necessary, monitoring the health status of employees, consulting in the development and maintenance of an adequate medical record system and advising the administrator regarding the scope and appropriateness of medical services for residents, the facility's equipment, and its support staff.

(12) The medical records administrator reports directly to the administrator and will be responsible for assuring that the medical records are complete, readily accessible, and systematically diagnosed to facilitate retrieval and the compilation of information. In addition, he is responsible for maintaining the security and confidentiality of records and assuring that only authorized personnel have access to them.

(13) The social services director reports directly to the assistant administrator and is responsible for providing services necessary to identify and meet the psychological needs of all residents. He will be responsible for participating in resident care management by being a part of the multi-disciplinary team, assessing the residents' psychosocial needs and assisting in developing a multidisciplinary plan of care for each resident. Social services provides the liaison between the resident, his family, the community, and the facility.

[Recompiled 10/31/01]

7.25.10.11 EQUAL OPPORTUNITY AND CIVIL RIGHTS:

A. Purpose: To assure full compliance with state and federal laws, rules, and regulations in relation to non-discrimination and civil rights.

B. Policy: It shall be the policy of the New Mexico veterans center, in accordance with New Mexico Statutes Annotated, 1978 Compilation, Section 28-1-7, that:

(1) It is an unlawful discriminatory practice for an employee, unless based on a bona fide occupational qualification, to refuse to hire, to discharge, to promote or demote, or to discriminate in matters of compensation, terms, conditions, or privileges of employment against any person otherwise qualified because of race, age, religion, color, national origin, ancestry, sex, or physical or mental handicap.

(2) Furthermore, the facility subscribes to the requirements and intent of the Civil Rights Act of 1964, the Age Discrimination Act of 1967, and the Rehabilitation Act of 1973.

(3) If an employee feels he has been discriminated, he may elect to contact the human rights commission in Santa Fe. An employee filing a charge of discrimination based on any area of illegal or unlawful discrimination is protected from any type of reprisal. Any employee may freely file an allegation of discrimination and be assured of full and fair consideration of that complaint.

[Recompiled 10/31/01]

7.25.10.12 ESTABLISHMENT OF POLICY AND PROCEDURE:

A. Purpose: To provide guidance and direction for establishment of center policy and procedure.

B. Background: New Mexico Statutes Annotated, 1978 Compilation, Section 28-13-5, provide that the veterans service commission, as part of their powers and duties, shall make rules and regulations as may be necessary. As part of the duties of the administrator, he shall establish procedures to carry out the policies of the commission.

C. Definitions:

(1) Policy: The overall plan embracing the general goals and objectives of the facility.

(2) Procedure: A particular method for carrying out the policy of the facility.

D. Policy: It shall be the policy of the New Mexico veterans center that only the veterans service commission can establish policy. Policy must be formally adopted by the Commission at a public meeting and signed off by the commission chairman.

(1) Any section which implies a new policy or procedure or a change in an existing policy or procedure shall be referred to the administrator. He shall have it formalized in writing, and, if necessary, submitted to the veterans service commission for approval.

(2) All facility procedures will be signed by and issued from the office of the administrator.

(3) Each division and department will develop written procedure manuals for their respective areas.

(4) All procedures and policies shall be reviewed at least annually by the veterans service commission and the administrator.

[Recompiled 10/31/01]

7.25.10.13 CODE OF CONDUCT:

A. Purpose: To prescribe a code of conduct for the New Mexico Veterans Center in accordance with New Mexico Statutes Annotated, 1978 Compilation, Section 10-16-11.

B. Policy: It shall be the policy of the New Mexico veterans center that a code of conduct for employees shall be established and shall be required reading by all employees.

C. General requirements:

(1) Each employee shall be expected to serve diligently, loyally, and cooperatively; to exercise courtesy and dignity; and to conduct himself, both on and off duty, in a manner reflecting credit upon himself and the New Mexico veterans center.

(2) An employee shall avoid any action which might result in, or create the appearance of:

(a) using public office for private gain;

(b) giving preferential treatment to any person, group, or organization;

(c) impeding state government efficiency or economy;

(d) losing complete independence or impartiality;

(e) making a state government decision outside official channels.

(3) An employee shall not attempt to accomplish indirectly - through his immediate family or otherwise any activity which he is prohibited from doing directly.

(4) Employees shall not discriminate on the grounds of race, age, religion, ancestry, color, sex, or national origin in providing services. They shall not discriminate on those grounds or any other improper ground in any employment matter. Employees are responsible to cooperate in making equal opportunity for all a reality in the New Mexico veterans center.

(5) The veterans service commission and the administrator shall encourage the good conduct of employees by setting the example, by dealing with them considerately and impartially, and by showing sincere concern for them as individuals.

D. Financial interests:

(1) An employee shall not have a direct or indirect financial interest that conflicts substantially, or appears to conflict substantially, with his state government duties and responsibilities.

(2) An employee shall not engage, directly or indirectly, in a financial transaction as a result of or primarily relying on, information obtained through his state employment.

E. Use of state government property:

(1) Each employee shall protect and conserve state government property, including equipment, supplies, and other property entrusted or issued to him.

(2) An employee shall not willfully damage or otherwise misuse state government property, including vehicles, equipment, tools, and instruments.

F. Disclosure or misuse of information:

(1) An employee shall not, directly or indirectly, use for the purpose of furthering a private interest, or allow such use of, official information obtained through or in connection with his state employment which has not been made available to the general public.

(2) An employee shall not, except as specifically authorized, disclose any official information which represents a matter of confidence or trust or any other official information of such character that its disclosure or use would be contrary to the best interest of the state, the veterans service commission, or the veterans being served by the New Mexico veterans center.

G. I hereby certify that I have read the above code of conduct in its entirety, and as an employee of the New Mexico veterans service commission state of New Mexico, I further certify that I have complied with every action of the above code of conduct and have no conflict of interest in any manner with the above.

[Recompiled 10/31/01]

7.25.10.14 ADMISSION REQUIREMENTS:

A. Purpose: To establish policy and procedures relating to admission requirements to the New Mexico veterans center.

B. Background: The New Mexico veterans center was established by the New Mexico legislature to provide residential services to veterans of service in the armed forces of the United States. These services provide for the highest quality of nursing care along with a safe environment which will give the veteran a sense of well-being and dignity in his or her remaining years and to rehabilitate him or her to his or her highest potential.

C. Policy: It shall be the policy of the New Mexico veterans center, in accordance with New Mexico Statutes Annotated, 1978 Compilation, Section 23-4-3, that:

(1) Occupancy in the center shall be only for veterans of service in the armed forces of the United States who have served at least ninety days of active duty during a period of war or who have served under conditions comparable thereto, pursuant to rules and regulations adopted by the New Mexico veterans service commission. The following requirements for admission and continued occupancy shall prevail:

(a) release or separation from the service with an honorable discharge; and

(b) residency in New Mexico at the time of entering the armed forces, or in the alternative, residing in the state for five or more of the nine years immediately preceding the date of application.

(2) Whenever a law, rule or regulation of the veterans administration of the federal government or any other law permits the state to receive federal funds for the use and benefit of the center, upon acceptance of a veteran of the armed forces of the United States not meeting the requirements of Subsection A of this section [now Subsection A of 7.25.10.14 NMAC], the New Mexico veterans service commission may adopt rules and regulations to authorize such veteran's acceptance.

(3) Preference and priority in admission shall be granted to New Mexico veterans in accordance with the laws of New Mexico.

(4) If there are vacant beds available, veterans of other states shall then be allowed admission, provided they have been separated from the service with an honorable discharge.

D. Levels of care:

(1) Domiciliary: Residents should possess self-help skills, e.g., dressing, feeding, and bathing self; require no hospital care or nursing care; not be acutely ill; and should not be a danger to self or others.

(2) Nursing: Residents may be ambulatory or non-ambulatory; may require assistance with self-help skills; require immediate nursing care; and should not be a danger to self or others.

(3) Residents admitted should be free of communicable diseases as determined by the center medical director or physician.

E. Procedure:

(1) An approved application from, including biographical data, establishing eligibility. Applicants must include evidence of military service in the form of an honorable discharge from the armed forces of the United States (DD-124 or equivalent document.)

(2) An agreement for payment of fees where applicable.

(3) A physical examination by a physician licensed to practice in New Mexico.

(4) An agreement to abide by the rules and regulations of the Center.

F. All applicants will be reviewed by the admissions committee consisting of the administrator, medical director, director of nurses, social worker, and medical records administrator, who shall determine eligibility and appropriateness of admission. Applicants will promptly be notified of the findings of the committee, and if approved and a vacancy exists, the applicant will be invited for admission. Should a vacancy not exist, the applicant will be placed on a waiting list and advised in writing of the delay to be expected.

G. Should the applicant disagree with the review of the admissions committee, he or she may appeal the findings to the veterans service commission, who shall review the decision of the committee.

[Recompiled 10/31/01]

7.25.10.15 CARE AND MAINTENANCE CHARGES:

A. Purpose: To establish policy and procedures relating to the scope and care offered and the maintenance charges for service.

B. Background: Although the state of New Mexico and the veterans administration pay for the majority of costs of care, it is necessary for the center to charge residents for

services in order to provide the full range of services offered. These charges shall be based upon total income of the residents and based on their ability to pay.

C. Policy: It shall be the policy of the New Mexico veterans center, in accordance with the New Mexico Statutes Annotated, 1978 Compilation, Section 23-4-4, that:

(1) Patients of the New Mexico veterans center shall be assessed a monthly care and maintenance charge based upon the level of care provided to them and their individual ability to pay. The claim of the state for such care and treatment shall constitute a valid indebtedness against any such patient and his estate shall not be barred by any statute of limitations. At the death of the patient, this claim shall be allowed and paid as other lawful claims against the estate.

(2) Nursing care charge and scope of services provided:

(a) The charge for nursing care of patients shall be set by the veterans service commission.

(b) Nursing care shall include room and board in the nursing care section of the veterans center and the full range of medical and nursing services offered in-house at the center. Medical and nursing services shall minimally include: staff physician services, intermediate nursing care, all required medications and their administration, all necessary x-ray and laboratory services which are performed by the center, and all required therapy performed by the center. Nursing care does not include those medical or other services which a patient requires or receives beyond those provided within or by the center, personal discretionary use items, such as tobacco or the purchase or laundry of street clothes.

(3) Domiciliary care charge and scope of services provided:

(a) The charge for domiciliary care to patients shall be set by the veterans service commission.

(b) Domiciliary care shall include room and board in the domiciliary section of the veterans center and limited medical care services offered by the center. Medical services shall minimally include staff physician services, all required medications, all necessary x-ray and laboratory services which are performed by the center, and all required therapy performed by the center. Domiciliary care does not include intermediate nursing care, administration of medications, required medical or other services not performed by the center, personal discretionary use items, such as tobacco or the purchase or laundry of street clothes.

(4) Care and maintenance charge adjustments and exclusions:

(a) Care and maintenance charges shall be computed in a manner to maximize the veterans administration pension and compensation benefits to which the veteran is entitled.

(b) Care and maintenance charges shall be computed in a manner to assure that the veteran retains an equitable amount to be set by the veterans service commission.

(c) The care and maintenance charge shall not exceed three times the per diem paid by the veterans administration for the type of care provided.

(d) The ability or inability of a resident to pay the established rates shall not reflect adversely upon his admission to the center.

(e) Any patient of the New Mexico veterans center or his/her guardian may seek a reduction or waiver of care and maintenance charges for reasons of financial hardship by requesting a review of his/her case by the New Mexico veterans service commission. Requests for review of care and maintenance charges shall be submitted in writing to the center administrator or to the chairman of the veterans service commission and shall describe as fully as possible the reasons the patient is seeking relief and the extent of the relief from care and maintenance charges requested. Upon receiving a request for relief of care and maintenance charges from a patient, the veterans center administrator shall assist the veteran in preparing the formal request and shall conduct a thorough investigation of the circumstances. The request for relief, all pertinent information, and the recommendation of the center administrator shall then be forwarded to the chairman of the veterans service commission for submission to the veterans service commission for review and action.

(5) Other factors governing assessment and payment of care and maintenance charges:

(a) Care and maintenance charges begin on the first day of admission.

(b) Care and maintenance charges are to be paid on the first of each month or as soon thereafter as possible for the care and maintenance to be received in the following month.

(c) Any patient, his/her guardian, or legal spouse, who knowingly withholds or falsifies income or resource date or who withholds payment of assessed care and maintenance charges may subject the patient to discharge and forfeiture of benefits and may subject the patient, or other parties responsible, to legal action related to the recovery of valid indebtedness to the state of New Mexico.

(d) When a patient's veterans administration compensation and pension benefits have been reduced or stopped due to excessive resources or estate, a care and maintenance charge shall continue to be assessed at the level which would

otherwise be indicated if the-patient was still entitled to receive full veterans administration compensation and benefits.

(e) Income will be rounded to the nearest whole dollar when computing care and maintenance charges, and the care and maintenance charges will be rounded to the nearest whole dollar when assessments are made.

(f) Patients on leave from the center for outside hospitalization or medical care shall not be charged for care and maintenance after their fourth day of absence. Patients on leave from the center for personal reasons of their own volition shall continue to be charged for care and maintenance for such period of their leave that their bed is being held open for them.

[Recompiled 10/31/01]

7.25.10.16 NEPOTISM:

A. Purpose: To establish guidelines concerning hiring, transfer or promotion of employees who are related to other employees.

B. Definition: Relative is defined as the parent, spouse, child, brother, sister, brother-in-law, sister-in-law, father-in-law, mother-in-law, and persons residing in the incumbent's household.

C. Policy: It is the policy of the New Mexico veterans center to regulate the hiring and supervision of relatives in the following manner:

(1) Applicants for vacant positions will be required to complete a form disclosing any relatives he/she has in the hospital. (See attached form.)

(2) New hires related to current employees shall not be selected for any vacancy if the selection will result in either the candidate or his/her relative becoming the supervisor of the other.

(3) All current employees who wish to apply for vacancies will be made aware of the fact that no transfer or promotion will be approved or permitted if, as a result of transfer or promotion, either the candidate or his/her relative will be an immediate supervisor of the other.

(4) In addition to the preceding, it is strongly recommended that close relatives, as defined above, not work in the same department or section.

(5) Any exception from the above will be justified to the hospital administrator and/or the chairman of the veterans service commission.

[Recompiled 10/31/01]

CHAPTER 26: DEVELOPMENTAL DISABILITIES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.2 NMAC.]

PART 3: RIGHTS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.3 NMAC.]

PART 4: CLIENT COMPLAINT PROCEDURES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.4 NMAC.]

PART 5: SERVICE PLANS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.5 NMAC.]

PART 6: REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES COMMUNITY PROGRAMS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.6 NMAC.]

PART 7: (APPENDIX A) INDIVIDUAL TRANSITION PLANNING PROCESS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.7 NMAC.]

PART 8: (APPENDIX B) DISPUTE RESOLUTION PROCESS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.8 NMAC.]

PART 9: ADMISSION, DISCHARGE AND TRANSFER OF ELIGIBLE RECIPIENTS FOR SERVICES IN ICF/MR FACILITIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.371.9 NMAC.]

CHAPTER 27: EMERGENCY MEDICAL SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: LICENSING OF EMERGENCY MEDICAL SERVICES PERSONNEL

7.27.2.1 ISSUING AGENCY:

New Mexico Department of Health (DOH), Epidemiology and Response Division (ERD), Emergency Medical Systems Bureau (EMSB).

[7.27.2.1 NMAC - Rp, 7.27.2.1 NMAC, 12/12/2017]

7.27.2.2 SCOPE:

These rules apply to New Mexico emergency medical services, including the service directors and medical directors of those services; approved New Mexico EMS education programs and graduates of approved New Mexico EMS education programs; New Mexico licensed EMS personnel including those previously licensed; persons trained, certified, or licensed in another state or territory seeking to acquire licensure in New Mexico; EMS licensing commission; individuals certified with the national registry of emergency medical technicians; and any other entity associated with the licensing of emergency medical services personnel in New Mexico.

[7.27.2.2 NMAC - Rp, 7.27.2.2 NMAC, 12/12/2017]

7.27.2.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: 1) the New Mexico Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to "make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions;" and; 2) the Emergency Medical Services Act, Subsection A of Section 24-10B-5 NMSA 1978, which authorizes the department to adopt and enforce licensure requirements by regulation, and Paragraph (3) of Subsection B of Section 24-10B-5 NMSA 1978, which authorizes the department to establish a schedule of reasonable fees for application, examination, licensure and regular renewal thereof.

A. Administration: Administration and enforcement of these rules is the responsibility of the emergency medical systems bureau of the epidemiology and response division, department of health.

B. Guidelines: In the absence of specific direction in the law or these rules as to the standard of practice, the current national standard for emergency cardiac care (ECC), the national highway traffic safety administration of the United States department of transportation standard curriculum, and the EMT code of ethics, as

adopted in 1978 by the national association of emergency medical technicians, shall serve as guidelines.

C. Other law and regulations: These rules are subject to the provisions of the department of health's 7.1.3 NMAC, "*health records*."

D. Use of certain terms prohibited: The use of "licensed emergency medical dispatcher", "licensed emergency medical dispatch instructor", "licensed emergency medical services first responder", "licensed emergency medical technician (EMT)-basic", "licensed EMT-intermediate", or "licensed EMT-paramedic", or display of the "star of life" except as allowed in the United States department of transportation (US-DOT) trademark specifications, or similar terms or emblems connoting expertise in basic or advanced life support by any person not licensed hereunder is hereby prohibited. See Emergency Medical Services Act, Paragraph (1) of Subsection C of 24-10B-5 NMSA 1978.

[7.27.2.3 NMAC - Rp, 7.27.2.3 NMAC, 12/12/2017]

7.27.2.4 DURATION:

Permanent.

[7.27.2.4 NMAC - Rp, 7.27.2.4 NMAC, 12/12/2017]

7.27.2.5 EFFECTIVE DATE:

December 12, 2017, unless a later date is cited at the end of a section.

[7.27.2.5 NMAC - Rp, 7.27.2.5 NMAC, 12/12/2017]

7.27.2.6 OBJECTIVE:

These rules will inform the emergency medical services community of licensure requirements for emergency medical services personnel. It is the purpose of these rules to provide for the licensure of emergency medical dispatchers, emergency medical dispatch-instructors, emergency medical services first responders, and emergency medical technicians, and to assist in the provision of a comprehensive system of emergency medical services in the state of New Mexico.

[7.27.2.6 NMAC - Rp, 7.27.2.6 NMAC, 12/12/2017]

7.27.2.7 DEFINITIONS:

A. "Academy" means a separately funded emergency medical services education program administered through the department of emergency medicine of the university of New Mexico school of medicine.

B. "Act" means the Emergency Medical Services Act, Section 24-10B-1, *et seq*., NMSA 1978.

C. "Advance directive" means a written instruction, such as a living will, durable power of attorney for health care, or emergency medical services do not resuscitate form recognizable under state law and relating to the provision of health care when an individual is incapacitated.

D. "Advisory committee" means the statewide emergency medical services advisory committee appointed by the secretary of health.

E. "Ambulance service" means any provider of ambulance service subject to the jurisdiction of the department of health pursuant to and subject to the jurisdiction of the New Mexico public regulation commission, pursuant to the Ambulance Standards Act, Section 65-6-1, *et seq*., NMSA 1978, Article XI of the New Mexico Constitution, the Municipal Transit Law Section 3-52-1, *et seq*., NMSA 1978, and other laws.

F. "Applicant" means a person who has indicated an intention to gain licensure as an EMS first responder, emergency medical dispatcher, emergency medical dispatcher instructor, or an EMT in the state of New Mexico, as evidenced by submission of the proper fees, documentation, and bureau approved application form.

G. "Approved emergency medical services education program" means an emergency medical services education program that is sponsored by a post-secondary educational institution, accredited by a national educational accrediting organization for emergency medical services or active in the accreditation process and is approved by the joint organization on education committee and participates in the joint organization on education committee.

H. "Basic emergency medical technician" or **"EMT-B"** means a provider who has been licensed by the department to provide patient care according to the current scopes of practice.

I. "Bureau" means the emergency medical systems bureau of the epidemiology and response division of the New Mexico department of health.

J. "Bureau approved" means any course, form, or official document that has received the approval of the bureau for use in an education or licensure context.

K. "Cardio-pulmonary resuscitation (CPR)" means training required for licensure that meets the intent of the current national emergency cardiac care (ECC) guidelines for professional rescuers, as approved by the bureau.

L. "Certified emergency medical service" means an organization that meets minimum standards to provide emergency services and is approved by the bureau,

including emergency medical dispatch agencies, pre-hospital or inter-facility care services, and special event services organized to provide emergency medical services.

M. "Contact hour" means a unit of measurement of 60 minutes of bureau-approved organized learning experience which is designed to meet educational objectives for continuing education.

N. "Commission" means the New Mexico emergency medical services licensing commission appointed by the secretary of health.

O. "Continuing education" or **"CE"** means EMS education that is approved by the bureau and is required every two years for renewal of licensure.

P. "Conviction" means an adjudication of guilt, and does not include a deferred adjudication that results in dismissal of a charge.

Q. "Curriculum" means a program of study utilizing approved minimum curricula content based on the national standard curriculum for EMS as published by the national highway and traffic safety administration (NHTSA) and approved by the joint organization on education for formal education courses required for EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

R. "Department" means the New Mexico department of health (DOH).

S. "Distance Education - Asynchronous", also known as distributive education means a method of delivering training and education that does not require an educator and student to interact in real time. This may include computer-based-training and education, self-study modules, recorded broadcasts via satellite, internet, or other media, and other methods of out-of-classroom didactic education that includes an evaluation component.

T. "Distance Education - Synchronous" means a method of delivering training and education via electronic media that links an educator and students, allowing them to interact in real time despite being in different places. This includes live, instructor interactive satellite broadcasts, or webcasts that allow for live video, audio, or other immediate feedback, and communication between the instructor and the students.

U. "Emergency medical dispatcher" or **"EMD"** means a person who is trained and licensed pursuant to Subsection G of Section 24-10B-4 NMSA 1978 to receive calls for emergency medical assistance, provide pre-arrival medical instructions, dispatch emergency medical assistance and coordinate its response.

V. "Emergency medical dispatch agency" or **"EMDA"** means any organization, or a combination of organizations working cooperatively, that routinely accepts calls for emergency medical assistance and employs emergency medical dispatch priority reference system (EMDPRS) techniques.

W. "Emergency medical dispatch priority reference system" or **"EMDPRS"** means a medically approved reference system used by an emergency medical dispatch agency (EMDA) to dispatch aid to medical emergencies, which includes systematized caller interrogation; systematized pre-arrival instructions to the caller based upon protocols matching the dispatcher's evaluation of injury or illness severity; and prioritized vehicle response.

X. "Emergency medical services" or **"EMS"** means the services rendered by licensed providers in response to an individual's need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

Y. "Emergency medical services first responder" or **"EMSFR"** means a person who is licensed by the department, and who functions within the emergency medical services system to provide initial emergency aid according to the current scopes of practice.

Z. "Emergency medical services instructor/coordinator" or **"EMT-I/C"** means an individual who has met the qualifications of the joint organization on education and has been approved by an EMS education institution to conduct and instruct EMS education programs.

AA. "Emergency medical technician" or **"EMT"** means a provider who has been licensed by the
department to provide patient care according to the current scopes of practice.

BB. "Examination attempt" means an attempt to successfully complete the bureau approved EMS licensing examination. An attempt constitutes taking a written or practical examination. Retests of either a written or practical examination are considered an examination attempt.

CC. "Fully licensed" means an individual licensed to practice medical patient care at a specified level.

DD. "Graduate license" means a license issued to graduates of a bureau approved EMS education program used for performing EMS duties under supervision and direct observation prior to full licensure. The graduate license shall be valid for a period of up to six months from the date of course completion or until failure of any part of the bureau approved licensing examination.

EE. "Initial licensure" means the first time a person is licensed in New Mexico as an EMD, EMD instructor, EMS first responder, EMT, or subsequent licensure of a previously licensed New Mexico EMT, who has retaken a full curriculum or accomplished re-entry procedures to regain an expired license.

FF."Intermediate emergency medical technician" or **"EMT-I"** means a provider who has been

licensed by the department to provide patient care according to the current scopes of practice.

GG. **"License"** means a full, temporary or graduate license issued by the department to all EMDs, first responders, and EMTs pursuant to the Emergency Medical Services Act, Section 24-10B-5 NMSA 1978.

HH. **"Medical control"** means supervision provided by or under the direction of physicians to providers by written protocols or direct communication.

II. **"Medical direction"** means guidance or supervision provided by a physician to a provider or emergency medical services system and which includes authority over and responsibility for emergency medical dispatch, direct patient care and transport of patients, arrangements for medical control and all other aspects of patient care delivered by a provider.

JJ. **"Medical direction committee"** means a committee of physicians and EMTs, appointed by the secretary of health to advise the bureau on all matters relating to medical control and medical direction.

KK. **"Medical director"** means a physician who is responsible for all aspects of patient care provided by an EMS system or EMS provider service, in accordance with 7.27.3 NMAC.

LL."Moral turpitude" means conduct contrary to justice, honesty, modesty or good morals including such acts as fraud, theft, sexual assault, and other similar behavior.

MM. **"National registry"** means the national registry of emergency medical technicians based in Columbus, Ohio.

NN. **"Offline medical control"** means performing EMS actions or medication administration under
standing orders or protocols.

OO. **"Online medical control"** means direct voice contact with a medical control physician.

PP. **"Out-of-state transition course"** means a standardized education course required and approved by the bureau for an out-of-state EMT applicant seeking licensure in New Mexico.

QQ. **"Paramedic"** or **"EMT-P"** means a provider who has been licensed by the department to provide patient care according to the current scopes of practice.

RR. "Physician" means a doctor of medicine or doctor of osteopathy who is licensed or otherwise authorized to practice medicine or osteopathic medicine in New Mexico.

SS. "Protocol" means a predetermined, written medical care plan approved by the medical director and includes standing orders.

TT."Provider" means a person who has been licensed by the department to provide patient care
pursuant to the Emergency Medical Services Act.

UU. "Re-entry" means a process for a person, whose license has been expired for less than two years, to accomplish a given set of requirements to re-enter a previously held level of licensure.

VV. "Regional office" means an emergency medical services planning and development agency
formally recognized and supported by the bureau.

WW. "Re-instatement" means a process for those persons who have completed the renewal requirements before the December 31st deadline, but fail to renew licensure by March 31st, to renew licensure between April 1st and May 31st of the expiration year.

XX. "Renewal" means re-licensure every two years after completion of all requirements for specified levels by December 31st that occurs prior to expiration of licensure. Renewal applications shall be received or postmarked by the last day of February prior to the expiration to avoid a higher March fee, and may be postmarked or received by March 31 to avoid expiration or the payment of reinstatement or other higher fees.

YY. "Retest" means licensing examination given after failure of the applicant's initial examination.

ZZ."Secretary" means the New Mexico secretary of health.

AAA. "Special skills" means a set of procedures or therapies that are beyond the usual scope of practice of a given level of licensure and that have been approved by the medical direction committee for use by a specified provider.

BBB. "Standing orders" means strictly defined written orders for actions, techniques or drug administration, signed by the medical director, to be utilized when communication has not been made with an online medical control physician.

CCC. "State emergency medical services medical director" means a physician designated by the department to provide overall medical direction to the

statewide emergency medical services system, whose duties include serving as a liaison to the medical community and chairing the medical direction committee.

DDD. "Temporary license" means a license issued by the department to applicants that are fully licensed in another state or certified with the national registry of EMTs, as determined by the bureau. The temporary license shall be valid for a period of up to six months from the date issued, or until failure of any part of the licensing examination.

[7.27.2.7 NMAC - Rp, 7.27.2.7 NMAC, 12/12/2017]

7.27.2.8 GENERAL LICENSURE:

A. Authorizations to practice: No person shall function as, or represent themselves as an
emergency medical services provider or offer, whether or not for compensation, any services included in these rules, unless currently licensed as an emergency medical dispatcher (EMD), emergency medical dispatcher instructor (EMD-I), EMS first responder, or EMT under these rules. This provision is enforceable by civil action as provided by state law.

B. Licensing agency: As provided by law, the agency responsible for the licensure of an EMD EMD-I, EMS first responder, and EMTs in New Mexico is the emergency medical systems bureau of the epidemiology and response division of the department of health.

C. Eligibility: Initial licensure as an EMD, EMD-I, EMS first responder, or EMT is open to all persons who have met the requirements prescribed in these rules, whether or not they are affiliated with an ambulance service, fire department, rescue service, or other emergency medical service in New Mexico, and irrespective of their monetary remuneration for such service. Applicants for licensure must complete the criminal history background screening process as described at Section 24-10B-5.2 NMSA 1978.

D. The New Mexico registry of emergency medical services personnel: The New Mexico registry of emergency medical services personnel is established and maintained at the bureau. The registry is a database containing contact and other relevant licensure information for all licensed New Mexico EMS licensees.

E. Authorized classifications: There are six classifications of fully licensed EMS provider that are recognized in the New Mexico registry of emergency medical services personnel. The most recently attained level of provider licensure will be shown on the person’s certificate and licensure card. This section does not apply to a graduate license.

(1) Emergency medical dispatcher (EMD).

(2) Emergency medical dispatcher instructor (EMD-I).

(3) Emergency medical services first responder (EMSFR).

(4) Emergency medical technician - basic (EMT-B).

(5) Emergency medical technician - intermediate (EMT-I).

(6) Emergency medical technician - paramedic (EMT-P).

F. General education standards: New Mexico EMS education programs shall meet the education standards for approval by the joint organization on education and EMS bureau. The joint organization on education and EMS bureau shall periodically evaluate the education standards in each approved EMS education program, which may include an on-site inspection and review for compliance with the standards outlined in this section. Failure to maintain compliance with these standards may result in the loss of the approved program status, as determined by the joint organization on education. The joint organization on education and EMS bureau approved New Mexico EMS education program shall:

(1) when requested by the bureau or joint organization on education, submit a report to the joint organization on education and the EMS bureau that contains the following elements:

(a) number of courses that were instructed by the education program by level of education, i.e., EMS first responder, EMT-basic, EMT-intermediate, EMT-paramedic, EMS instructor-coordinator;

(b) pass/fail rate of each course of instruction where students are enrolled to receive course completion certificates, including the name of the course and the name of the instructor-coordinator;

(c) aggregate pass/fail rate of each level of EMS instruction where students are enrolled to receive course completion certificates;

(d) list of current instructor-coordinators employed with the bureau approved education program;

(e) list of new instructor-coordinators employed with the education program over the time period of the report;

(f) any changes in the status of any instructor-coordinator;

(g) any changes to the EMS curriculum at any level of instruction;

(h) summary of any quality improvement activities accomplished during the time period of the report;

(i) list of clinical skills required for course completion by level, if applicable;

(j) list of satellite campuses; and

(k) contact information of key staff with the education program;

(2) be accredited by a national education accrediting organization for emergency medical services;

(3) utilize approved minimum curricula content based on the national standard curriculum
for EMS as published by the national highway and traffic safety administration (NHTSA) and approved by the joint organization for education committee (JOE);

(4) have, at a minimum, an administrative director, an EMS medical director, and a lead instructor-coordinator for each EMS licensing or refresher course;

(5) ensure that an instructor-coordinator is in attendance at all didactic and practical education sessions, with substitution permissible as approved by the joint organization;

(6) inform the bureau if an instructor/coordinator is terminated due to inappropriate conduct or negligence; the bureau shall be notified by the education program of the termination within 10 working days;

(7) develop and utilize an instructional quality assurance program to review course and instructor effectiveness; a copy of the quality assurance program shall be provided to the joint organization on education and the EMS bureau; complaints, reports, or course trends may indicate the need for a quality assurance review by the joint organization on education and the EMS bureau;

(8) submit to the bureau for approval, refresher course curricula that follow the New Mexico refresher course blueprints as outlined in 7.27.2.11 NMAC of these rules, whether the course is conducted by the education program or through a service education agreement, which has been approved by the education program;

(9) use distributive and distance education for initial formal education courses as deemed necessary by the approved EMS education program, based on the education guidelines provided by the joint organization on education committee;

(10) review and approve any formal EMS courses and course content that will allow graduates to apply for EMS licensure in the state of New Mexico, prior to delivery by an instructor-coordinator;

(11) ensure that all affiliated instructor-coordinators are approved by the joint organization on education;

(12) ensure that a formal preceptor program is developed and utilized for all field and clinical education; the preceptor program shall include the following standards:

(a) EMS providers functioning as preceptors within an EMS service have written approval from the EMS service director, the EMS service medical director, the education program service director, and the education program medical director; preceptors shall be licensed as a provider at or above the student's level of education; preceptors shall ensure that only approved skills, commensurate with the student's scope of education, are performed by the student under direct observation by the approved preceptor;

(b) students practicing in a field education environment shall function under a formal field preceptorship agreement between the EMS service and the education program;

(c) students performing field or clinical skills as part of a bureau approved EMT-intermediate or EMT-paramedic education program must be fully licensed at a minimum of the New Mexico EMT-basic level, or have been granted special permission by the EMS bureau; and

(d) students from approved New Mexico EMS education programs may participate in a field education environment (which includes both clinical and internship experience) within the state of New Mexico; EMS educational programs based out of state must be nationally accredited by an EMS bureau approved accrediting organization, and obtain permission from the EMS bureau and JOE for their students to participate in a field education environment within the state of New Mexico.

G. Education program instructor-coordinator standards: Approved New Mexico EMS education programs shall maintain instructor-coordinator standards to ensure quality of instruction. Instructor-coordinators shall:

(1) be affiliated with an approved EMS education program;

(2) successfully complete an instructor-coordinator education course that meets or exceeds the national standard curriculum for EMS instructor-coordinators as published by NHTSA and approved by the joint organization on education and the EMS bureau;

(3) be currently licensed as a New Mexico EMS provider; and

(4) shall meet the qualifications for instructor-coordinators as established by the joint organization on education committee.

H. Scope of practice: The scope of practice for each level of licensure is found in 7.27.11.2 NMAC and shall be updated at least annually and issued by the bureau in accordance with the EMS Act, Paragraph (4) of Subsection C of Section 24-10B-7 NMSA 1978. Licensed EMDs, EMSFRs and EMTs shall only perform those skills, techniques, medications, and procedures found within the New Mexico scope of practice and as authorized by the service medical director (also see EMS medical direction rule 7.27.3 NMAC).

I. Training and education required: As outlined in the New Mexico scopes of practice, prior to utilizing any new skill, technique, medication, or procedure designated as "service medical director approved", it shall be documented by the service director, medical director, or bureau approved EMS education program that the EMS provider has been appropriately trained to administer the medications or perform the skills, techniques, medications, or procedures. Additionally, each EMS provider must have a signed authorization from the services medical director on file at the EMS services headquarters, or administrative offices.

J. Medical direction approval/control required: Medical control is required for certain skills and medications use at all levels of EMS as outlined in the New Mexico scopes of practice. Those EMS personnel who function without medical direction shall only perform those skills, techniques, and procedures that do not require medical director approval. Any person who is issued a temporary or graduate license shall only administer the medications or perform the skills, techniques, medications, and procedures for the approved level, as established by the medical direction committee and found in the applicable scope of practice.

K. Special skills: Special skills, which are all considered advanced life support, are skills outside the usual scope of practice for a level of licensure. EMS services or systems that wish to apply for special skills authorization shall submit a written application as set forth in 7.27.11.10 NMAC. Services or systems may apply for any skill at any level. Personnel who successfully complete a special skills program shall be authorized to utilize advanced skills and drugs only with medical director approval and under the medical control of the EMS system that received the program approval.

L. Licensing application procedures: Persons seeking New Mexico licensure in any of the six classifications shall apply using the appropriate forms as provided by the bureau and present the required documentation, which shall remain in the person’s licensure file. Applications and forms can be obtained from the bureau.

M. Licensure periods: Licensure periods are 27 months in length except for the initial period, which varies according to the date of the initial license. The second or subsequent period of licensure will be for a full 27 month period, regardless of the date of application for renewal, or the date for processing of the renewal license. This period will begin on January 1 of the renewal year. Requirements for renewal of licensure shall be completed by the December 31st that occurs prior to expiration of licensure.

N. Expiration dates: The expiration date for a license is established as March 31 of a given year. The year of initial expiration will depend on what month during the year a person was originally licensed.

(1) The initial licensure period shall begin on January 1 for persons who are licensed during the first six months of a given year. The expiration date for this license will be 27 months later or March 31. All subsequent renewal periods will be for a full 27 month period running from January 1 for twenty-seven months, and ending in March.

(2) For persons who are initially licensed during the last six months of a given year, the expiration date shall be calculated from January 1 of the following year.

O. New Mexico EMS bureau approved licensing examinations: All EMS candidates must successfully complete the bureau approved licensing examination.

(1) The initial licensing examination shall be completed within twelve months based from the date of course completion. Successful completion of the licensing examination process that results in the issuance of a license shall be completed within 24 months based from the date of course completion. Should a candidate fail to become licensed within 24 months, not complete the initial licensing examination attempt within twelve months of course completion, or fail to successfully complete the bureau approved licensing examination within six attempts, the candidate must complete a new initial education course. The EMS bureau chief or designee may approve an initial licensing testing extension on a case by case basis.

(2) Applicants for state licensure shall pay the appropriate licensing fee upon submission of application to the bureau (see 7.27.2.13 NMAC for a complete description of licensing fees).

(3) There will be no refund of fees, except in unusual circumstances as determined by the bureau.

P. Graduate license for all EMT levels: The role of the EMS graduate license is to grant graduates of a bureau approved EMS education program authorization to practice skills commensurate with their scope of training and education in the field setting under the direct observation and supervision of a New Mexico EMS provider licensed at or above the graduate's education program level. The graduate license shall only be used under approved medical direction. The EMS service director and the EMS service medical director shall identify and maintain a list of approved preceptors. The graduate licensee shall be fully supervised by the preceptor when performing patient care. The preceptor will be responsible for all patient care including patient care activities in the patient compartment when transporting to a medical facility. This will necessitate a vehicle driver in addition to the licensed EMT preceptor and the graduate licensee. During a mass casualty incident, the graduate licensee shall only provide assessment and treatment at the level for which the graduate licensee is fully licensed; if the graduate licensee is not fully licensed at a lower level, they shall only provide non-

medical assistance. The EMS graduate license shall remain in effect for a period of six months after the course completion date or until failure of any portion of the bureau approved licensing examination. All applicants for graduate licensure shall:

(1) submit a completed bureau approved license application form;

(2) provide evidence of current bureau approved CPR certification;

(3) provide evidence of current bureau approved ACLS certification (paramedic only);

(4) provide a course completion certificate from a bureau approved EMS education program; and

(5) pay all licensure fees as required by these rules.

Q. Americans with Disabilities Act: When requested by an applicant who otherwise meets the minimum qualifications, the department shall reasonably accommodate the qualified person with disabilities in the licensure process, in accordance with the Americans with Disabilities Act and other applicable state and federal laws. Persons requiring accommodations must make an advance request at least 30 calendar days prior to the EMS bureau scheduled activity. The request for accommodation shall be forwarded to the bureau for consideration of such an accommodation, to include supporting documentation from the applicant’s health care provider and a medical or professional diagnosis.

R. Recognition of out-of-state licensure for emergency incidents and other short term and mission specific situations: During emergency situations and other short term and mission specific situations, the bureau may waive initial licensure requirements for out-of-state EMS personnel based on the following:

(1) an individual or agency must be responding to a specific emergency incident;

(2) an individual or agency shall contact the EMS bureau prior to beginning EMS operations in New Mexico;

(3) the individual or agency shall provide evidence (copies) of individual certification or licensure from another state or the national registry;

(4) if wildland fire, an individual or agency shall provide a national wildland fire "request for recognition" form;

(5) an individual or agency shall provide evidence of written medical protocols and scope of practice; the bureau may restrict the provided scope of practice;

(6) the individual or agency shall contact the local EMS system for coordination of services; and

(7) the maximum approved time for out-of-state licensure for a specific emergency incident is 30 days and may be renewed on a case by case basis.

[7.27.2.8 NMAC - Rp, 7.27.2.8 NMAC, 12/12/2017]

7.27.2.9 INITIAL LICENSURE:

A. General: This section specifies requirements for initial licensure. This section applies to all applicants who are graduates of bureau approved EMS education programs. Any person applying for New Mexico licensure from out-of-state, other programs, or with national registry certification shall meet the requirements for licensure described in Section 7.27.2.10 NMAC. Specific time periods apply for EMS licensing examinations, according to Subsection O of 7.27.2.8 NMAC.

B. Recognition: The bureau may legally recognize other states, programs, or the national registry of emergency medical technicians requirements, where accreditation, EMS scope of practice, education standards, certification or licensure standards meet or exceed those of New Mexico.

C. Licensed emergency medical dispatcher (EMD): Licensure as an emergency medical dispatcher in New Mexico is mandatory for all persons who provide pre-arrival medical instructions to the emergency and non-emergency caller.

(1) An applicant for licensure as an EMD shall:

(a) be 18 years of age, and be of good character;

(b) provide evidence of a current bureau approved CPR certification; or, if physically unable to be CPR certified, provide written documentation of current knowledge and practical applications of CPR, as defined in these rules;

(c) successfully complete an EMD education course, which has been approved by the bureau, that meets or exceeds the U.S. department of transportation (USDOT) standards for EMD, within the previous 12 months;

(d) meet all other licensing requirements found in 7.27.2.8 NMAC of these rules;

(e) submit the required application and licensure fees as required by these rules; and **(f)** provide a valid personal (i.e., non-service or business) address in the application materials.

(2) Persons who do not have a certificate of completion from a New Mexico approved EMD
education program but are currently certified or licensed in another state as an EMD, or have successfully completed an equivalent out-of-state EMD education course as determined by the bureau, within the previous 12 months, may apply for licensure by submitting an application along with documentation of current out-of-state certification or licensure, or an out-of-state EMD course completion certificate.

(3) Upon recognition by the bureau, the person may be fully licensed as an EMD.

D. Licensed EMD-instructor: An applicant for licensure as an EMD-instructor shall:

(1) be a licensed EMT-basic, or higher level of licensure; or, if physically unable to be licensed as an EMT-basic, provide verification of successful course completion from an EMT-B education program;

(2) have graduated from high school or possess a general education diploma (GED);

(3) be 18 years of age, and be of good character;

(4) provide evidence of a current bureau approved CPR certification; or, if physically unable to be certified for CPR, provide written documentation of current knowledge and practical applications of CPR, as defined by these regulations;

(5) be currently licensed as an EMD;

(6) have successfully completed, within the previous 12 months, an EMD-instructor education course from an EMD program which is approved by the bureau;

(7) provide a valid personal (i.e., non-service or business) address in the application materials;

(8) meet all other licensing requirements found in 7.27.2.8 NMAC of these rules; and submit the required application and licensure fees as required by these rules.

E. Licensed emergency medical services first responder: An applicant for licensure as an EMS

first responder shall:

(1) be of good character; and

(2) be at least 18 years of age; or

(3) be at least 16 years of age and meet the following requirements:

(a) be affiliated with a service, and shall submit a letter of support from the service director;

(b) shall notify the bureau, in writing, of any change of service affiliation; and

(c) shall submit a notarized parental or guardian consent;

(4) all applicants shall meet the following requirements:

(a) submit a completed, bureau approved license application form;

(b) provide evidence of current bureau approved CPR certification;

(c) present a certificate of completion from an EMSFR course completed within the previous 24 months at a bureau approved EMS education program;

(d) successfully complete the bureau approved EMSFR licensing examination within six attempts; the initial licensing examination shall be completed within twelve months from the date of course completion; successful completion of the licensing examination process that results in the issuance of a license shall be completed within 24 months from the date of course completion;

(e) copy of national registry of EMTs emergency medical responder certification card acquired after bureau approved course and examination completion;

(f) provide a valid personal (i.e., non-service or business) address in the application materials;

(g) meet all other licensing requirements found in 7.27.2.8 NMAC of these rules; and

(h) pay all licensure fees as required by these rules.

F. Emergency medical technician basic (EMT-B): An applicant for licensure as an EMT-B shall
meet the following requirements:

(1) shall be of good character; and

(2) be at least 18 years old; or

(3) be at least 17 years of age and meet the following requirements:

(a) be affiliated with an EMS service, and shall submit a letter of support from the service director;

(b) shall notify the bureau, in writing, of any change of service affiliation; and

(c) shall submit a notarized parental or guardian consent;

(4) all applicants who are graduates of a bureau approved EMS education program may apply for graduate licensing, which allows them to work temporarily under direct supervision, as outlined in 7.27.2.8 NMAC of these rules;

(5) all applicants applying to be licensed, shall meet the following requirements:

(a) submit a completed, bureau approved license application form;

(b) provide evidence of current bureau approved CPR certification;

(c) present a certificate of completion from an EMT-B course completed at a bureau approved EMS education program, and accomplished within the previous 24 months;

(d) successfully complete the bureau approved EMT-B licensing examination within six attempts; the initial licensing examination shall be completed within twelve months based on the date of course completion; successful completion of the licensing examination process that results in the issuance of a license shall be completed within 24 months based on the date of course completion;

(e) copy of national registry of EMTs emergency medical technician certification card acquired after bureau approved course and examination completion;

(f) provide a valid personal (i.e., non-service or business) address in the application materials;

(g) meet all other licensing requirements found in 7.27.2.8 NMAC of these rules;

(h) pay all licensure fees as required by these rules.

G. Emergency medical technician-intermediate (EMT-I): An applicant for licensure as an EMT-I shall meet the following requirements:

(1) be 18 years old, and be of good character;

(2) submit a completed, bureau approved license application form;

(3) provide evidence of current bureau approved CPR certification;

(4) be fully licensed as an EMT-basic;

(5) present a certificate of completion from an EMT-I course completed at a bureau approved EMS education program, and accomplished within the previous 24 months;

(6) successfully complete the bureau approved EMT-I licensing examination within six attempts; the initial state licensing examination shall be completed within twelve months based on the date of course completion; successful completion of the licensing examination process that results in the issuance of a license shall be completed within 24 months based on the date of course completion;

(7) submit a copy of national registry of EMTs advanced emergency medical technician certification card acquired after bureau approved course and examination completion;

(8) provide a valid personal (i.e., non-service or business) address in the application materials;

(9) meet all other licensing requirements found in 7.27.2.8 NMAC of these rules;

(10) pay all licensure fees as required by these rules;

(11) all applicants who are graduates of a bureau approved EMS education program may apply for graduate licensing which allows them to work temporarily under supervision, as outlined in 7.27.2.8 NMAC of these rules.

H. Emergency medical technician paramedic (EMT-P): All applicants applying to be licensed at the EMT-P level shall meet the following requirements:

(1) be 18 years old, and be of good character;

(2) present, at a minimum, a high school diploma or general education diploma (GED);

(3) submit a completed bureau approved license application form;

(4) provide evidence of current bureau approved CPR certification;

(5) present proof of current bureau approved education which meets or exceeds the current national standard for advanced cardiac life support (ACLS) on emergency cardiac care (ECC);

(6) provide a valid personal (i.e., non-service or business) address in the application materials;

(7) pay all licensure fees as required by these rules.

I. Graduates of an approved and accredited New Mexico education program shall:

(1) submit a certificate of completion from the education program; successful completion of the EMT-P education program must have been accomplished within the previous 24 months;

(2) successfully complete the bureau approved EMT-P licensing examination;

(3) copy of national registry of EMTs paramedic certification card acquired after bureau approved course and examination completion;

(4) meet all other licensing requirements found in 7.27.2.8 NMAC of these rules; and

(5) all applicants who are graduates of a bureau approved EMS education program may apply for graduate licensing which allows them to work temporarily under direct supervision, as outlined in 7.27.2.8 NMAC;

(6) be fully licensed as an EMT-B or EMT I.

J. Surrendering a license in order to downgrade to a lower level of licensure: EMS personnel may petition the bureau to surrender their current license and downgrade to a lower level of licensure per the following:

(1) they are in good standing at the current level of licensure;

(2) the eligibility and renewal requirements (if doing this at the time of renewal) have been met for the lower EMS level (i.e., CE, CPR, criminal background check, etc.); and

(3) if the provider requests that the downgraded license be upgraded to the original level of licensure, the provider must meet the re-entry requirements to reacquire the original level of licensure in accordance with Subsection L of 7.27.2.11 NMAC of these rules.

[7.27.2.9 NMAC - Rp, 7.27.2.9 NMAC, 12/12/2017]

7.27.2.10 RECIPROCITY:

A. Individuals who are currently licensed or certified in another state may apply for New Mexico EMS licensure as provided in this section. Individuals holding a certification

with the national registry of EMTs at any level must also be licensed/certified by a state or other recognized jurisdictional authority to be eligible for reciprocity, unless otherwise approved by the bureau. The individual shall:

(1) submit an application for the appropriate licensure level along with a copy of a current state certification/licensure card;

(2) provide a copy of a current bureau approved CPR certification card;

(3) if applying for the EMT-P level, provide a copy of current bureau approved education which meets or exceeds the current national standard for advanced cardiac life support (ACLS) on emergency cardiac care (ECC);

(4) pay the appropriate out-of-state reciprocity fee as required by these rules; there will be no refund of fees, except in unusual circumstances; as determined by the bureau;

(5) if applying for the EMSFR, EMT-B and EMT-I level, successfully complete a bureau approved transition course for out-of-state applicants, as determined by the EMS bureau;

(6) successfully complete the New Mexico reciprocity written examination at the appropriate licensure level within three attempts and if, requested by the EMS bureau, successfully demonstrate appropriate practical skills proficiency; the initial state reciprocity examination shall be completed within nine months from the date the application was received at the EMS bureau; successful completion of the examination process that results in the issuance of a NM EMS license shall be complete within 12 months from the date the application was received at the EMS bureau; and

(7) meet all other licensing requirements found in 7.27.2.8 NMAC of these rules.

B. Additional provisions:

(1) **Frequency:** an out-of-state reciprocity application for an individual will only be accepted once in a 12 month time period.

(2) **Temporary licensure:** a reciprocity applicant may be granted a temporary license to
practice at the appropriate licensure level for a period of up to six months or until failure of any part of the reciprocity examination, whichever occurs first.

(a) while under a temporary license, those applicants seeking full New Mexico licensure at the EMSFR, EMT-B, or EMT-I level shall complete a bureau approved out-of-state transition course and complete the New Mexico reciprocity examination;

applicants applying at the EMT-P level shall complete the New Mexico paramedic reciprocity examination;

(b) applicants holding a temporary license shall be fully licensed when they have successfully completed New Mexico EMS reciprocity examination at the appropriate licensure level and remit payments of required fees, all applicants are required to keep their out-of-state license or certification current until the New Mexico reciprocity process is successfully completed;

(c) temporary licenses issued to out-of-state reciprocity candidates shall only be issued once during a 12 month period;

(d) temporary licensure commences on the issue date of the temporary license from the bureau;

(e) a temporary license may be issued only upon application and payment of required fees.

(3) Seasonal licensure: an out-of-state EMS caregiver may apply for a seasonal license. A seasonal license will allow the caregiver to provide care at a scope of practice approved by the bureau, not to exceed the New Mexico scope of practice:

(a) seasonal licenses issued to applicants for a seasonal license shall be issued once in a 12 month period, unless otherwise determined by the bureau for good cause; the seasonal license is valid for three months from the date of issue, except as otherwise approved by the bureau;

(b) the applicant must provide proof of licensure from another state, unless otherwise determined by the bureau;

(c) applicants for a seasonal license must show proof of New Mexico medical direction provided by a medical director in accordance with 7.27.3 NMAC, and provide the bureau with the medical director approved protocols;

(d) the applicant must submit a completed application with appropriate fees.

[7.27.2.10 NMAC - Rp, 7.27.2. 10 NMAC, 12/12/2017]

7.27.2.11 LICENSURE RENEWAL:

All licensed New Mexico EMS providers are required to renew their license every two years. Current renewal documents and information may be obtained from the bureau, website, or by requesting them from the bureau. Individuals renewing their New Mexico EMS provider's license shall submit verification of the required number of continuing education (CE) hours, as described for each licensure level. Required certification or education, such as *advanced cardiac life support* (ACLS) or cardiopulmonary

resuscitation (CPR), may each be used once to fulfill a portion of the CE hour requirement during each two year renewal period. Additional cards may not be used for additional CEs. New Mexico license renewal requirements may not match those of national registry or other states; it is the individual's responsibility to assure their completed CE meets the requirements of other states or the national registry if they want to renew those certifications and licensures. A maximum of one-half of the required number of CEs necessary for renewal for each level may come from asynchronous distance/distributive learning programs as defined later in this rule. This may differ from the requirement for maintaining national registry certification.

A. Receipt of licensure renewal from the EMS bureau: Licensing renewal is the responsibility of each individual licensee. A renewal applicant shall provide a valid personal (i.e., non-service or business) address in the application materials. If an individual licensee fails to notify the bureau of a change of address within one-year from the date of relocation, as determined by the bureau, a bad address fee may be assessed by the bureau. For individuals who have submitted their complete licensure renewal packet to the bureau in a timely manner, the bureau will review the renewal requests in the order they are received.

(1) If there is a delay in notification from the bureau about the status of the licensure renewal beyond the expiration of the license, the individual shall remain licensed until:

(a) notified by the bureau that the license application has been denied or the license expired without renewal; or

(b) they receive their license from the bureau or the bureau website lists the individual as licensed.

(2) If an individual's renewal packet is incomplete, the individual shall be notified by the bureau by U.S. postal mail or by electronic mail.

(3) If an individual licensee is notified that a renewal problem exists with their license, and the license has expired, the individual shall not remain licensed, and their name will be removed from the list of those licensed on the bureau website.

B. Renewal deadlines: Specific renewal requirements must be completed no later than the December 31st that occurs prior to licensure expiration. Required CPR and ACLS certifications and education are exempt from the December 31st deadline and must be current at the time of renewal, unless the renewal applicant is also using the ACLS or CPR certification(s) for CE, at which time the course(s) must have been completed prior to December 31. In order to pay the standard renewal fees, renewal applications must be postmarked or received by the bureau by the last day of February prior to expiration of licensure. Renewal applications postmarked or received after the last day of February, but before March 31, will be accepted but require a higher fee as described later in this rule.

(1) The applicant may submit the complete renewal application to the bureau as soon as requirements are complete; the complete renewal application shall be postmarked no later than the final month of licensure. A normal renewal fee is assessed for renewal applications postmarked prior to the final month of licensure.

(2) Renewal applications received during the final month of licensure will be accepted, but will be assessed a higher renewal fee due to the requirement for speedier processing.

(3) Applications for renewal of licensure shall be postmarked or received no later than the last day of licensure (March 31st).

C. Mandatory updates: The bureau may require mandatory updates to education in any given year of licensure. Mandatory updates may include required content hours during specific continuing education courses or other mandatory classes.

D. Audits: The bureau may require full documentation of continuing education, including copies of certification cards, course completion certificates, and any other relevant documents from any individual applying for renewal of their license.

E. Waivers: The licensing commission may, for good cause shown, waive portions of these rules pertaining to licensure renewal pursuant to 7.27.2.14 NMAC of these rules. Persons requesting waivers for licensure renewal shall submit requests in writing to the EMS licensing commission, in care of the bureau.

F. Licensed emergency medical dispatcher (EMD): Renewal for a licensed EMD is required within each licensure period. Documentation must show that all renewal requirements have been completed before the December 31st that occurs prior to expiration of licensure. Cardiopulmonary resuscitation (CPR) education/certification is exempt from the December 31st deadline and must be current at the time of renewal, unless the renewal applicant is also using the CPR certification for CE, at which time the course must have been completed prior to December 31. If the EMD is concurrently licensed as an EMT-B, EMT-I, or EMT-P, the renewal dates for EMD licensure may be adjusted by the bureau to match the renewal dates for the EMT-B, EMT-I, or EMT-P license. The following requirements are necessary for a person to renew their EMD license:

(1) submit copies of course completion certificates or verification showing a minimum of 20 contact hours of CE activity; of which at least 10 hours shall be medical subjects/skills of bureau approved CE activity and 10 hours of dispatch related subjects/skills, unless the EMD is also licensed at the EMT-B, EMT-I, or EMT-P level; the EMD may then use those contact hours of CE activity obtained during the renewal period for the EMT-B, EMT-I, or EMT-P licensure toward the medical renewal requirements;

(2) provide evidence of current bureau approved CPR certification and education; or, if physically unable to be certified for CPR, provide written documentation of current knowledge and practical applications of CPR; and

(3) submit required application and payment of all license renewal fees as required by these rules.

G. Licensed emergency medical dispatcher-instructor: Renewal of a licensed EMD-instructor is required within each licensure period. Documentation must show that all renewal requirements have been completed before the December 31st that occurs prior to expiration of licensure. Cardiopulmonary resuscitation (CPR) education/certification is exempt from the December 31st deadline and must be current at the time of renewal, unless the renewal applicant is also using the CPR certification for CE, at which time the course must have been completed prior to December 31. The following requirements are necessary for a person to renew their EMD-I license:

(1) submit verification from a bureau approved EMD education program showing that the EMD- instructor is current and in good standing with the approved EMD education program;

(2) submit verification of completion of all EMD CE renewal requirements;

(3) submit a copy of current licensure at the EMT-B or higher level;

(4) provide evidence of current bureau approved cardiopulmonary resuscitation (CPR) education or certification; or, if physically unable to be certified for CPR, provide written documentation of current knowledge and practical applications of CPR; and

(5) submit the required application and payment of all licensure renewal fees as required by these rules.

H. Emergency medical services first responder: Renewal of the EMSFR license is required within each licensure period. Documentation must show that all renewal requirements have been completed on or before the December 31st that occurs prior to expiration of licensure. Cardiopulmonary resuscitation (CPR) education/certification is exempt from the December 31st deadline and shall be current at the time of renewal, unless the renewal applicant is also using the CPR certification for CE, at which time the course must have been completed prior to December 31. The following requirements are necessary for a person to renew their license:

(1) submit a completed renewal application;

(2) submit verification of a minimum of twenty contact hours of bureau approved CE activity consisting of the following subjects and minimum hours per subject:

(a) preparatory/operations, two hours;

(b) airway and ventilation, three hours;

(c) cardiovascular emergencies, two hours;

(d) medical emergencies, four hours;

(e) trauma emergencies, four hours;

(f) special considerations, five hours, two of which must consist of pediatric content.

(3) provide evidence of current bureau approved cardiopulmonary resuscitation education or certification;

(4) provide a statement of verification, signed by the service medical director, that the applicant is competent in all EMSFR skills listed in the current scopes of practice that require medical direction; and

(5) submit payment of all licensure renewal fees as required by these rules.

I. Emergency medical technician basic (EMT-B): Renewal of the EMT-B license is required within each licensure period. Documentation must show that all renewal requirements have been completed on or before the December 31st that occurs prior to expiration of licensure. Cardiopulmonary resuscitation (CPR) education/certification is exempt from the December 31st deadline and shall be current at the time of renewal, unless the renewal applicant is also using the CPR certification for CE, at which time the course must have been completed prior to December 31. The following requirements are necessary for an EMT-B to renew their license:

(1) submit a completed renewal application;

(2) submit verification of a minimum of 40 contact hours of bureau approved CE activity, consisting of the following subjects and minimum hours per subject:

(a) preparatory/operations, four hours;

(b) airway and ventilation, six hours;

(c) cardiovascular emergencies, six hours;

(d) medical emergencies, eight hours;

(e) trauma emergencies, eight hours;

(f) special considerations, eight hours, four of which must consist of pediatric content.

(3) provide evidence of current bureau approved cardiopulmonary resuscitation (CPR) education or certification;

(4) provide a statement of verification, signed by the service medical director, that the applicant is competent in all EMT-basic skills listed in the current scopes of practice that require medical direction;

(5) submit payment of all licensure renewal fees as required by these rules; and

(6) applicants who have completed a bureau approved EMT-I or EMT-P course or completed appropriate sections of the EMT-I or EMT-P course, as determined by the bureau, may fulfill the CE requirement.

J. Emergency medical technician intermediate (EMT-I): Renewal of the EMT-I license is required within each licensure period. Documentation must show that all renewal requirements have been met on or before the December 31st that occurs prior to expiration of licensure. Cardiopulmonary resuscitation (CPR) education/certification is exempt from the December 31st deadline and shall be current at the time of renewal, unless the renewal applicant is also using the CPR certification for CE, at which time the course must have been completed prior to December 31. The following requirements are necessary for an EMT-I to renew their license:

(1) submit a completed renewal application;

(2) submit verification of a minimum of 50 contact hours of bureau approved CE activity, consisting of the following subjects and minimum hours per subject:

(a) preparatory/operations, four hours;

(b) airway and ventilation, eight hours;

(c) cardiovascular emergencies, six hours;

(d) medical emergencies, 12 hours;

(e) trauma emergencies, 10 hours;

(f) special considerations, 10 hours, five of which must consist of pediatric content.

(3) provide evidence of current bureau approved cardiopulmonary resuscitation (CPR) education or certification;

(4) provide a statement of verification, signed by the service medical director, that the applicant is competent in all EMT-intermediate skills listed in the current scopes of practice that require medical direction. Persons who are not currently providing care through an EMS provider service and do not have a service medical director may for good cause petition the bureau for designation of inactive status, which will remain in effect until the bureau is notified of the applicant obtaining medical direction. No patient care should be performed until the inactive status is removed;

(5) submit payment of all licensure renewal fees as required by 7.27.2.13 NMAC of these rules; and

(6) applicants who have completed a bureau approved EMT-P course or completed appropriate sections of the EMT-P course, as determined by the bureau, may fulfill the continuing education requirement.

K. Emergency medical technician paramedic (EMT-P): Renewal of the EMT-P license is required within each licensure period. Documentation must show that all renewal requirements have been completed on or before the December 31st that occurs prior to the expiration of licensure. Cardiopulmonary resuscitation (CPR) education/certification and advanced emergency cardiac care education/advanced cardiac life support (ACLS) certifications are exempt from the December 31st deadline and shall be current at the time of renewal, unless the renewal applicant is also using the ACLS or CPR certification(s) for CE, at which time the course(s) must have been completed prior to December 31. The following requirements are necessary for an EMT-P to renew their license:

(1) submit a completed renewal application;

(2) submit verification of a minimum of 60 contact hours of bureau approved CE activity at any level, consisting of the following subjects and minimum hours per subject:

(a) preparatory/operations, six hours;

(b) airway and ventilation, eight hours;

(c) cardiovascular emergencies, 10 hours;

(d) medical emergencies, 14 hours;

(e) trauma emergencies, 10 hours;

(f) special considerations, 12 hours, six of which must consist of pediatric content.

(3) provide a statement of verification, signed by the service medical director, that the applicant is competent in all EMT-paramedic skills listed in the current scopes of practice that require medical direction. Persons who are not currently providing care through an EMS provider service and do not have a service medical director may for good cause petition the bureau for designation of inactive status, which will remain in effect until the bureau is notified of the applicant obtaining medical direction. No patient care should be performed until the inactive status is removed;

(4) submit proof of current bureau approved education which meets or exceeds the current national standards for advanced emergency cardiac care education, or advanced cardiac life support (ACLS) certification;

(5) provide evidence of current bureau approved cardiopulmonary resuscitation (CPR) education or certification; and

(6) submit payment of all licensure renewal fees as required by 7.27.2.13 NMAC of these rules.

L. Re-attaining a license after expiration for all categories: The bureau provides three methods for expired licensees to regain their licensure; reinstatement, re-entry, and re-licensure.

(1) Reinstatement: Those persons who have completed the renewal requirements on or before the December 31st cutoff, but failed to renew licensure by March 31st, may renew between April 1st and May 31st of the expiration year. A complete renewal application for reinstatement must be received at the bureau by May 31st. Paperwork postmarked after March 31st will be assessed with an additional late fee (see fees, 7.27.2.13 NMAC).

(2) Re-entry: A person whose license is expired, who does not meet the circumstances of Paragraph (1) of Subsection L of 7.27.2.11 NMAC above, but whose date of expiration of the previously held license is less than two years, may re-enter EMS at the previously held or lower level if the person left EMS in good standing and successfully completes the following:

(a) for basic, intermediate and paramedic, complete a minimum of half of the number of hours of bureau approved continuing education at the appropriate level within the twelve months preceding the date of application for re-entry; the number and subjects of CEs must equal a minimum of half of the requirements for renewal of the level for which the individual is applying for, as described herein;

(b) for first responder, complete a minimum of 10 hours of bureau approved continuing education within the twelve months preceding the request for re-entry; the number and subjects of CEs must equal a minimum of half of the requirements for renewal of the first responder level as described herein;

(c) provide evidence of current bureau approved cardiopulmonary resuscitation (CPR) education or education, which may not be used as part of the CE hour requirement;

(d) successfully complete an approved New Mexico licensing examination and other practical examinations, as determined by the bureau, at the appropriate provider licensure level (maximum of two examination attempts allowed), if applicable;

(e) if EMD or EMD-I applicant, provide verification of a minimum of 10 contact hours of bureau approved CE activity, of which 5 hours shall be medical subjects/skills and 5 hours shall be dispatch related subjects/skills of bureau approved CE activity;

(f) if an EMT-P applicant, provide evidence of bureau approved advanced emergency cardiac care education/advanced cardiac life support (ACLS) certification education which may not be used as part of the CE hour requirement; and

(g) submit required application and payment of licensure fees as identified for the appropriate level in 7.2.27.13 NMAC of these rules;

(h) the re-entry process may only be attempted once; if a candidate for re-entry does not successfully complete the exam within two testing attempts, the re-entry candidate must complete a full licensure course at the appropriate licensure level to be eligible for NM EMS licensure.

(3) Re-licensure: A person whose license has been expired for more than two years from the date of expiration shall be considered an initial licensure applicant. To become licensed, a person must complete the requirements of 7.27.2.9 NMAC of these rules.

M. Expiration of licensure: All New Mexico EMS personnel, whose licensure expires on March 31st of any given year, will receive notification of EMS license expiration, and that they are no longer authorized to perform patient care. The bureau will send this notice to the address of record notifying the former licensee of expiration during the first week of April, will remove the former licensee from the bureau website list of licensed personnel, and will notify the national registry of EMTs if applicable.

N. Bureau approved continuing education: Continuing education (CE) credit may be granted for any education that has been approved in advance by the bureau. All individuals or EMS services wishing to grant CE credit to licensed EMDs, EMD-Is, EMSFRs, EMTs, and paramedics in New Mexico shall submit the appropriate documentation to the bureau at least 30 days in advance. Bureau approved CEs must include information that addresses the New Mexico scope of practice. CEs submitted to the bureau for approval after education has been completed may be denied, and will be reviewed for approval or disapproval on a case-by-case basis. Application for CE approval shall be made utilizing the bureau's "notification of intent to conduct a CE

program" application form available from the bureau. Information regarding CEs may be found on the bureau website.

(1) Purpose: Continuing education is designed to meet three main objectives:

(a) to provide exposure to new and current trends in the area of patient care;

(b) to review areas of patient assessment and management that are not used on a frequent basis;

(c) to meet licensure renewal requirements.

(2) Continuing education categories: The EMS bureau has adopted the CE category designations similar to those published by many states and national EMS organizations. A more detailed explanation of these categories can be found in the "EMS CE user's guide" available from the bureau. The CE categories are:

(a) preparatory and operations topics: preparatory topics include roles and responsibilities, well-being of the EMT, injury prevention, medical/legal issues, ethics, anatomy/physiology, principles of pathophysiology, principles of pharmacology, IV therapy and medication administration, therapeutic communications; operations topics include ambulance operations, medical incident command, rescue awareness and operations, hazardous materials incidents, crime scene awareness;

(b) airway and ventilation;

(c) cardiovascular emergencies: general topics include treatment of cardiac arrest, post resuscitation care, congestive heart failure, ventricle assist devices, acute coronary syndrome, multi-lead ECG, myocardial infarction, general cardiology, stroke (stroke may also be considered neurology/medical emergency);

(d) medical emergencies: general topics include pulmonary, neurology, endocrinology, allergies and anaphylaxis, gastroenterology, urology/renal, toxicology, hematology, environmental conditions, infectious and communicable diseases, behavioral and psychiatric disorders, gynecology, obstetrics;

(e) trauma emergencies: general topics include kinematics, blunt trauma, penetrating trauma, hemorrhage and shock, soft tissue trauma, burns, head and facial trauma, spinal trauma, thoracic trauma, abdominal trauma, musculoskeletal trauma; and

(f) special considerations: general topics include neonatology, pediatrics, geriatrics, abuse and neglect, patients with special challenges, acute interventions for the home health care patient.

(3) Forms of CE: The following forms of CE are currently recognized by the bureau. The bureau reserves the right to approve additional forms of CE as necessary. More detailed information may be found in the "EMS CE user's guide" available from the bureau.

(a) Classroom instruction: Standard instructor-student relationship in the classroom or field setting.

(b) Pre-approved courses: A list of national and statewide recognized certification courses that are pre-approved for CE credit is found in the CE guide available online and from the bureau. Individuals completing any of these courses need only to submit their course completion certificate or card when renewing their licenses. Courses that are approved by a bureau approved nationally recognized CE course approval entity are, at the discretion of the bureau, pre-approved for credit in New Mexico.

(c) EMS related college courses: Credit may be awarded to individuals who are attending college courses relevant to EMS. Individuals who are interested in receiving credit should submit a copy of their unofficial student transcript and course syllabus. The EMS bureau will determine relevance and the number of CE hours allowed.

(d) Teaching bureau approved courses: Licensed individuals who teach bureau approved courses may receive the same number of CE hours as students who are taking the program; refer to the "EMS CE user's guide" for a more complete description.

(e) Field or clinical preceptorship: A maximum of 20 hours of CE may be allowed for EMS preceptor activities; documentation of preceptor activities must be on letterhead from an approved New Mexico EMS education institution or EMS service director.

(f) Asynchronous distance/distributive education learning programs: This is a method of delivering training and education that does not require an educator and student to interact in real time. This may include EMS videos, computer-based-education, self-study modules, recorded broadcasts via satellite, internet, or other media, and other methods of out-of-classroom didactic education that includes a student evaluation component (i.e.: post course test/quiz). A maximum of one-half of the required number of CEs necessary for renewal for each level may come from asynchronous distance/distributive learning programs. Please note, this may differ from the requirement for maintaining national registry certification.

(g) Synchronous distance education learning programs: This is a method of delivering training and education via electronic media that links an educator and students, allowing them to interact in real time despite being in different places. This includes live, instructor interactive satellite broadcasts or webcasts that allow for live

video, audio, or other immediate feedback and communication between the instructor and the students. There is no limit to the number of CE hours a licensed individual may obtain through this method. The CE certification must document that the offering was provided and completed via a live broadcast. The decision regarding a CE being accepted as synchronous distance learning is discretionary and rests with the EMS bureau alone.

(h) EMS agency/fire department medical director courses: The medical director may conduct CE courses without a bureau approved CE number. All other requirements for conducting an EMS CE course must be followed, and records must be maintained by the agency/department CE coordinator, including class roster and teaching outlines. CEs submitted as medical director courses must include the physician's signature.

(i) On-the-job education/staff meetings: A maximum of eight hours of CE will be accepted for agency/department staff meetings, job orientation classes, take home work sheets, etc., for each renewal period

(j) Meetings/Committees: A maximum of eight hours of CE will be accepted for attending EMS related committees/meetings for each renewal period.

(k) Unacceptable CE: CEs obtained for completing evaluations for any EMS classes or conferences, participating in EMS related surveys, etc., will not be accepted.

(4) Record keeping: Once approval of a CE program is obtained and the course is presented, records of attendance must be maintained. The bureau may audit the CE records of an approved CE program. Attendance records with original signatures of course participants and a copy of any course presentation material must be kept for a minimum of 36 months by the service, for bureau audit purposes.

(a) In order for participating EMS personnel to receive credit, each individual shall be given a certificate, letter of attendance/completion, or copy of course attendance roster and advised to retain it until their licensure renewal. Many EMD Agencies (EMDA) and EMS services have computerized records of their personnel concerning CE. The EMS bureau will recognize CE summary documentation, on letterhead, from EMDA or EMS service directors, education coordinators, medical directors, or CE coordinators with appropriate original signatures.

(b) Course completion letters, certificates, and course rosters shall contain the following information:

(i) location and date of the CE program;

(ii) title and short description of the class or course;

(iii) number of actual contact hours (half hour increments are acceptable);

(iv) CE category;

(v) name of participant;

(vi) CE coordinator's name with designation "CE coordinator" placed after

the name;

(vii) signature of CE coordinator;

(viii) the statement: "reviewed and approved by the New Mexico EMS bureau for CE"; and

(ix) method of delivery (classroom, asynchronous, or synchronous distance program); and

(x) EMS bureau approval number.

(5) CE audits for EMS services and personnel: The bureau may periodically perform audits of CE programs. These audits are usually provided as a way for services to evaluate their current program, identify areas in which the program excels, as well as areas that may be problematic. The following types of CE audits may be conducted by the bureau:

(a) CE course audit: this audit evaluates the actual class or course being conducted; the purpose of this audit is to provide written feedback to the instructor on presentation, content, and participant evaluations conducted at the end of the class; this audit is usually unannounced;

(b) CE recordkeeping audit: this audit evaluates the CE program sponsor recordkeeping process; records of prior classes or courses conducted are inspected for completeness and feedback is provided to the CE program sponsor that identify areas for improvement; CE program sponsors will be given at least five days advance notification of these audits; records that will be inspected include:

(i) original copies of attendance rosters with the signatures of course participants;

(ii) course presentation materials/outlines or learning objectives;

(iii) handouts that were given to participants;

(iv) any evaluation tools, including written exams or practical skill forms; and

(v) CE approval letter or approval numbers;

(c) CE complaint audit: this audit is a preliminary investigation conducted by the EMS bureau based on a complaint concerning falsification of the CE process.

(6) Refreshers: The EMS bureau does not require a refresher certificate for renewal, but refresher certificates from approved New Mexico EMS education institutions may be used to satisfy an equivalent number of hours for the CE requirement. The refresher documentation submitted must describe the number of CE hours for each CE category, and the number of synchronous and asynchronous hours that were delivered in the class. If a portion of the refresher was completed in an online or other asynchronous distance/distributive education format, the CE hours will be categorized as asynchronous CE by the bureau, and will count towards the maximum number of asynchronous education. For a formal refresher certificate from entities other than New Mexico approved institutions to be accepted for CEs, the course curriculum must be approved prior to an applicant completing the refresher.

[7.27.2.11 NMAC - Rp, 7.27.2.11 NMAC, 12/12/2017; A, 8/10/2021]

7.27.2.12 IDENTIFICATION OF EMS PERSONNEL:

Licensed EMDs, EMD- Is, EMSFRs, EMTs, and paramedics will be issued: one license certificate, and one uniform patch (if available).

A. The bureau shall charge a reasonable fee for replacement of lost documents. The bureau shall also charge a reasonable fee for additional uniform patches, pursuant to 7.27.2.12 NMAC of these rules.

B. Licensed EMDs, EMD-Is, EMSFRs, EMTs, and paramedics shall be listed as fully licensed on the bureau's list of licensed personnel, and upon demand, present proof of this listing and licensure status.

C. Licensed EMDs, EMD-Is, EMSFRs, EMTs, and paramedics shall promptly notify the bureau of any changes of name, address or EMS employment/affiliation status.

D. All volunteer, paid, and career EMS agencies regulated by the PRC or the EMS bureau utilizing EMS caregivers to perform patient care are required to verify the license of any volunteer or career EMS caregiver via direct contact with the EMS bureau or by accessing the bureau's license verification list. National Registry certification does not constitute licensure. Any other organization, business, or individual that employs or otherwise utilizes licensed EMS caregivers to provide medical care utilizing emergency medical dispatchers or emergency medical technicians including paramedics is strongly advised to verify the New Mexico license of the emergency medical dispatchers or

emergency medical technicians via direct contact with the bureau or by accessing the bureau's license verification list.

[7.27.2.12 NMAC - Rp, 7.27.2.12 NMAC, 12/12/2017; A, 8/10/2021]

7.27.2.13 FEES:

A. Examination, licensure, renewal and assorted fees: The bureau shall charge reasonable fees for
the examination, licensure, and renewal of licensed EMS providers in New Mexico, according to the following schedule.

(1) In-state application fees will apply to individuals who have completed an EMS licensing course through a bureau approved New Mexico EMS education program.

(2) Reciprocity and seasonal licensure application fees will apply to individuals applying for licensure through the reciprocity and seasonal process education.

B. Initial license fees:

DESCRIPTION	**IN-STATE APPLICATION FEE**	**RECIPROCITY & SEASONAL APPLICATION FEE**
Licensed EMD	$25.00	$50.00
Licensed EMD-instructor	$35.00	$70.00
Licensed EMS first responder	$25.00	$50.00
Licensed EMT-basic	$65.00	$130.00
Licensed EMT-intermediate	$75.00	$150.00
Licensed EMT-paramedic	$85.00	$170.00

C. Reciprocity & re-entry examination re-test fees:

DESCRIPTION	**RE-TEST FEE FOR IN-STATE AND OUT OF STATE APPLICATION**
First responder examination retest fee	$25.00
EMT-basic examination fee	
EMT-intermediate written/practical examination fee	$30.00
EMT-paramedic written/practical examination fee	$35.00 $40.00

D. Licensure renewal application fees:

DESCRIPTION	FEE TYPE	FEE
Licensed EMD	normal fee	$20.00
	March renewal fee	$60.00
Licensed EMD-instructor	normal fee	$25.00
	March renewal fee	$75.00
Licensed EMS first responder	normal fee	$20.00
	March renewal fee	$60.00
Licensed EMT-basic	normal fee	$30.00
	March renewal fee	$90.00
Licensed EMT-intermediate	normal fee	$40.00
	March renewal fee	$120.00
Licensed EMT-paramedic	normal fee	$50.00
	March renewal fee	$150.00

E. Reinstatement application fees:

DESCRIPTION	FEE
Licensed EMD	$120.00
Licensed EMD-instructor	$150.00
Licensed EMS first responder	$120.00
Licensed EMT-basic	$180.00
Licensed EMT-intermediate	$240.00
Licensed EMT-paramedic	$300.00

F. Re-entry application fees-same as March renewal fees:

DESCRIPTION	FEE
Licensed EMD	$60.00
Licensed EMD-instructor	$75.00
Licensed EMS first responder	$60.00
Licensed EMT-basic	$90.00
Licensed EMT-intermediate	$120.00
Licensed EMT-paramedic	$150.00

G. Miscellaneous fees:

DESCRIPTION	FEE
Additional patches-each	Bureau Cost
Replacement licensure card-each occurrence	$10.00
Bad check fee-each occurrence	$20.00
National healthcare practitioner query fee-each occurrence as determined by the bureau	$15.00
Bad address fee-each occurrence, as determined by the bureau	$20.00

H. Use of fees: Fees collected by the bureau under these rules shall be used expressly for licensing related operations.

I. Payment of fees: State fees shall be made payable to the bureau by check, money order or other bureau approved method of payment. Licensure and examination fees are due and payable at the time of licensure application. Licensure applications will not be processed until payment of the required fees.

J. Waiver of fees: Applicants for licensure under these rules who, for good cause, are unable to pay the licensure fees may petition the bureau for a waiver. Applications for fee waiver under these rules shall be submitted to the bureau in the form of a written letter, and shall document the exact nature of the applicant's inability to pay. Waiver requests shall be submitted to the EMS bureau chief or designee for approval.

[7.27.2.13 NMAC - Rp, 7.27.2.13 NMAC, 12/12/2017]

7.27.2.14 ENFORCEMENT:

A. EMS licensing commission:

(1) Statutory basis: The emergency medical services licensing commission is established
pursuant to Section 24-10B-5.1 NMSA 1978 of the act.

(2) Duties: The duties of the commission are to:

(a) provide a forum for the receipt of public comment regarding emergency medical services licensing matters;

(b) oversee the bureau's licensing and enforcement functions;

(c) receive complaints, direct investigations, and authorize the initiation of actions by the bureau regarding contemplated refusal to grant initial licensure and for disciplinary actions against licensees; and

(d) grant waivers, for good cause shown, of regulations pertaining to licensure renewal.

(3) Organization: Members of the commission are appointed by the secretary as provided by law.

(a) Commission members shall serve until their successors have been appointed by the secretary.

(b) In the event of a vacancy on the commission by resignation or removal, the bureau shall immediately notify the secretary so as to expedite the appointment of a new commission member. The secretary shall appoint such vacancies.

(c) The commission may recommend to the secretary removal of any commission member for the following reasons:

(i) failing to attend or otherwise participate in two consecutive meetings without a valid reason; or

(ii) any other good cause.

(d) The commission shall elect a chair and vice-chair annually. The term of office
begins with the meeting at which the officer is elected.

(e) The bureau shall serve as staff for the commission.

(4) Commission meetings: The commission shall meet as needed, but not less than semi-annually.

(a) Commission meetings for receipt of public comment regarding emergency medical services licensing functions and oversight of the bureau's licensure function shall be subject to the Open Meetings Act, Section 10-15-1, *et seq*., NMSA 1978.

(b) Meetings pertaining to the issuance, suspension, renewal or revocation of a license, or other personnel matters, are closed meetings as provided by the Open Meetings Act.

(c) A meeting notice resolution, consistent with the provisions of the Open Meetings Act, shall be adopted by the commission and shall be reviewed in November of each year at a regularly scheduled meeting of the commission.

(d) Minutes of meetings shall be taken and maintained in accordance with the Open Meetings Act.

(e) A commission member may attend a meeting of the commission via telephone or other teleconferencing technology, if it otherwise difficult or impossible for the member to attend in person.

(5) Receipt of public comment: There shall be an opportunity for receipt of public comment regarding licensure matters, in writing or orally, at each open commission meeting.

(a) Written public comment intended for consideration by the commission shall be mailed to the bureau. The comments must include the person's name, address, and telephone number, if available. Unidentified comments may or may not be considered by the commission.

(b) The commission, upon receipt of public comments, may make an appropriate recommendation to the bureau to take action based on those comments.

(6) Oversight: During each regularly scheduled meeting, the bureau will provide a report of its licensure functions to the commission. Commission members may, at any time, request information about licensure functions from the bureau.

B. Complaint/incident procedures: Any person may communicate a written complaint or knowledge of an incident to the bureau or the commission.

(1) When the bureau has knowledge of a complaint that may affect a person's license, it shall notify the chair of the commission as soon as practicable.

(2) Similarly, when the commission has knowledge of a complaint or incident affecting licensure, it shall notify the bureau.

(3) Other complaints, which would not affect licensure, will be directed to, and examined by the bureau.

(4) The bureau shall communicate to the chair or designee its opinion as to whether or not an investigation of the complaint should be initiated.

(5) Upon knowledge of a complaint, the chair, or designee, after consultation with other members of the commission, as feasible, shall authorize that an investigation be conducted.

(6) The chair or designee shall direct the course of the investigation through periodic communication with the bureau as necessary.

(7) If an investigation indicates that the complaint may affect a person's license, the licensee shall be notified that the bureau is conducting an investigation, unless extenuating circumstances reasonably preclude notification.

(a) At the conclusion of the bureau's investigation, the bureau shall report its findings to the commission in a closed meeting at which a majority of commission members participate, either in person or by means of a conference telephone or other similar communications equipment.

(b) The commission, after consideration of the bureau's report, may authorize the initiation of an action by the bureau regarding contemplated refusal to grant initial licensure, or for disciplinary action against a licensee, by a majority vote of commission members participating in the closed meeting. The commission may immediately authorize a cease and desist order or other immediate action, including but not limited to suspension, subject to expedited hearing rights as outlined in Paragraph **(**5**)** of Subsection G of 7.27.2.14 NMAC, if it determines that the health and safety of the public would be jeopardized unless the bureau takes action as soon as possible.

(c) The chair of the commission may immediately authorize the initiation of an action by the bureau regarding contemplated refusal to grant initial licensure, or for disciplinary action against a licensee, without consulting the other members of the commission. This immediate action may be used if the chair makes a good faith judgment that the health and safety of the public would be jeopardized unless the bureau takes action as soon as possible. Actions may include cease and desist orders or immediate suspension, subject to expedited hearing rights pursuant to Paragraph **(**5**)** of Subsection G of 7.27.2.14 NMAC of these rules. If the chair authorizes the initiation of an action by the bureau, the bureau shall notify each commission member in writing of such action within 10 working days of the initiation of the action.

(d) Upon receipt of authorization from the commission to initiate an action, the bureau may deny, suspend or revoke licensure or take other disciplinary action, in accordance with the provisions of the act, Paragraph (2) of Subsection B of Section 24-10B-5 NMSA 1978 and the Uniform Licensing Act, Sections 61-1-1, *et seq*., NMSA 1978.

C. Conduct of investigations: Investigations shall normally be conducted by the bureau.

(1) Preliminary investigations: When the bureau receives information that might form the basis for disciplinary action against a person, it shall begin a preliminary investigation. This is a fact finding, information gathering investigation that will attempt to determine for the commission whether justification exists for the commission to authorize the bureau to initiate an action or to conduct a formal investigation. The results of the preliminary investigation will be presented to the commission.

(2) Formal investigations: Formal investigations are authorized by the commission for the purpose of obtaining additional information to allow the commission to determine if it will authorize the bureau to initiate an action. The results of the formal investigation will be presented to the commission. Notice will be given to the person

who is the subject of the formal investigation unless extenuating circumstances exist which would reasonably preclude notification.

D. Subpoena authority: In accordance with Subsection C of Section 24-10B-5. 1 NMSA 1978 of the EMS Act and Subsection A of Section 61-1-4 NMSA 1978 of the Uniform Licensing Act, the EMS licensing commission or the bureau, pursuant to the commissions authorization may, subject to the rules of privilege and confidentiality recognized by law, require the furnishing of information, the attendance of witnesses, and the production of books, records, papers or other objects necessary and proper for the purposes before it, and may take sworn statements of witnesses, including parties.

E. Waivers: The commission, upon good cause or for extenuating circumstances shown by a licensee, may grant a waiver of a specific regulation or regulations pertaining to licensure renewal for that licensee.

(1) A licensee shall demonstrate good cause to the commission by submitting written justification that identifies any extenuating circumstances, to the bureau. The licensee shall include any reasonable supporting documentation to relevant to the request.

(2) The bureau shall distribute the submitted written justification and supporting documentation to the members of the commission prior to their next meeting.

(3) The commission, as soon as practicable, shall determine if good cause exists to grant a waiver by a majority vote of commission members meeting in a closed meeting. To accomplish this, the commission shall evaluate the documentation and, if necessary, review other pertinent documentation requested from the licensee.

(4) The commission may also meet with the licensee at a closed meeting of the commission prior to rendering its decision as to whether good cause exists to grant a waiver.

(5) If the commission grants the waiver to the licensee, it shall direct the bureau to take appropriate action to implement the terms and conditions of the waiver.

(6) A licensee applying for a waiver shall be notified by the bureau of the commission’s decision in writing within 20 calendar days of receipt of the commission’s decision.

(7) The chair or his designee, with a recommendation from the bureau, may authorize a temporary waiver for licensure renewal, where they feel it may be justified, i.e., loss of employment, pecuniary interests, etc., subject to subsequent commission review and approval.

F. Impaired practitioner program: An EMT who voluntarily self-identifies to the bureau or the impaired practitioner committee that he is experiencing a physical or

mental impairment shall be considered for the impaired practitioner program ("diversion program"). Consideration may not result in participation in the diversion program. Also, any impaired-EMT who the bureau, with the advice of the commission, determines may benefit from the impaired practitioner program may be compelled to attend the impaired practitioner committee.

(1) The bureau, with the advice of the commission, may appoint an impaired-EMT rehabilitation committee to organize and administer a program that will:

(a) serve as a diversion program to which the bureau may refer licensees in lieu of, or in addition to, other disciplinary action taken by the bureau under these regulations; and

(b) be a source of referral for EMTs who, on a voluntary basis, desire to avail themselves of treatment for behavioral health based or chemical-dependence impairments.

(2) The impaired practitioner committee shall be composed as a minimum of:

(a) one bureau staff member;

(b) one commission member;

(c) one mental health specialist; and

(d) one physician.

(3) The impaired practitioner committee shall:

(a) arrange evaluations for EMTs who request participation in the diversion program;

(b) review and designate treatment facilities and services to which EMTs in the diversion program may be referred;

(c) receive and review information concerning the status and progress of participants in the diversion program;

(d) publicize the diversion program in coordination with EMS professional organizations and the bureau; and

(e) prepare and provide reports as needed to the bureau and the commission.

(4) Each EMT entering the diversion program shall be informed of the procedures applicable to the diversion program, of the rights and responsibilities associated with participation in the diversion program and of the possible consequences

of failure to participate in the diversion program. Failure to comply with any treatment requirement of the diversion program may result in termination of the diversion program participation. The bureau shall report termination of diversion program participation to the commission. Participation in the diversion program shall not be a defense against, but may be considered in mitigating any disciplinary action authorized by the commission and taken by the bureau. The commission is not precluded from authorizing the bureau to commence a disciplinary action against an EMT who is participating in the diversion program or has been terminated from the diversion program.

G. Denial, suspension, and revocation: A license may be denied, suspended, or revoked, or may be subject to any lesser disciplinary action, in accordance with the following:

(1) upon authorization by the commission, the bureau may suspend, revoke, or refuse to issue any license, or take other disciplinary action, in accordance with the provisions of the EMS Act, Subsection B of of Section 24-10B-5, NMSA 1978 and the Uniform Licensing Act, Section 61-1-1, *et seq*., NMSA 1978, for any of the reasons outlined below;

(2) if final disciplinary action is taken against a licensed EMS provider by the bureau, upon authorization from the commission, the bureau may publish the action in a periodical or other medium that has statewide distribution, and will notify the national registry of EMTs of the disciplinary action;

(3) grounds for denial, suspension, revocation or other disciplinary action are:

(a) misconduct in obtaining licensure;

(b) fraud, deceit, misrepresentation in obtaining licensure, including, but not limited to, cheating on an examination or attempting to subvert the initial or renewal licensing process;

(c) unprofessional conduct, whether committed while on duty or off duty, to include but not limited to, the following:

(i) dissemination of a patient's health information to individuals not entitled to such information and where such information is protected by law from disclosure;

(ii) falsifying or altering patient records or personnel records;

(iii) misappropriation of money, drugs or property;

(iv) obtaining or attempting to obtain any fee for patient services for one's self or for another through fraud, misrepresentation, or deceit;

(v) aiding, abetting, assisting or hiring an individual to violate the EMS Act or these duly promulgated rules;

(vi) failure to follow established procedure and documentation regarding controlled substances;

(vii) failure to make or keep accurate, intelligible entries in records as required by law, policy and standards for the practice of pre-hospital emergency care;

(viii) failure to report an EMS provider who is suspected of violating the New Mexico Emergency Medical Services Act or these rules;

(ix) intentionally engaging in sexual contact with or toward a patient.

(d) conviction of a felony, when the conviction relates directly to the profession or the practice of emergency medical services;

(e) negligence in the delivery of emergency medical services to include, but not limited to:

(i) practicing outside the standard of care, scope of licensure or without appropriate medical direction;

(ii) malpractice;

(iii) incompetence, in performance of pre-hospital emergency medical functions, whether direct patient care or the administration or management of that care. An EMS provider is under legal duty to possess and to apply the knowledge, skill and care that is ordinarily possessed and exercised by other EMS providers of the same licensure status and required by the generally accepted standards of the profession; the failure to possess or to apply to a substantial degree such knowledge, skill and care constitutes incompetence for purposes of disciplinary proceedings. It shall not be necessary to show that actual harm resulted from the act or omission or series of acts or omissions, so long as the conduct is of such a character that harm could have resulted to the patient or to the public;

(iv) patient abandonment: patient abandonment occurs when the EMS provider has accepted the patient assignment thus establishing a provider-patient relationship and then severs the relationship without giving reasonable notice to a qualified person who can make arrangements for the continuation of care.

(f) unauthorized disclosure of medical or other confidential information;

(g) physical or mental incapacity which could result or has resulted in performance

of emergency medical service duties in a manner which endangers the health and safety of the patient or others;

(h) any demonstrated pattern of alcohol or other substance abuse; or any single instance of alcohol or substance abuse in the performance of emergency medical services duties;

(i) failure to successfully complete the impaired practitioner program; or failure to meet the terms and conditions of an impaired practitioner agreement;

(j) failure to meet licensure requirements;

(k) dispensing, administering, distributing or diversion of controlled substances, other than those authorized in the scope of practice, as defined in the New Mexico Controlled Substance Act, Section 30-31-1, *et seq*., NMSA 1978;

(l) failure to report revocation, suspension, denial, or other adverse actions taken in any other state or jurisdiction affecting the ability to practice emergency medical services;

(m) misrepresentation of the level of licensure or certification;

(n) performing duties as a licensed EMT without being licensed by the bureau to perform the authorized scope of practice for a level of licensure, including practicing after expiration of a license;

(o) any false, fraudulent, or deceptive statement in any document connected with the practice of emergency medical services, including, but not limited to, documents associated with:

(i) initial licensure;

(ii) renewal licensure;

(iii) licensure certificates, wallet cards; or

(iv) continuing education.

(p) failure to cooperate with an investigation, including but not limited to, failure to furnish the commission or bureau with information requested, or to appear for an interview as requested;

(q) inappropriate conduct or negligence by a licensed EMT who is also a registered instructor-coordinator;

(r) failure to comply with a judgment and order for child support or a warrant relating to paternity or child support proceedings issued by a district or tribal court, as provided in the Parental Responsibility Act, Section 40-5A-1 *et seq*., NMSA 1978;

(s) failure to notify the bureau in writing of the entry against the licensee or applicant, at any time in any state or jurisdiction, of either a felony conviction, or a misdemeanor conviction involving the use, dispensation, administration or distribution of a drug, the use of alcohol, sexual contact, or the possession or use of a weapon, within 10 calendar days of the conviction;

(t) intimidating, threatening, or taking any adverse action against a person for providing information to the bureau or commission, either directly or through an agent;

(u) impersonating an agent or employee of the bureau; and

(v) issuing non-sufficient funds check for the payment of licensing related fees.

(4) the provisions of the New Mexico Criminal Offender Employment Act, Section 28-2-1 *et seq*., NMSA 1978, shall apply to disciplinary actions proposed pursuant to this rule;

(5) procedures for enforcement of the Parental Responsibility Act:

(a) the New Mexico human services department (HSD) shall issue to the bureau a certified list of obligors (meaning persons who have been ordered to pay child support pursuant to a judgment and order for support issued by a district or tribal court) not in compliance with their judgment and order of support;

(b) upon determination by the bureau that the name and social security number of an applicant for licensure, a licensed person, or licensee, appears on the certified list, the bureau shall require that applicants for licensure:

(i) provide a statement of compliance from HSD to the bureau no later than 48 hours prior to scheduled attendance at a state EMS examination site; or

(ii) provide a statement of compliance from HSD to the bureau no later than the close of business, 60 days from the date of the letter of notification; or

(iii) if the applicant fails to provide a statement of compliance, the bureau shall be authorized by the commission to issue a notice of contemplated action to deny the application;

(iv) that persons currently licensed shall provide the bureau with a statement of compliance from HSD by the earlier of the application for licensure renewal or a specified date not to exceed 60 days;

(v) if the licensed person fails to provide the statement of compliance, the bureau shall be authorized by the commission to issue a notice of contemplated action to take appropriate action.

(c) upon authorization by the commission to issue a notice of contemplated action concerning violation of the Parental Enforcement Act, the bureau shall serve upon an applicant for licensure or licensee a notice of contemplated action in accordance with the Uniform Licensing Act stating that the bureau has grounds to take such action, and that the bureau shall take such action unless the applicant or licensed person mails a letter (certified mail, return receipt requested) within 20 days after service of the notice requesting a hearing, or provides the bureau, within 30 days of receipt of the notice of contemplated action, a statement of compliance from HSD; if the applicant or licensed person disagrees with the determination of non-compliance, or wishes to come into compliance, the applicant or licensed person shall contact the HSD child support enforcement division;

(d) in any hearing under this subparagraph, the following standards shall apply:

(i) a statement of non-compliance is conclusive evidence that requires the bureau to take appropriate action, unless the applicant or licensee provides the bureau with a subsequent statement of compliance, which shall preclude the bureau from taking any further action under this section;

(ii) when an action is taken against an applicant or licensee solely because the applicant or licensed person is not in compliance with a judgment and order for support, the order shall state that the application, license shall be reinstated upon presentation to the bureau of a subsequent statement of compliance.

(e) the secretary may also include in the order any other conditions necessary to comply with requirements for reapplication and re-issuance of licensure, including, but not limited to, requiring a surcharge fee of $50, in addition to any other applicable fees.

(6) right to a hearing: in accordance with the provisions of the Uniform Licensing Act, Sections 61- 1-1, *et seq*., NMSA 1978, every applicant or person licensed, shall be afforded notice and opportunity for a hearing, before the department shall have authority to take action, the effect of which would be to deny permission to take an examination for licensure for which application has been duly made, or to deny, suspend, or revoke a certification or license, or take other disciplinary action; exception:

(a) right to expedited hearing for an immediate suspension of a person's license: the person whose license is immediately suspended may request a hearing before a hearing officer appointed by the secretary to contest the action, by mailing a certified return receipt letter addressed to the bureau within 20 days after service of the notice;

(b) expedited hearing for a person whose license has been immediately suspended upon receipt of a timely request for a hearing, the department shall appoint a hearing officer and schedule a hearing, in accordance with the hearings portion of this rule.

(7) records management: a licensing record is maintained for every licensed EMT in New Mexico; any request for records maintained by the bureau will be processed in accordance with the Inspection of Public Records Act; if the bureau begins a preliminary or formal investigation, a separate confidential record will be created containing all investigatory material;

(a) confidentiality: the commission and the bureau will take every precaution to insure that preliminary and formal investigations are conducted in a confidential manner; if the commission authorizes the bureau to initiate an action, all records not exempt from disclosure under the Inspection of Public Records Act, Sections 14-2-1, *et seq*., NMSA 1978, will be placed in the licensee's licensing record, if one exists;

(b) records confidentiality: any files or records in the possession of the bureau, a regional office or a provider containing identifying information about individuals requesting or receiving treatment or other health services and any unsubstantiated complaints received by the bureau regarding any provider shall be confidential and not subject to public inspection; such files, records and complaints may be subject to subpoena for use in any pending cause, in any administrative proceeding, or in any of the courts of this state, unless otherwise provided by state or federal law.

H. Enforcement of education standards:

(1) Process for non-compliance: The bureau will make every attempt to resolve non-compliance of education standards at the lowest level possible. The following process shall be utilized:

(a) the bureau will notify the approved New Mexico education program, in writing, of any suspected or reported non-compliance of education standards received by complaint, report or course trends;

(b) the approved New Mexico education program will provide a plan to correct items of noncompliance and will submit the plan to the bureau in writing within 30 days;

(c) the bureau will re-evaluate the plan and progress reports for compliance of the education standards in three month increments until the problem is resolved; and

(d) if the bureau determines that non-compliance has not been adequately resolved, the bureau may initiate an enforcement action against the education program or the licensed EMT who is an instructor-coordinator.

(2) Complaint/incident procedures: Any person may communicate a complaint or knowledge of an incident to the bureau. Complaints shall be submitted in signed written form to the bureau. The bureau may begin an investigation if there is sufficient cause.

(a) When a complaint is received by the bureau, written acknowledgment shall be made within 10 working days and the bureau staff shall decide whether or not a preliminary or formal investigation of the complaint shall be initiated.

(b) Approved New Mexico EMS education programs being formally investigated shall receive written notification within 10 working days after a decision is made to begin a formal investigation.

(c) At the conclusion of the bureau's formal investigation, the bureau may report its findings to the investigated education program in written form. If the bureau investigation warrants an enforcement action, the education program will be given a notice of contemplated action.

(d) If no investigation is warranted, the education program or person filing a complaint will be notified, as determined by the bureau.

(3) Investigations: The bureau shall normally conduct preliminary and formal investigations.

(a) Preliminary investigations: When the bureau receives information that forms the basis for an enforcement action, it shall begin a preliminary investigation. This is a fact finding, information gathering investigation that will attempt to determine for the bureau whether justification exists to initiate an action or to conduct a formal investigation.

(b) Formal investigations: Formal investigations are for the purpose of obtaining additional information to allow the bureau to determine if it will initiate an action. Notice will be given of the formal investigation, unless extenuating circumstances exist which would reasonably preclude notification.

(c) Confidentiality: The bureau will take every precaution to insure that preliminary and formal investigations are conducted in a confidential manner.

(d) Records: An official record is maintained for every approved New Mexico EMS education program. If the bureau begins a preliminary or formal investigation, a separate confidential record will be created containing all investigation material. If the bureau initiates an action, all records not exempt from disclosure under the Inspection of Public Records Act, Sections 14-2-1, *et seq*., NMSA 1978, will be placed in the education program's official record. Any request for records maintained by the bureau will be processed in accordance with the Inspection of Public Records Act.

(4) Grounds for enforcement actions: Enforcement actions may result in an action taken against an approved New Mexico EMS education program or an instructor-coordinator affiliated with the education program. These enforcement actions may result in the following actions:

(a) probation or suspension of the education program for a specified period of time;

(b) non-recognition of a education program course;

(c) withdrawal of approval status of a education program by the bureau;

(d) under 7.27.2.14 NMAC, a licensing action may be initiated against an instructor-coordinator when the bureau determines that there may be inappropriate conduct or negligence; grounds for enforcement actions include, but are not limited to the following:

(i) failure to comply with law or rules including but not limited to the failure to properly educate students on the licensure process; failure to comply with the education standards or non-compliance with a education standard found in these rules;

(ii) falsifying documents to include use of any false, fraudulent, or deceptive statement in any document;

(iii) failure to cooperate with an investigation to include failure to furnish the bureau with requested information, as provided by law;

(iv) failure of students or instructors to function within the approved New Mexico scopes of practice, New Mexico treatment guidelines and the drug formulary, as approved by the medical direction committee;

(v) failure to report required documentation including patient care data and annual education reports.

(5) Right to appeal: Any approved New Mexico EMS education program may appeal a decision by the bureau to take an enforcement action.

(6) Notice of contemplated action: When the bureau contemplates taking any action
specified in this section, it shall serve upon the approved New Mexico EMS education program a written notice containing a statement of the grounds or subject upon which the proposed action is based and the rule(s) violated.

(7) Right to hearing: The approved New Mexico EMS education program may request a hearing before a hearing officer appointed by the secretary to contest the

proposed enforcement action, by mailing a certified return receipt letter addressed to the bureau within 20 days after service of the notice.

(8) Hearing: Upon receipt of a timely request for a hearing, the department of health shall appoint a hearing officer and schedule a hearing, to be held in Santa Fe, New Mexico, within 45 working days of receipt of the timely request for a hearing.

(9) Notice of hearing: The department shall notify the approved New Mexico EMS education program of the date, time, and place of the hearing, the identity of the hearing officer, and the subject matter of the hearing, not less than 30 days prior to the date of the hearing.

(10) Hearing officer duties: The hearing officer shall preside over the hearing, administer oaths, take evidence, decide evidentiary objections, and rule on any motions or other matters that arise prior to the hearing.

(11) Discovery: Upon written request to another party, any party is entitled to: obtain the names and addresses of witnesses who will or may be called by the other party to testify at the hearing; and inspect and copy any documents or items, which the other party will or may introduce in evidence at the hearing.

(12) Conduct of hearing: Hearings are open to the public unless either party makes a request for closed meeting.

(13) Hearing officer written report and recommendation(s): The hearing officer shall make a written report and recommendation(s) to the secretary containing a statement of the issues raised at the hearing proposed findings of fact and conclusions of law, and a recommended determination. The hearing officer or designee shall record the hearing by means of a mechanical sound recording device provided by the department for a record of the hearing. The hearing officer written report shall be submitted to the secretary no later than 30 working days after the close of the hearing.

(14) Secretary's determination: The secretary shall render a final determination within 45 calendar days of the submission of the hearing officer's written report. A copy of the final decision shall be mailed to the appealing party by certified mail, return receipt requested. A copy shall be provided to legal counsel for the bureau.

[7.27.2.14 NMAC - Rp, 7.27.2.14 NMAC, 12/12/2017; A, 8/10/2021]

7.27.2.15 HEARINGS:

A. Right to appeal: A licensee or applicant may appeal a decision by the department to take a disciplinary action against the licensee or applicant under this rule.

B. Right to hearing: A licensee or applicant may request a hearing before a hearing officer appointed by the secretary to contest a proposed action or immediate

suspension under this rule, by mailing a certified letter, return receipt requested, to the bureau within 20 days after service of the notice of the contemplated action or immediate suspension. If the licensee or applicant fails to request a hearing in the time and manner required by this section, the licensee or applicant shall forfeit the right to a hearing, and the proposed action shall become final and not subject to judicial review.

C. Scheduling the hearing:

(1) Appointment of hearing officer: Upon the bureau's receipt of a timely request for a hearing, the department shall appoint a hearing officer and schedule a hearing.

(2) Hearing date: The hearing shall be held not more than 60 days and not less than 15 days from the date of service of the notice of the hearing. **Exception for immediate suspensions; expedited hearing:** In the event that the bureau immediately suspends an individual's license, the department shall afford the individual an expedited hearing within 20 days of the date of the bureau's timely receipt of the licensee's request for a hearing, unless the individual waives this provision.

(3) Notice of hearing: The department shall notify the licensee or applicant of the date, time, and place of the hearing and the identity of the hearing officer, and shall identify the statute(s) and regulation(s) authorizing the department to take the contemplated action (unless previously disclosed), within 20 days of the bureau's timely receipt of the request for hearing. **Exception for immediate suspensions:** In the event that the bureau immediately suspends an individual's license, the department shall notify the individual of the expedited hearing not less than seven days prior to the scheduled date of the expedited hearing.

(4) Hearing venue: The hearing shall be held in the county in which the person whose license is involved maintains his residence, or at the election of the hearing officer, in any county in which the acts complained of occurred. In any case, the hearing officer may, with the agreement of the parties, hold the hearing in some other county. **Exceptions; expedited hearings and cases involving initial licensure:** Expedited hearings shall be held in Santa Fe, New Mexico. Hearings in cases involving initial licensure shall also be held in Santa Fe, New Mexico.

D. Method of service: Any notice or decision required to be served under this section may be served
either personally or by certified mail, return receipt requested, directed to the licensee or applicant at the last known mailing address (or, if service is made personally, by the last known physical address) shown by the records of the bureau. If the notice or decision is served personally, service shall be made in the same manner allowed by the rules of civil procedure for the state district courts of New Mexico. Where the notice or decision is served by certified mail, it shall be deemed to have been served on the date borne by the return receipt showing delivery, or the date of the last attempted delivery of the notice or decision, or the date of the addressee's refusal to accept delivery.

E. Excusal of the hearing officer:

(1) Peremptory excusal: A party shall have the ability to excuse one hearing officer. The party may request the peremptory excusal by submitting to the secretary a motion for peremptory excusal at least 20 days prior to the date of the hearing, or at least five days prior to the date of an expedited hearing concerning the immediate suspension of an individual's license.

(2) Excusal for good cause shown: A party may request that a hearing officer be excused for good cause shown by submitting to the secretary a motion of excusal for good cause at least 20 days prior to the date of the hearing, or at least five days prior to an expedited hearing concerning the immediate suspension of an individual's license.

F. Hearing officer duties: The hearing officer shall conduct the hearing, rule on any motions or
other matters that arise prior to the hearing, and issue a written report and recommendation(s) to the secretary following the close of the hearing.

G. Official file: Upon appointment, the hearing officer shall establish an official file which shall
contain all notices, hearing requests, pleadings, motions, written stipulations, evidence, briefs, and correspondence received in the case. The official file shall also contain proffered items not admitted into evidence, which shall be so identified and shall be separately maintained. Upon conclusion of the proceeding and following issuance of the final decision, the hearing officer shall tender the complete official file to the department for its retention as an official record of the proceedings.

H. Powers of hearing officer: The hearing officer shall have all the powers necessary to conduct a hearing and to take all necessary action to avoid delay, maintain order, and assure development of a clear and complete record, including but not limited to the power to: administer oaths or affirmations; schedule continuances; direct discovery; examine witnesses and direct witnesses to testify; subpoena witnesses and relevant books, papers, documents, and other evidence; limit repetitious and cumulative testimony; set reasonable limits on the amount of time a witness may testify; decide objections to the admissibility of evidence or receive the evidence subject to later ruling; receive offers of proof for the record; take notice of judicially cognizable facts or take notice of general, technical, or scientific facts within the hearing officer's specialized knowledge (provided that the hearing officer notifies the parties beforehand and offers the parties an opportunity to contest the fact so noticed); direct parties to appear and confer for the settlement or simplification of issues, and otherwise conduct pre-hearing conferences; impose appropriate evidentiary sanctions against a party who fails to provide discovery or who fails to comply with a subpoena; dispose of procedural requests or similar matters; and enter proposed findings of fact and conclusions of law, orders, reports and recommendations. The hearing officer may utilize his or her

experience, technical competence, or specialized knowledge in the evaluation of evidence presented.

I. Minimum discovery; inspection and copying of documents: Upon written request to another party, any party shall have access to documents in the possession of the other party that are relevant to the subject matter of the appeal, except confidential or privileged documents.

J. Minimum discovery; witnesses: The parties shall each disclose to each other and to the hearing officer, either orally or in writing, the names of witnesses to be called, together with a brief summary of the testimony of each witness. In situations where written statements will be offered into evidence in lieu of a witness's oral testimony, the names of the persons making the statements and a brief summary of the statements shall be disclosed.

K. Depositions: Depositions may be taken by any party after service of notice in accordance with the Rules of Civil Procedure for the district courts. Depositions may be used as in proceedings governed by those rules.

L. Subpoenas: A party may have subpoenas and subpoenas duces tecum (to compel discovery and the attendance of witnesses and the production of relevant books, papers, documents and other evidence) issued as of right prior to the commencement of a hearing upon making written request therefor to the hearing officer. The issuance of such subpoenas after the commencement of the hearing rests in the discretion of the hearing officer.

M. Subpoena limits; service: Geographical limits upon the subpoena power shall be the same as if the hearing officer were a district court sitting at the location at which the hearing or discovery proceeding is to take place. The method of service shall be the same as that under the rules of civil procedure for the district courts, except that rules requiring the tendering of fees shall not apply to the department.

N. Pre-hearing disposition: The subject matter of any hearing may be disposed of by stipulation, settlement or consent order, unless otherwise precluded by law. Any stipulation, settlement, or consent order reached between the parties shall be written and shall be signed by the hearing officer and the parties or their attorneys.

O. Postponement or continuance: The hearing officer, at his or her discretion, may postpone or continue a hearing upon his or her own motion, or upon the motion of a party, for good cause shown. Notice of any postponement or continuance shall be given in person, by telephone, or by mail to all parties within a reasonable time in advance of the previously scheduled hearing date.

P. Conduct of hearing: Pursuant to the NM Open Meetings Act, Section 10-15-1, *et seq*., NMSA 1978, hearings shall be open to the public; provided, however, that

hearings may be closed in part to prevent the disclosure of confidential information, including but not limited to health information protected by state and federal laws.

Q. Telephonic testimony: Upon timely notice to the opposing party and the hearing officer, and with the approval of the hearing officer, the parties may present witnesses by telephone or live video (if available).

R. Legal representation: A licensee or applicant may be represented by an attorney licensed to practice in New Mexico, or by a licensed EMT, or both. The department may be represented by a department employee or an attorney licensed to practice in New Mexico, or both.

S. Recording: The hearing officer or a designee shall record the hearing by means of a mechanical sound recording device provided by the department for a record of the hearing. Such recording need not be transcribed, unless requested by a party who shall arrange and pay for the transcription.

T. Burden of proof: Except as otherwise provided in this rule, the department has the burden of proving by a preponderance of the evidence the basis for the proposed action. Exception in denied application cases: in cases arising from the denial of permission to take a licensing examination for which application has been properly made, denial of a license for any cause other than failure to pass an examination, or denial of a license for which application has been properly made on the basis of reciprocity or endorsement or acceptance of a national certificate of qualification, the applicant shall bear the initial burden of proving by a preponderance of the evidence the applicant's qualifications.

U. Order of presentation; general rule: Except as provided in this rule, the order of presentation for hearings in all cases shall be:

(1) appearances: opening of proceeding and taking of appearances by the hearing officer;

(2) pending matters: disposition by the hearing officer of preliminary and pending matters;

(3) opening statements: the opening statement of the department; and then the opening statement of the party challenging the department's action or proposed action;

(4) cases: the department's case-in-chief, and then the case-in-chief of the party challenging
the department's action;

(5) rebuttal: the department's case-in-rebuttal;

(6) closing argument: the department's closing statement, which may include legal argument; and then the closing statement of the party opposing the department's action or proposed action, which may include legal argument; and

(7) close: close of proceedings by the hearing officer.

V. Order of presentation in denied application cases: The order of presentation in cases arising
from the denial of permission to take a licensing examination for which application has been properly made, denial of a license for any cause other than failure to pass an examination, or denial of a license for which application has been properly made on the basis of reciprocity or endorsement or acceptance of a national certificate of qualification shall be:

(1) appearances: opening of proceeding and taking of appearances by the hearing officer;

(2) pending matters: disposition by the hearing officer of preliminary and pending matters;

(3) opening statements: applicant's opening statement; and then the opening statement of the department;

(4) cases: the applicant's case-in-chief, and then the department's case-in-chief;

(5) rebuttal: the applicant's case-in-rebuttal;

(6) closing argument: the applicant's closing statement, which may include legal argument; and then the department's closing statement, which may include legal argument; and

(7) close: close of proceedings by the hearing officer.

W. Admissible evidence; rules of evidence not applicable: The hearing officer may admit evidence and may give probative effect to evidence that is of a kind commonly relied on by reasonably prudent persons in the conduct of serious affairs. Rules of evidence, such as the New Mexico rules of evidence for the district courts, shall not apply but may be considered in determining the weight to be given any item of evidence. The hearing officer may at his or her discretion, upon his or her motion or the motion of a party or a party's representative, exclude incompetent, irrelevant, immaterial, or unduly repetitious evidence, including testimony, and may exclude confidential or privileged evidence.

X. Objections: A party may timely object to evidentiary offers by stating the objection together with a succinct statement of the grounds for the objection. The

hearing officer may rule on the admissibility of evidence at the time an objection is made or may receive the evidence subject to later ruling.

Y. Official notice: The hearing officer may take notice of any facts of which judicial notice may be taken, and may take notice of general, technical, or scientific facts within his or her specialized knowledge. When the hearing officer takes notice of a fact, the parties shall be notified either before or during the hearing of the fact so noticed and its source, and the parties shall be afforded an opportunity to contest the fact so noticed.

Z. Record content: The record of a hearing shall include all documents contained in the official file maintained by the hearing officer, including all evidence received during the course of the hearing, proposed findings of fact and conclusions of law, the recommendations of the hearing officer, and the final decision of the secretary.

AAWritten evidence from witnesses: The hearing officer may admit evidence in the form of a written statement made by a witness, when doing so will serve to expedite the hearing and will not substantially prejudice the interests of the parties.

BB. Failure to appear: If a party who has requested a hearing or a party's representative fails to
appear on the date, time, or location announced for a hearing, and if no continuance was previously granted, the hearing officer may proceed to hear the evidence of such witnesses as may have appeared or may accept offers of proof regarding anticipated testimony and other evidence, and the hearing officer may further proceed to consider the matter and issue his report and recommendation(s) based on the evidence presented; and the secretary may subsequently render a final decision. Where a person fails to appear at a hearing because of accident, sickness, or other cause, the person may within a reasonable time apply to the hearing officer to reopen the proceeding, and the hearing officer may, upon finding sufficient cause, fix a time and place for a hearing and give notice to the parties.

CC. Hearing officer written report and recommendation(s): The hearing officer shall submit a written report and recommendation(s) to the secretary that contains a statement of the issues raised at the hearing, proposed findings of fact and conclusions of law, and a recommended determination. Proposed findings of fact shall be based upon the evidence presented at the hearing or known to all parties, including matters officially noticed by the hearing officer. The hearing officer's recommended decision is a recommendation to the secretary of the New Mexico department of health and is not a final order.

DD. Submission for final decision: The hearing officer's report and recommendation(s) shall be submitted together with the complete official file to the secretary of the New Mexico department of health for a final decision no later than 30 days after the hearing.

EE. Secretary's final decision: The secretary shall render a final decision within 45 calendar days of the submission of the hearing officer's written report. The final decision shall contain a statement informing the applicant or licensee of their right to judicial review and the time within which such review must be brought (see below). A copy of the final decision shall be mailed to the appealing party by certified mail, return receipt requested, within 15 days after the final decision is rendered and signed. A copy shall be provided to legal counsel for the bureau.

FF.Right to judicial review: Pursuant to Section 39-3-1.1 NMSA 1978, a licensee or applicant who is entitled to a hearing under this rule and who is aggrieved by an adverse final decision may obtain a judicial review of the decision by filing in state district court a notice of appeal within 30 days of the entry of the final decision by the secretary.

GG. Court-ordered stay: Filing for judicial review shall not itself stay enforcement of the final decision. Any party may petition the court whose jurisdiction has been properly invoked for an order staying enforcement.

[7.27.2.15 NMAC - Rp, 7.27.2.15 NMAC, 12/12/2017]

7.27.2.16 CRIMINAL HISTORY SCREENING:

A. Authority; use of criminal history information: The emergency medical services (EMS) bureau is authorized to obtain the criminal history records of applicants and licensees, and to exchange fingerprint data directly with the federal bureau of investigation, department of public safety (DPS) and any other law enforcement agency or organization. The EMS bureau shall require fingerprinting of applicants and licensees for the purposes of this section. Information regarding felonies may form the basis of a denial, suspension or revocation of licensure, and other disciplinary action when the conviction relates directly to the profession or the practice of emergency medical services.

B. Procedure for applicants and licensees:

(1) If an applicant or licensee otherwise meets the application and eligibility requirements, then the bureau shall require the applicant or licensee to submit a request to the federal bureau of investigation, DPS or a DPS designated vendor for a current criminal history screening through the national crime information center ("NCIC"). The applicant or licensee shall undergo the criminal history screening when first applying for either initial or renewal licensure after the effective date of this rule, and every four years thereafter.

(2) The department shall provide applicants and licensees with the department's originating agency identification (ORI) number for the purposes of criminal history screening.

(3) An applicant or licensee shall provide to DPS or a DPS designated vendor a criminal background screening request, fingerprints, and supporting documentation including an authorization for release of information to the department in accordance with the procedures of DPS or the DPS designated vendor.

(4) DPS or the DPS designated vendor will review state records and also transmit the fingerprints to the federal bureau of investigation for a national screening. The results of the screening will be made available to the department for review.

(5) Applicants and licensees shall bear any costs associated with ordering or conducting criminal history screening. Fees are determined by and payable to DPS or a DPS designated vendor. Fees cannot be waived by the department.

(6) The EMS bureau may, within its discretion, waive the criminal history screening requirements of this section for an applicant or licensee who has submitted to, and provided proof of, an equivalent criminal history screening through DPS or through the DPS designated vendor within the previous nine months and was found to have no criminal convictions.

(7) The EMS bureau shall comply with applicable confidentiality requirements of the DPS and the federal bureau of investigation regarding the handling and dissemination of criminal history information.

C. EMS bureau review of criminal history screening information:

(1) The EMS bureau shall conduct a review of applicants and licensees with an associated history of felonies. The bureau may require the submission of additional information in writing from the applicant or licensee in order to determine whether to pursue disciplinary action. Such information may include (but not be limited to) evidence of acquittal or dismissal, information concerning conviction of a lesser included crime, or evidence of rehabilitation.

(2) The Criminal Offender Employment Act, Section 28-2-1 *et seq*., NMSA 1978 shall govern any consideration of criminal records required or permitted by this section. In accordance with Section 28-2-4 NMSA 1978 of that act, the following provisions shall apply:

If an applicant or licensee has been convicted of a felony, and if that conviction relates directly to the profession or the practice of emergency medical services, the department may deny, suspend, or revoke licensure, or take other disciplinary action, on the basis of the conviction(s). The burden of proof shall rest with the applicant or licensee to prove that he or she has been sufficiently rehabilitated.

(3) Factors that may be considered by the EMS bureau in determining whether to pursue disciplinary action against a licensee or applicant on the basis of the individual's criminal history may include, but shall not be limited to:

(a) the total number of convictions;

(b) the time elapsed since the most recent conviction;

(c) the circumstances and severity of the crime(s), including whether drugs or violence were involved;

(d) activities evidencing rehabilitation, including but not limited to completion of probation and completion of drug or alcohol rehabilitation programs;

(e) any false or misleading statements made by the applicant or licensee in an application or other materials; and

(f) evidence concerning whether an applicant or licensee poses a risk of harm to the health and safety of patients or the public.

(4) An applicant or licensee whose license is denied, suspended, or revoked, or who is otherwise made the subject of a contemplated disciplinary action based on information obtained in a criminal history background screening, shall be entitled to review the information obtained pursuant to this section and to appeal the decision pursuant to the Uniform Licensing Act, Section 61-1-1 *et seq*., NMSA 1978, in accordance with department rules.

[7.27.2.16 NMAC - Rp, 7.27.2.16 NMAC, 12/12/2017; A, 8/10/2021]

7.27.2.17 REVOCATION:

A. Effect of revocation of NM EMS licensure:

(1) Any person whose New Mexico EMSFR, EMT-B, EMT-I, or EMT-P licensure was revoked shall be ineligible to apply for EMSFR, EMT-B, EMT-I, or EMT-P licensure, except as otherwise permitted by this rule section.

(2) Any person whose New Mexico EMD or EMD-I licensure was revoked shall be ineligible to apply for EMD or EMD-I licensure, except as otherwise permitted by this rule section.

(3) A person whose NM EMS licensure was previously revoked cannot utilize the re-entry or reciprocity processes to become relicensed.

B. Application for preliminary approval for licensure after revocation:

(1) A person whose New Mexico licensure was revoked no less than five years ago and whose application for relicensure is prohibited as stated above (hereafter, a "revoked individual") may request preliminary approval for licensure at the first responder, EMT basic or EMD level by submitting a preliminary approval application to the EMS bureau.

(2) A revoked individual who applies for preliminary approval for licensure shall submit all documentation that they wish to be considered in support of the request, including any records to demonstrate rehabilitation. Records that demonstrate rehabilitation are materials that demonstrate that it is likely that the revoked individual will not engage in conduct that is the same or similar to that which resulted in the revocation, and which demonstrate that the revoked individual warrants the public trust.

(3) At all times in this licensure process, the burden shall rest solely with the revoked individual to demonstrate their rehabilitation and their fitness to practice emergency medicine.

(4) The EMS Bureau's receipt of an application for preliminary approval for licensure of an individual whose license was previously revoked shall in no way guarantee that the application will be granted or that the revoked individual will be permitted to apply for licensure.

C. Final decision on application for preliminary approval for licensure after revocation:

(1) The EMS bureau shall review the application for preliminary approval and shall submit that application and any attached materials to the licensing commission for its consideration in the closed session of a regularly scheduled meeting of the commission. The EMS bureau shall make a recommendation to the licensing commission to grant or deny the application, and the commission shall review the application, during a closed meeting at which a majority of commission members participate, either in person or by means of a conference telephone or similar communications equipment. The licensing commission shall authorize the EMS bureau to grant or deny the application for preliminary approval for licensure by a majority vote of the commission members in attendance.

(2) Upon receiving authorization from the commission to grant or deny an application for preliminary approval for licensure, the bureau may render the final decision via written notice to the applicant.

(3) The bureau's grant or denial of an application for preliminary approval for licensure constitutes the final administrative action on that application, and, except as otherwise provided by law, that decision shall not be subject to any further proceeding or appeal. Nothing in this rule section conveys a right of action to any person with respect to a final decision concerning licensure after revocation, and nothing in this rule generates a right of judicial appeal with respect to that decision.

(4) A revoked individual whose application for preliminary approval for licensure is denied shall be prohibited from applying for licensure, and may not thereafter reapply for preliminary approval for licensure, until the passage of at least three years from the date of the denial.

(5) A revoked individual whose application for preliminary approval for licensure is granted may apply for licensure, and shall complete all applicable requirements of the rule in order to become licensed at this initial level and all subsequent levels of desired licensure.

D. Effect of licensure after revocation: The licensure after revocation process enables a revoked individual to again obtain NM EMS licensure. This licensure does not constitute reinstatement, revival or renewal of a license that was previously issued or revoked. The record of a revoked individual's prior revocation shall remain a part of their EMS licensing file, and shall remain a matter of public record, without regard to the outcome of the preliminary approval process.

[7.27.2.17 NMAC - N, 12/12/2017]

PART 3: MEDICAL DIRECTION FOR EMERGENCY MEDICAL SERVICES

7.27.3.1 ISSUING AGENCY:

New Mexico Department of Health, Public Health Division.

[3/16/95, 1/1/97, 4/1/98; Recompiled 10/31/01]

7.27.3.2 SCOPE:

These regulations are applicable to all emergency medical services (EMS), EMS medical directors, EMS administrators, EMS providers certified/licensed to provide pre-hospital health care in the state of New Mexico, and the medical direction committee.

[3/16/95, 1/1/97; Recompiled 10/31/01]

7.27.3.3 STATUTORY AUTHORITY:

These regulations are promulgated pursuant to the following statutory authorities:

A. the Department of Health Act, Section 9-7-6.E NMSA 1978, which authorizes the secretary of the department of health to "...make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions", and

B. the Emergency Medical Services Act (as amended by Laws of 1993, Chapter 161), Section 24-10B-4.D NMSA 1978, which authorizes the department of health to

adopt "regulations for medical direction of a provider or emergency medical system upon the recommendation of the medical direction committee..." The medical direction committee is established pursuant to Section 24-10B-7C NMSA 1978 of the EMS Act.

[3/16/95, 1/1/97; Recompiled 10/31/01]

7.27.3.4 DURATION:

Permanent.

[3/16/95, 1/1/97; Recompiled 10/31/01]

7.27.3.5 EFFECTIVE DATE:

January 1, 1997, unless a later date is cited at the end of a section or paragraph.

[3/16/95, 1/1/97; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.27.3.6 OBJECTIVE:

The purpose of these regulations are three fold:

A. they establish the administrative functions for the medical direction committee of the department; and

B. they provide guidelines that outline the elements of medical direction necessary for all components of an EMS system in New Mexico pursuant to Section 24-10B-4D(1) NMSA 1978 of the EMS Act.

C. they establish the legal basis for use of "jumpkits" by EMT providers that are physically separate from ambulance/rescue vehicles.

[3/16/95, 1/1/97, 4/1/98; Recompiled 10/31/01]

7.27.3.7 DEFINITIONS:

A. "Academy" means the emergency medical services training program administered through the department of emergency medicine at the university of New Mexico school of medicine.

B. "Advanced directive" means a written instruction, such as living will or durable power of attorney for health care, recognizable under state law and relating to the provision of health care when a person is incapacitated.

C. "Advanced life support (ALS)" means advanced pre-hospital and inter-facility care and treatment, including basic and intermediate life support, as prescribed by regulation, which may be performed only by a person licensed as a paramedic by the bureau and operating under medical control.

D. "Basic life support (BLS)" means pre-hospital and inter-facility care and treatment, as prescribed by regulation, which can be performed by all licensed emergency medical technicians.

E. "Board-certified" means a physician who has obtained emergency medicine certification by a recognized board of medicine.

F. "Bureau" means the injury prevention and emergency medical services bureau of the public health division of the department.

G. "Commission" means the New Mexico emergency medical services licensing commission appointed by the secretary.

H. "Committee" means the medical direction committee of the bureau.

I. "Consulting pharmacist" means a pharmacist whose services are engaged on a routine part-time basis by an EMS service:

(1) to assist in drawing up correct procedures, rules and regulations for the distribution of dangerous drugs;

(2) to assume the overall responsibility for the system of control and distribution of drugs;

(3) to see that a designated person has the responsibility for day-to-day operation of the EMS service’s dangerous drug supplies; and

(4) to visit the EMS service on a regularly scheduled basis in the course of his/her duties.

J. "Controlled substance" means any drug, substance or immediate precursor enumerated in Schedules I through V of the Controlled Substance Act, Section 30-31-1, et seq. NMSA 1978.

K. "Dangerous drug" means a drug that is determined by law to be unsafe for self-medication and that is enumerated in the New Mexico Drug, Device and Cosmetic Act, Section 26-1-1, et seq. NMSA 1978.

L. "Department" means the New Mexico department of health.

M. "EMS medical director" means a physician who is responsible for all aspects of patient care for an EMS system or EMS provider service, including providing for or ensuring the medical control of EMS providers; the development, implementation, evaluation of medical protocols; and oversight of quality assurance activities.

N. "Emergency medical dispatcher" means a person who is trained and certified pursuant to Subsection G of Section 24-10B-4 NMSA 1978 to receive calls for emergency medical assistance, provide pre-arrival medical instructions, dispatch emergency medical assistance and coordinate its response.

O. "Emergency medical service (EMS)" means the services rendered by licensed emergency medical technicians, certified emergency medical services first responders or emergency medical dispatchers in response to a person’s need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

P. "Emergency medical technician (EMT)" means a health care provider who has been certified or licensed to practice by the bureau.

Q. "Intermediate life support (ILS)" means certain advanced pre-hospital and inter-facility care and treatment, including basic life support, as prescribed by regulation, which may be performed only by a person licensed by the bureau and operating under medical control.

R. "Jumpkits" means portable carrying devices that contain emergency medical equipment and/or approved quantities of dangerous drugs and controlled substances that are in the possession of a licensed emergency provider and whose contents are authorized by the service’s EMS medical director.

S. "Medical control" means supervision provided by or under the direction of physicians to providers by written protocol or direct communications.

T. "Medical direction" means guidance or supervision provided by a physician to a provider or emergency medical services system and which includes authority over and responsibility for emergency medical dispatch, direct patient care and transport of patients, arrangements for medical control and all other aspects of patient care delivered by a provider.

U. "New Mexico board of pharmacy" means the authorized board established by the New Mexico Pharmacy Act to regulate pharmaceutical practices in the state of New Mexico.

V. "Physician" means a doctor of medicine or doctor of osteopathy who is licensed or otherwise authorized to practice medicine or osteopathic medicine in New Mexico.

W. "Protocols" means predetermined, written medical care plans and includes standing orders.

X. "Provider" means a person or entity delivering emergency medical services in New Mexico.

Y. "Secretary" means the secretary of the department.

Z. "Scope of practice" means a listing of skills, techniques and medications allowed for use by each level of life support in New Mexico.

AA. "Special Skills" means a set of procedures or therapies that are beyond the usual scope of practice of a given level of life support and that have been approved by the medical direction committee for use by a specified provider.

BB. "Standing Orders" means strictly defined written orders for actions, techniques or drug administration, signed by a physician, to be utilized when an on-line medical control physician is not available.

[3/16/95, 1/1/97, 4/1/98; Recompiled 10/31/01]

7.27.3.8 MEDICAL DIRECTION ADMINISTRATION:

A. Duties: The duties of the medical direction committee shall be:

(1) reviewing the medical appropriateness of all regulations proposed by the bureau;

(2) reviewing and approving the applications of providers for special skills authorizations, as outlined in 7 NMAC 27.2 [now 7.27.2 NMAC] "Certification and Licensing of EMS Personnel", or such other regulations as may be adopted by the department;

(3) assisting in the development of regulations pertaining to medical direction;

(4) updating at least annually a list of skills, techniques, and medications approved for each level of life support that will be approved by the secretary and issued by the bureau. These skills, techniques and medications shall be called the "scope of practice" and will be attached as an Appendix to 7 NMAC 27.3 [now 7.27.3 NMAC] "Certification and Licensing of EMS Personnel", or such other regulations as may be adopted by the department; and,

(5) as needed, develop guidelines and appendices to regulations governing medical direction issues as prescribed by law;

(6) collecting data from the EMS community in order to oversee the actual medical impact of the approved scope of practice for each level and for actions undertaken or contemplated.

B. Organization: Members of the medical direction committee are appointed by the secretary as provided by law.

(1) Membership shall be nine individuals including:

(a) the state EMS medical director who shall serve as chair;

(b) one physician representative experienced in pre-hospital care selected from a list proposed by the New Mexico chapter of the American college of emergency physicians;

(c) one physician representative from the EMS academy;

(d) one physician from each of the EMS geographic regions (may be the regional medical director or other physician within the region); and,

(e) one emergency medical technician from each level of life support.

(f) There shall be no designated term of service for these members who shall serve at the pleasure of the secretary.

(2) In the event of a vacancy on the committee by resignation or removal, the bureau shall immediately notify the secretary so as to expedite the appointment of a new member.

(3) The committee may recommend to the secretary the removal of any member for the following reasons:

(a) failing to attend or otherwise participate in two (2) consecutive meetings without a valid reason; or,

(b) any other good cause.

(4) The state EMS medical director shall serve as chair. If he/she is unable to chair a meeting, the chair shall be assumed by a member appointed by the state EMS medical director.

(5) The bureau shall serve as staff for the committee.

C. Meetings: The committee shall meet as needed, but not less than semiannually. Minutes of the meetings shall be taken and maintained at the bureau.

D. Reconsideration process: If a recommendation made by the committee is not accepted by the bureau:

(1) the bureau shall communicate in writing to the committee as to the reasons for that recommendation not being accepted.

(2) at the request of the committee, the decision shall be submitted for reconsideration to the director of the public health division of the department and subsequently to the secretary.

(3) any decision made pursuant to a request for reconsideration shall be communicated in writing by the department to the committee.

[3/16/95, 1/1/97, 4/1/98; Recompiled 10/31/01]

7.27.3.9 MEDICAL DIRECTION GUIDELINES:

A. General: These guidelines provide overall guidance for the performance of medical direction in New Mexico. The guidelines set forth the qualifications, responsibilities and activities of a system’s designated medical director. The guidelines will also define a process for notifying the EMS bureau of the withdrawal of medical control by a physician from a provider, and specifying requirements for medical direction of intermediate and advanced life support personnel and basic life support personnel with special skills approval. Finally, the guidelines with set forth the legal requirements for an EMS system to maintain "jumpkits" under the authorization of the EMS medical director. Each guideline in Paragraphs 9 and 10 are prefaced by either the word "mandatory" or the word "recommended". Mandatory items are required, while recommended items are highly recommended.

B. Medical director oversight:

(1) (Mandatory) A designated medical director shall be required for all the situations outlined below:

(a) a certified ambulance carrier as defined in state corporation commission (SCC) Regulation 18 NMAC 4.2 [now 18.4.2 NMAC], or such other rules as may be promulgated by the SCC or its successor agency;

(b) all advanced life support and intermediate life support EMTs;

(c) all basic life support EMTs who provide advanced life support skills, medications, and/or techniques authorized under the scope of practice or special skills authorizations; and

(d) all EMTs or first responders who provide semi-automatic defibrillation services.

(2) (Recommended) All other services operating on a basic life support (BLS) level are urged to have a local or system-wide medical director as feasible by local situations and availabilities.

C. Medical director qualifications: The qualifications for an EMS medical director are provided below. A medical director:

(1) (Mandatory) shall be an M.D. or D.O. licensed or otherwise authorized to practice medicine in New Mexico;

(2) (Mandatory) shall, if a new medical director, complete one of the below listed medical direction education/training methods within one year of assuming the responsibilities of a medical director; current medical directors shall complete one of the below listed methods of medical direction education/training within two years of the effective date of this regulation:

(a) a nationally-recognized EMS medical director's course; or

(b) a bureau-recognized orientation course; or

(c) a local orientation provided by a regional or state EMS medical director.

(3) (Mandatory) The bureau shall be notified within thirty (30) days when a new EMS medical director assumes responsibilities or when a medical director is no longer providing those duties for a service.

(4) (Recommended) may be familiar with the design and operation of EMS systems;

(5) (Recommended) may be experienced in, and possess current knowledge of, emergency care of patients who are acutely ill or traumatized (emergency medicine board-certification and/or certification in recognized training such as advanced cardiac life support (ACLS), advanced trauma life support (ATLS), or pediatric advanced life support (PALS) are recommended);

(6) (Recommended) may be actively involved and knowledgeable in:

(a) the emergency management of acutely ill or injured patients;

(b) the training and continuing education of EMS personnel under the medical director's supervision at their level of certification;

(c) the quality assurance program of a service including, but not limited to, medical audit, review and critique of basic and advanced level EMS personnel;

(d) the administrative and legislative processes affecting regional and/or state pre-hospital EMS organizations; and

(e) the laws and regulations affecting local, regional and state EMS services and personnel.

D. Administrative and system oversight responsibilities: The EMS medical director, in conjunction with the local EMS service director and other local advisory boards or committees shall provide the responsibilities outlined below (any element of these responsibilities may be delegated as appropriate to other qualified individuals within the EMS system):

(1) advise the program administrator on all elements of the EMS program as to their medical appropriateness and to assure the quality medical services are being provided;

(2) approve the level of pre-hospital care which may be rendered locally by each of the EMS personnel employed by and/or volunteering with the services under the medical director's supervision;

(3) regardless of an EMS provider's level of state certification or licensure, approve the level that each EMS provider may function at locally, before the provider is permitted to perform pre-hospital care to the public;

(4) establish and monitor field performance standards for EMS personnel in the service;

(5) assist in development of local disaster and mass casualty plans;

(6) develop and sign a contract or letter of agreement between the medical director and the EMS service outlining the specific responsibilities, authorities and, if appropriate, compensation of the EMS medical director;

(7) develop procedures with the service on a method by which the medical director may withdraw medical control for an EMS provider who is non-compliant with these guidelines, other relevant laws and regulations and accepted medical standards. The procedure shall be outlined in the contract or letter of agreement between the medical director and the service; shall reflect any internal procedures of that EMS service and due process afforded individual providers, if any, as outlined by the service; and

(8) establish local medical standards for dispatch procedures to assure the appropriate EMS response units are dispatched to the medical emergency scene. This should include development of a relevant emergency medical dispatch system with the local agency providing dispatch for the EMS service.

E. Protocol development: The medical director shall:

(1) develop, implement, and revise written treatment protocols and standing orders governing pre-hospital care and medical aspects of patient triage, transport, transfer, dispatch, extrication, rescue and radio telephone communication by the EMS service; and

(2) establish written protocols under which circumstances the EMS service may:

(a) not transport a patient when there has been an initial call for services;

(b) transport a patient against his/her will, in accordance with state law including procedure, appropriate forms and review process;

(c) handle emergency treatment of a minor, especially in cases where that patient refuses treatment and transport;

(d) interaction with an intervening health care provider at the scene of an emergency;

(e) not begin or terminate life support measures in patients with EMS do not resuscitate (DNR) orders, hospice protocols and other legally recognized advanced directives; and

(f) triage and transport trauma patients consistent with state patient triage criteria and transport protocols.

F. Training responsibilities: The medical director shall:

(1) establish and monitor the training standards of a service for initial and continuing medical education; and

(2) provide, as appropriate, educational sessions for EMS personnel within the service.

G. Quality assurance/improvement responsibilities: The medical director shall plan, develop and implement a system for ongoing medical audit of pre-hospital patient care rendered by the EMS service and its personnel. This auditing system shall provide for, but not be limited to:

(1) an organized method for internal collection of operational and patient care data, including access to both pre-hospital and outcome records to permit identification and resolution of problems impacting the quality of patient care;

(2) a comprehensive mechanism for receipt, investigation and resolution of medically-related complaints about the EMS service;

(3) regular review and on-site evaluation of EMS personnel operating within the service; and

(4) regular review of the overall system to assure compliance with state corporation commission Regulation 18 NMAC 4.2 [now 18.4.2 NMAC], or such other rules as may be adopted by the SCC or its successor agency.

H. Medical liaison responsibilities: The medical director shall:

(1) function as the liaison between the EMS system and the local medical community, medical facilities and regional/state EMS medical directors; and

(2) as needed, be available to represent the medical aspects of an EMS service to local, regional or state boards/committees, as well as political subdivisions such as municipal governing bodies or legislatures.

I. Notification of withdrawal or restriction of medical support: An EMS medical director may withdraw or restrict all or any of the medical control authorized to a provider under his/her medical direction in the following manner:

(1) the withdrawal or restriction shall be made in writing and sent to the EMS provider, EMS service director and operations section of the bureau within five (5) working days of the action; and

(2) the bureau shall perform a preliminary investigation and decide, after consultation with the EMS medical director and service director, whether or not the matter shall be referred to the commission for investigation with potential impact on licensure or be handled locally within the service.

J. Medication control and storage: The EMS medical director shall: if appropriate for the local service, develop a program whereby reasonable quantities of dangerous drugs may be possessed and transported to other locations by authorized personnel in "jumpkits". These "jumpkits" will be kept at the authorized personnel’s residence(s) or vehicle(s) and will be stored according to the New Mexico board of pharmacy regulations (i.e., temperature control and security).

(1) The specific dangerous drugs and the quantities allowed in "jumpkits" will be determined and approved by the EMS medical director and made available to the New Mexico board of pharmacy or its staff, as requested.

(2) A list of authorized personnel who maintain "jumpkits" shall be made available at the request of the New Mexico board of pharmacy or its staff.

(3) An inventory of all dangerous drugs, including controlled substances, issued to authorized personnel for "jumpkits" will be kept for a period of three (3) years and will include the following:

(a) date issued;

(b) name of authorized personnel;

(c) name and strength of dangerous drugs or controlled substances issued.

(4) The "jumpkits" will be made available during consulting pharmacist inspections, as requested, and with advance notice, to the New Mexico board of pharmacy inspectors.

(5) "Jumpkits" which are authorized by the EMS medical director, to including [sic] specifically approved quantities of controlled substances, shall be on the EMT's person or double-locked and secure. Controlled substances shall not be stored in unattended vehicles.

[3/16/95, 1/1/97, 4/1/98; Recompiled 10/31/01]

PART 4: EMERGENCY MEDICAL SERVICES FUND ACT

7.27.4.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.27.4.1 NMAC - Rp, 7.27.4.1 NMAC, 8/13/2004]

7.27.4.2 SCOPE:

The Emergency Medical Services Fund Act shall apply to requests made for funds available pursuant to the Emergency Medical Services Fund Act, Section 24-10A-1, et seq., NMSA 1978.

[7.27.4.2 NMAC - Rp, 7.27.4.2 NMAC, 8/13/2004]

7.27.4.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to the following statutory authorities: 1) the Department of Health Act, Section 9-7-6.E., NMSA 1978, which authorizes the secretary of the department of health to ". . . make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions", and; 2) the Emergency Medical Services Fund Act (as amended by Laws of 2001, Chapter 273), Section 24-10A-3.1., NMSA 1978, which authorizes the department of health to adopt rules to carry out the provisions of the act.

[7.27.4.3 NMAC - Rp, 7.27.4.3 NMAC, 8/13/2004]

7.27.4.4 DURATION:

Permanent.

[7.27.4.4 NMAC - Rp, 7.27.4.4 NMAC, 8/13/2004]

7.27.4.5 EFFECTIVE DATE:

August 13, 2004, unless a later date is cited at the end of a section.

[7.27.4.5 NMAC - Rp, 7.27.4.5 NMAC, 8/13/2004]

7.27.4.6 OBJECTIVE:

The objective of Part 4, of Chapter 27 is to establish standards and procedures for regulating programs under the Emergency Medical Services Fund Act. These standards and procedures are designed for the purpose of making funds available to municipalities and counties, in proportion to their needs, for use in the establishment and enhancement of local emergency medical services in order to reduce injury and loss of life. This rule will inform New Mexico municipalities and counties of the procedures to access funds. The department of health, through the emergency medical systems bureau, will administer the fund pursuant to the Emergency Medical Services Fund Act and this rule.

[7.27.4.6 NMAC - Rp, 7.27.4.6 NMAC, 8/13/2004]

7.27.4.7 DEFINITIONS:

A. "Accumulation" means the expenditure or disposition in the current fiscal year of funds distributed in the prior fiscal year. However, a municipality or county may accumulate balances to purchase vehicles or equipment if the accumulation and a purchase plan have been approved by the bureau.

B. "Act" means the Emergency Medical Services Fund Act, Section 24-10A-1, et seq., NMSA 1978 (as amended by Laws of 2001, Chapter 273).

C. "Advisory committee" means those individuals, representing specific agencies, organizations, and consumers appointed by the secretary to advise the bureau on statewide EMS policy matters.

D. "Ambulance service" means a publicly or privately owned entity holding a current certificate of the New Mexico public regulation commission as an emergency response ambulance service and subject to the rules and regulations of the public regulation commission or its successor agency.

E. "Applicant" means an incorporated municipality or county applying on behalf of a local recipient. For special funding applications (i.e., statewide and local system improvement projects), applicant also includes EMS regional office, approved training institution or the bureau.

F. "Area" for purposes of pro-rata allocation of designated funds by county as described in Subsection D of 7.27.4.11 NMAC, of this rule, means the area, expressed in square miles, for each New Mexico county as reported in the U.S. department of commerce publication entitled *area measurement reports, areas of New Mexico: (most recent edition).*

G. "Bureau" means the emergency medical systems bureau of the office of health emergency management, New Mexico department of health.

H. "Chief" means the chief of the emergency medical systems bureau.

I. "Department" means the New Mexico department of health.

J. "Director" means the director of the epidemiology and response division.

K. "Division" means the epidemiology and response division.

L. "Eligible item" means a cost or item of proposed expenditure under the local EMS funding program, which is eligible for funding under the act and includes those categories listed in Subsection N of 7.27.4.11 NMAC of this rule.

M. "Emergency medical dispatch agency (EMDA)" means an organization, or a combination of organizations working cooperatively, that routinely accepts calls for emergency medical assistance and employs emergency medical dispatch priority reference system (EMDPRS) techniques.

N. "EMS" means the services rendered by emergency medical technicians, licensed emergency medical services first responders or emergency medical dispatchers in response to an individual’s need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

O. "EMS regional office" means those regional planning and development agencies formally recognized and supported by the bureau.

P. "Fiscal year" means the state fiscal year that runs from July 1 through June 30 each year.

Q. "Federal fiscal year " means the federal fiscal year that runs from October 1 through September 30 each year.

R. "Fund" means the emergency medical services fund.

S. "Licensing fees" mean the licensure fees, licensure renewal fees, and travel and per-diem expenses associated with the licensing and the certification process in New Mexico required of emergency medical technicians and licensed EMS first responders under current regulations governing the certification and licensing of EMS personnel.

T. "Local EMS personnel" means an individual who is authorized to provide pre-hospital care and is affiliated with a local recipient.

U. "Local emergency medical services system" means coordinated system of health care in a defined geographic area, including but not limited to community education and prevention programs, centralized access, emergency medical dispatch, law enforcement, licensed EMS personnel, fire medical rescue, ambulance, and hospital which support, respond to and/or provide emergency medical care in an organized fashion to the real or perceived needs of sick or injured persons in New Mexico and its border areas. For the purpose of funding, local emergency medical service system means one or more local recipients within a single EMS system.

V. "Local recipient" means an ambulance service, medical rescue service, fire department rescue service or fire district, air ambulance service, or other pre-hospital care provider:

(1) that routinely responds to an individual's need for immediate medical care in order to prevent loss of life or aggravation of physical or psychological illness or injury;

(2) whose application for funding through the Emergency Medical Services Fund Act is sponsored by a municipality or county;

(3) that meets department guidelines concerning personnel training, use of bureau-approved run forms, participation in mutual aid agreements and medical control and;

(4) receives funds distributed under the act and this rule.

W. "Medical director" means a physician currently licensed or otherwise authorized to practice in New Mexico who directs or supervises the practice of EMS personnel, or assists in the development and approval of local protocols and who participates in the development and implementation of quality assurance activities and training programs in connection with an EMS provider.

X. "Medical-rescue service" means a provider that is part of the emergency medical services system but not subject to the authority of the public regulation commission or its successor agency, under the Ambulance Standards Act (Sections 65-6-1 to 65-6-6, NMSA 1978) and which may be dispatched to the scene of an emergency to provide rescue or medical care.

Y. "Population" for purposes of pro-rata allocation of designed funds by county as described in Paragraph (1) of Subsection D of 7.27.4.11 NMAC of this rule, means the population estimates for each New Mexico county as shown in the most recent report of provisional figures in the U.S. department of commerce publication entitled population estimates, *"estimates of the population of New Mexico counties and metropolitan areas: (identifier)".*

Z. "Pre-hospital data base program" means the routine submission of essential pre-hospital data elements as defined by the bureau via bureau provided run forms or other methods.

AA. "Prevention program" means a planned activity with a defined purpose, stated objectives, implementation schedule and an evaluation component that seeks to prevent or reduce illness or injury. Examples include but not limited to bicycle helmet promotion, seat belt awareness campaign, child car seat distribution program, DWI prevention and first aid training.

BB. "Qualified instructor" means an individual who through education, training, and experience is approved by an approved EMS training program to teach local EMS personnel or by the bureau to teach continuing education.

CC. "Salaries and benefits" means regular compensation for services or work, including other payments made in accord with a salary agreement, such as insurance, retirement, leave accrual, etc.

DD. "Statewide" for the purpose of statewide EMS system improvement projects means two (2) or more EMS local systems, a county, a training institution, an EMS regional office or the bureau, which support, respond to and/or provide medical care in an organized fashion to the real or perceived needs of at risk, sick or injured persons in New Mexico and its border areas.

EE. "Routinely responds" means the local recipient is available and may be dispatched to a medical or traumatic emergency twenty-four (24) hours per day, seven (7) days per week.

FF."Run" means an EMS response dispatched to an existing or potential medical event, by one or more local recipients to provide EMS assistance and/or transportation of a patient, regardless of the number of patients on scene.

GG. "Secretary" means the secretary of the New Mexico department of health.

HH. "Training program" means a course provided by an approved EMS training program or any continuing education approved by the bureau.

II. **"Tuition"** means those charges, including fees and textbooks, for the enrollment of students in approved EMS training programs, continuing education, and conferences relevant to the education and training of local EMS personnel.

[7.27.4.7 NMAC - Rp, 7.27.4.7 NMAC, 8/13/2004]

7.27.4.8 DUTY OF THE BUREAU:

The bureau shall administer the fund and provide for the distribution of the fund pursuant to the act and this rule. The bureau shall certify the names and the amount distributed to each applicant and local recipient in accordance with the provisions of the act and this rule. To accumulate funds, municipalities or counties shall submit an accumulation and purchase plan, in writing to the bureau. The bureau shall review and approve/disapprove the plan in writing. Accumulated funds shall only be expended as outlined in the bureau approved purchase plan.

[7.27.4.8 NMAC - Rp, 7.27.4.8 NMAC, 8/13/2004]

7.27.4.9 ANNUAL REPORT:

The bureau shall prepare an annual report which includes a summary of the current fiscal year distribution, the number of approved applications for the local funding program, local and statewide system support projects, the vehicle purchase program and the approved budgets for administration and the trauma support program. In addition, the report will include the dollar amounts requested, amount of appropriation, average distribution amount, the types of local recipients, total number of runs, and a break down of the distribution by county. The report shall be made available to public entities and the public on request.

[7.27.4.9 NMAC - Rp, 7.27.4.9 NMAC, 8/13/2004]

7.27.4.10 EXTENSION OF TIME:

Extension of time for the filing of an application or document may be granted, if the person seeking the extension can show good cause to the satisfaction of the chief. Requests for extension of time shall be received in writing in advance of the date on which the application or document is due to be filed. No extension shall exceed ten (10) calendar days. Extensions shall be confirmed or denied in writing.

[7.27.4.10 NMAC - Rp 7.27.4.10 NMAC, 8/13/2004]

7.27.4.11 LOCAL EMS FUNDING PROGRAM:

In a fiscal year, no less than seventy-five percent (75%) of the money in the fund shall be used for the local emergency medical services funding program. The program shall provide for: the establishment or enhancement of local emergency medical services;

operational costs other than salaries and benefits of local emergency medical services personnel, purchase, repair and maintenance of emergency medical services vehicles, equipment and supplies; implementation of prevention program and the training and licensing of local emergency services personnel.

A. ASSURANCES: The bureau shall authorize distributions from money in the fund to the extent funds are available during a fiscal year. Distribution from money in the fund shall be made only to applicants on behalf of local recipients, that:

(1) submit an approved application to the bureau;

(2) demonstrate a need for a distribution from the fund and the amount required;

(3) agree to expend funds distributed from the fund only for the purposes stated in the application and approved by the bureau;

(4) authorization of the chief executive of the incorporated municipality or county on behalf of the local recipient upon vouchers issued by the treasurer and/or fiscal agent of each political subdivision shall also be required; accountability and reporting of these funds shall be in accordance with the requirements set forth by the local government division of the New Mexico department of finance and administration; and

(5) agree that the funds distributed under the act will not supplant other funds budgeted and designated for emergency medical service purposes by the applicant; applications for distributions of money from the fund shall be accompanied by a certified statement that the applicant shall not supplant any other public monies available for these same purposes.

B. UPPER FUNDING LIMITATION - STATUTORY REQUIREMENT: No more than one percent (1%) may be distributed from the fund through any one county or municipality in any one fiscal year on behalf of any one local recipient whose proposal for assistance has been approved by the incorporated county or municipality. The advisory committee will annually recommend maximum funding amount prior to the (November) mail out of applications.

C. MINIMUM FUNDING BASE ESTABLISHED - REGULATORY REQUIREMENT: In a fiscal year, each local recipient which has been approved pursuant to this rule, may be allocated a minimum distribution based on the criteria established in this section. Approved applications requesting less than the minimum will be funded in the amount requested. For the purpose of determining funding eligibility, local EMS personnel cannot be affiliated with more than (1) one local recipient.

(1) Emergency Medical Service - Start-Up Funding Level: This level is eligible to receive a one (1) time, minimum distribution of one thousand five hundred

dollars ($1,500), upon recommendation from the advisory committee. The minimum requirements for this level are to submit a:

(a) letter of commitment from the chief;

(b) letter of review and recommendation from the respective EMS regional office; and

(c) letter of support from the medical director.

(2) Medical-Rescue Service - Entry Level: This level is eligible to receive a minimum distribution of one thousand five hundred dollars ($1,500) if the following criteria are met and are verified by the applicant. The minimum criteria for this level are:

(a) at least fifty percent (50%) of EMS runs covered by a licensed first responder within two years of the initial request for funding;

(b) the service has at least basic medical supplies and equipment;

(c) the service has at least one written mutual aid agreement or other written cooperative plan with a transporting ambulance and will attach to the application a copy of the agreement(s);

(d) the service has a designated training coordinator; and

(e) the service shall participate in the bureau's pre-hospital data collection system as determined by the bureau, by using the bureau's software, web-site or by submitting compatible data.

(3) Medical-Rescue Service - First Responder Level: This level of service is eligible to receive a minimum distribution of three thousand dollars ($3,000) if the following criteria are met and are verified by the applicant. The minimum criteria for this level are:

(a) at least eighty percent (80%) of EMS runs were covered in the prior federal fiscal year (October 1 - September 30), by a licensed EMS first responder or higher licensed medical personnel and shall continue to demonstrate that EMS response level; there shall be a minimum of at least two licensed EMS first responders with the service;

(b) the service has at lease basic medical supplies and equipment;

(c) the service has at least one written mutual aid agreement or other written cooperative plan with a transporting ambulance and will attach to the application a copy of the agreement (s);

(d) the service has a designated training coordinator;

(**e)** the service shall participate in the bureau's pre-hospital data collection system, as determined by the bureau, by using the bureau's software, web-site or by submitted compatible data;

(f) the service has a medical director, if automatic defibrillation capable.

(4) Medical-Rescue Service or Ambulance - Basic Level: This level of service is eligible to receive a minimum distribution of five thousand dollars ($5,000) if the following criteria are met and are verified by the applicant. The minimum criteria for this level are:

(a) at least eighty percent (80%) of EMS runs shall be were covered in the prior federal fiscal year (October 1 - September 30), by a licensed EMT-basic or higher level of licensed medical personnel and shall continue to demonstrate that EMS response level; there shall be a minimum of at least two licensed EMT basics with the service;

(b) the service has at least basic medical supplies and equipment;

(c) the service has at least one written mutual aid agreement or other written cooperative plan with first response or transporting ambulance service(s) and will attach to the application a copy of the agreement(s);

(d) the service has a designated training coordinator;

(e) the service shall participate in the bureau's pre-hospital data collection system as determined by the bureau by using the bureau's software, web-site or by submitting compatible data;

(f) the service has a service medical director and appropriate medical protocols;

(g) the service complies with public regulation commission (PRC) Regulation 18.4.2 NMAC, if applicable, or such other regulations as may be adopted by the PRC or its successor agency regarding registered medical rescue and certified ambulances and;

(h) the service complies with the department's air ambulance certification regulations where applicable.

(5) Medical-Rescue Service or Ambulance - Advanced Level: This level is eligible to receive a minimum distribution of seven thousand dollars ($7,000) if the following criteria are met and are verified by the applicant. The minimum criteria for this level are:

(a) at least eighty percent (80%) of EMS runs were covered in the prior federal fiscal year (October 1 - September 30), by licensed EMT intermediate or paramedic level personnel; or, if an emergency medical dispatch priority reference system (EMDPRS) is utilized, at least 80% of all runs determined by dispatch to require an advance level response shall be covered by licensed EMT intermediate or paramedic level personnel and there shall be a least one additional licensed EMT with the service;

(b) the service has at least basic and advanced medical supplies and equipment;

(c) the service shall maintain at least one transport capable vehicle if appropriate within the local EMS system;

(d) the service has at least one written mutual aid agreement or other written cooperative agreement with first response or transporting ambulance service(s)and will attach to the application a copy of the agreement(s);

(e) the service shall participate in the bureau's pre-hospital data collection system as determined by the bureau by using the bureau's software, web-site or by submitting compatible data;

(f) the service has a designated training coordinator;

(g) the service has a service medical director and appropriate BLS and ALS medical protocols;

(h) the service routinely responds when dispatched for all medical and traumatic emergencies within its primary response area;

(i) the service complies with public regulation commission (PRC) Regulation 18.4.2 NMAC, if applicable, or such other regulations as may be adopted by the PRC or its successor agency regarding registered medical - rescue and certificated ambulances; and

(j) the service complies with the department's certification of air ambulance services regulations where applicable.

D. FUNDING FORMULA DEFINITION: If the money available is not sufficient to meet the funding requested in the applications of all local recipients at the statutory maximum, the bureau shall allocate the funds according to the following formula.

(1) After computation of the sum of minimum allocations pursuant to Subsection C of 7.27.4.11 NMAC, a total county share shall be determined. The balance of funds shall be divided into two equal portions. For each county, the first portion shall be prorated according to area of the county as a percentage of total state

area, and the other portion shall be prorated according to population of the county as a percentage of total state population.

(2) From the county share established above, the individual allocation to each local recipient shall be determined based on the relative number of runs in the prior federal fiscal year (October 1 through September 30) as reflected in the application of the local recipient and verified through the bureau's pre-hospital data base program.

(3) In the event that an incorporated municipality or county supports the applications of more than one local recipient, the bureau shall determine the pro-rata share for each local recipient in the allocation of funds based on the number of annual runs reported.

E. SPECIAL CONDITIONS EMERGENCY FUNDING: Subject to the availability of funds, the bureau will entertain applications for funding at any time based on the following criteria.

(1) The local recipient needs some immediate financial support for first year, startup services and the local community cannot provide adequate initial funding support. Financial need shall be verified by the bureau.

(2) The local recipient does not have financial support to continue operations due to an emergency situation. The bureau will consider an application for a one-time special financial award. The request for financial assistance will be verified by the bureau. To be eligible for emergency funding, applicant and local recipient shall provide a letter of support for the emergency funding from their respective EMS regional director and shall document the need for emergency funding based on the following criteria:

(a) the need for emergency funding is unanticipated;

(b) emergency funding is necessary to protect life, health and safety;

(c) applicant and local recipient have exhausted all reasonable alternative funding sources.

(3) The bureau will advise the advisory committee of such distributions.

(4) The decision is subject to the appeal provision of Subsection J of 7.27.4.11 NMAC, of this rule.

F. DISTRIBUTION METHOD TO ENSURE COMPLIANCE WITH STATUTORY LIMITATION: To comply with the statutory limitation per local recipient, the department shall certify for distribution only funds computed and allocated according to Subsection G of 7.27.4.11. NMAC. Individual distribution amounts computed that are in excess of the maximum amount for a local recipient shall be pro-rated in accordance with Paragraph (2) of Subsection D of 7.27.4.11 NMAC, to all other eligible remaining local

recipients in that county. If funding of all local recipients within a county is at the statutory maximum, and there still remains an overage in the county share, the balance shall be reallocated as described in Subsection G of 7.27.4.11 NMAC to all other counties, and distributed to local recipients within those counties still remaining eligible, in addition to their first distribution.

G. INDIVIDUAL DISTRIBUTION: Subject to Subsection F of 7.27.4.11 NMAC, the distribution to each local recipient shall be the sum of its share as calculated under Paragraph (2) of Subsection D of 7.27.4.11 NMAC and the minimum allocation under Subsection C of 7.27.4.11 NMAC, unless the entity's total distribution shall have been otherwise established pursuant to the exception in Subsection B of 7.27.4.11 NMAC.

H. APPLICATION: Applicants shall request and use the most current forms for preparation of applications. Applications will be made available to all counties, municipalities and local recipients.

I. APPLICATION CYCLE: The following cycle will apply for the local emergency medical services funding program.

(1) Applications will be distributed to all counties, municipalities and local recipients by November 1 of each year.

(2) The local recipient and applicant shall submit to the bureau, a completed application which shall be postmarked or hand-delivered by January 15.

(3) The bureau shall review the applications, calculate the distribution of funds and notify the applicant and local recipients of its determination by May 1 of each year.

J. PROCEDURES FOR APPEAL OF DETERMINATION: Pursuant to Section 24-10A-5 NMSA 1978, an applicant (county and/or municipality) desiring reconsideration of the bureau's determination as to its application for funding may appeal the determination by notifying the chief.

(1) The appeal shall be in writing and shall be received by the bureau within ten (10) working days after notification to the applicant of the bureau's determination.

(2) The bureau shall refer the appeal to the advisory committee for its review and recommendation. Upon receiving the advisory committee's recommendation, the secretary shall issue a final determination and send notice to the part appealing on or before June 15 of the results of the appeal.

K. DISBURSEMENT: The chief shall certify final determination to the state treasurer and the department of finance and administration (DFA) on or before June 30 for distribution as early as possible in the next fiscal year.

L. REPORTING REQUIREMENTS: The bureau may require special reports from applicants or local recipients regarding the appropriate use, maintenance and disposition of any items acquired with funds distributed under this section.

M. ELIGIBLE ITEMS OF EXPENDITURE: Items eligible for funding are:

(1) purchase, repair, and maintenance of ambulance and/or rescue vehicles;

(2) purchase, repair, and maintenance of medical and rescue training equipment;

(3) purchase, installation, repair, and maintenance of communications systems for use by local EMS systems;

(4) payment of EMS training program tuition, per-diem, and mileage for local EMS personnel to attend EMS related training and continuing education programs, either in-state or within one hundred and fifty (150) miles of New Mexico's borders; training beyond the one hundred and fifty (150) mile limit shall be justified and receive prior written approval from the bureau, in order to be an eligible expense;

(5) payment of fees to qualified instructors and reasonable expenses associated with the development and provision of EMS related training and continuing education programs on a local or regional basis;

(6) payment of fees for medical direction;

(7) the cost of New Mexico examination, certification and/or licensing fees for EMS personnel;

(8) payment of costs related to legally mandated health and safety measures for the protection of local EMS personnel, such as vaccine, chest x-rays, etc;

(9) all other operating expenses, including rent, utilities, insurance, gas and oil, etc., except those listed in Subsection N of 7.27.4.11 NMAC;

(10) reimbursement for such items as uniforms, cleaning expenses, meals, travel, etc. when on duty, and;

(11) expenditures associated with the implementation of a prevention program.

N. INELIGIBLE ITEMS OF EXPENDITURE: Costs which are not eligible for funding include:

(1) land;

(2) buildings and construction, except as provided in Paragraph (3) of Subsection M of 7.27.4.11 NMAC above;

(3) certification fees charged by the national registry of EMT's, unless required for New Mexico licensure;

(4) costs for salaries and benefits of local emergency medical services personnel and;

(5) medical care expenses for EMS personnel, except as provided in Subsection M of 7.27.4.11 NMAC of this rule.

O. BUDGET ADJUSTMENTS:

(1) An applicant or a local recipient may request a budget adjustment for any of the following

reasons or other good cause shown:

(a) to permit the expenditure of any balance of funds subsequent to the purchase of an eligible item;

(b) to permit expenditure on a pro-rata basis of funds allocated when the allocations are insufficient to fund the cost of the eligible item;

(c) to change priorities or change requested items;

(d) to permit expenditure of all or part of a given fiscal year's distribution in the following fiscal year; the deadline to request the bureau's approval to carry over funds shall be made in writing by October 31;

(e) to allow and facilitate intra-county or geographical region re-distribution of allocations to maximize the available funding; an intra-county or geographical region re-distribution of funds shall be requested by the applicant(s) and have the written concurrence of all involved local recipients.

(2) Each proposed budget adjustment shall be submitted in writing to the bureau and shall receive the bureau's approval prior to expending or encumbering the reallocated funds.

(3) Budget adjustments totaling less than two hundred and fifty dollars ($250) do not require bureau approval except as provided in Paragraph (2)of Subsection O of 7.27.4.11.NMAC.

P. OTHER CONSIDERATIONS:

(1) In the event a county and one or more incorporated municipalities apply on behalf of the same local recipient, only the county's application shall be accepted and certified for distribution.

(2) Individual applications may be approved by the bureau for separate locations of a local recipient that are at least fifteen (15) miles apart from the next closest station, as measured by the driving distance using the most direct route between the two (2) locations.

(3) Local recipient shall not submit multiple applications for the purpose of receiving additional EMS Fund Act distributions, except in special situations, as approved by the bureau on a case by case basis.

Q. TRANSITION:

(1) In the event that a local recipient ceases operations, an itemized year to date expenditure report of EMS Fund Act money shall be submitted to the bureau.

(2) It is the responsibility of the applicant to inventory and redistribute all equipment purchased with the EMS Fund Act money, to other local recipients in its county or municipality, and provide a report to the bureau.

[7.27.4.11 NMAC - Rp, 7.27.4.11 NMAC, 8/13/2004]

7.27.4.12 LOCAL EMS SYSTEM IMPROVEMENT PROJECTS, EMS VEHICLE PURCHASE PROJECTS, STATEWIDE EMS SYSTEM IMPROVEMENT PROJECTS AND EMD AGENCY SUPPORT PROGRAMS:

A. LOCAL EMS SYSTEM IMPROVEMENT PROJECTS, EMS VEHICLE PURCHASE PROJECTS, STATEWIDE EMS SYSTEM IMPROVEMENT PROJECTS AND EMD AGENCY SUPPORT PROGRAMS: In a fiscal year, no more than eighteen percent (18%) of the fund may be used for local and statewide emergency medical services system improvement projects, the purchase of emergency medical services vehicles, and funding for certified emergency medical dispatch agencies. Applicants shall be funded on a competitive basis. Applications under this section shall be submitted by incorporated municipalities or counties on behalf of local recipients, unless it is a statewide system improvement application, where applicant may be a training institution, EMS regional office or the bureau.

B. APPLICATION: Applicants and local recipients shall request and use the most current forms to apply for these funds. The applications will be made available to all applicants and local recipients.

C. APPLICATION CYCLE: The bureau shall distribute applications for local EMS system improvement projects , EMS vehicle purchase projects, statewide EMS system improvement projects, and certified EMD agencies as set forth below.

(1) The bureau shall issue a request for applications by August 15.

(2) The applicant or EMS service, with authorization from its fiscal agent, shall submit to the bureau, a completed application which shall be postmarked or hand-delivered by November 1. Technical assistance may be provided by the EMS regional office.

(3) The bureau shall provide copies of each local EMS system improvement application and EMS vehicle purchase project application to the respective EMS regional office and the statewide EMS system improvement applications to the EMS operations manager by no later than December 01, of each year.

D. REVIEW PROCESS: The EMS regional offices shall review all applications for local EMS system improvement projects and EMS vehicle purchase projects submitted by applicants within their respective regional areas. Each regional EMS advisory committee/governing board shall review the applications within its region and submit a prioritized listing of applications for funding to the advisory committee no later than March 01 of each year. EMS regional offices and the bureau shall collaboratively assign applications to the appropriate category of funding (statewide system or local system improvement) which shall not be changed unless recommended by a majority of the advisory committee. The advisory committee will review the prioritized listing and make recommendations to the bureau at their annual spring meeting. The bureau shall make its determination on projects to be funded by May 1.

E. LOCAL EMS SYSTEM IMPROVEMENT PROJECTS: At a minimum, an application for the local EMS system improvement projects shall address the following areas:

(1) a complete description of the existing EMS system for which the local EMS system improvement project is requested; this description should include all pertinent information which describes all local EMS components that would be affected by the project;

(2) a complete description of the proposed local EMS system improvement project including a detailed analysis of the need and a narrative showing how the project will contribute to the enhancement and/or integration of the local EMS system;

(3) a detailed proposed budget depicting all anticipated costs for implementation of the proposed project including a clear demonstration of local support via cash and/or in-kind participation; the demonstration of local support will be considered in the final determination;

(4) assurances of support and involvement from all parties involved in the project proposal;

(5) a one page abstract of the proposed project summarizing the request; and

(6) notarized signature(s) of the appropriate municipal and/or county officials;

(7) request for vehicles (ambulance, rescue, administrative etc.) are not considered to be a local system improvement project; requests for any type vehicle should be submitted under the EMS vehicle purchase program.

F. EMS VEHICLE PURCHASE PROJECTS: The following are required for the EMS vehicle purchase projects:

(1) the county or municipality submitting the application shall commit to providing matching funds of at least twenty-five percent (25%) of the base price of purchasing the vehicle only, without regard to equipment or operation costs; there shall be no restrictions on the source of the matching funds;

(2) a complete description of the proposed vehicle including a detailed analysis of the need and a narrative showing how the purchase will contribute to the enhancement and/or integration of the local EMS system;

(3) assurances by the applicant that the local recipient is capable of operating and maintaining the requested vehicle as evidenced by a proposed budget identifying all associated costs of equipping and operating the vehicle;

(4) the applicant shall submit with the application the emergency medical service vehicle assessment form as provided by the bureau and shall have been completed at the time of application;

(5) assurances of support from all parties involved in the project proposal;

(6) a one page abstract of the proposed project summarizing the request; and

(7) notarized signature(s) of the appropriate municipal and/or county officials;

(8) upon approval, local recipient will affix a bureau provided decal on the outside of the vehicle; the logo should always face, or be nearer to, the street side of the vehicle (i.e., left, rear left, driver side).

G. STATEWIDE EMS SYSTEM IMPROVEMENT PROJECTS: No more than three percent (3%) of the fund is authorized for projects, which improve the health, safety and training of emergency medical services personnel statewide.

(1) Applications may be submitted by applicants, local recipients, EMT’s or other interested parties.

(2) The bureau will present a prioritized listing to the advisory committee for its review and consideration. The advisory committee will make a final recommendation to the bureau at it’s spring meeting.

(3) The bureau will make a final determination by May 1.

(4) Funds not committed for statewide EMS system improvement projects may be allocated for additional vehicle purchase and/or local EMS system improvement projects consistent with recommendations from the advisory committee.

H. EMD AGENCY SUPPORT PROGRAM: Certified EMD agencies may apply for funding for allowable operational costs as an EMS system improvement project, as determined by the bureau, when funds are available. Funding of this program shall be recommended to the bureau by the advisory committee based on the available funds.

I. PROCEDURES FOR RECONSIDERATION: Applicants desiring reconsideration of the bureau's determination as to its application for funding under of 7.27.4.12 NMAC may appeal the determination by notifying the chief.

(1) The request for reconsideration shall be in writing and shall be received by the bureau within ten (10) working days after notification to the applicant of the bureau's determination.

(2) Upon receipt of the request for reconsideration, the chief shall issue a final determination and notify all parties on or before June 15.

J. DISBURSEMENT: The chief shall certify the results of final determination to the state treasurer on or before the last working day in June for distribution as early as possible in the next fiscal year.

K. REPORTING REQUIREMENTS:

(1) All applicants that receive funding for local EMS system improvement projects, vehicle purchase projects and statewide EMS system improvement projects shall submit a final report of the project no later than 120 calendar days following project completion, or annually, whichever occurs first. Certification will be provided when the bureau provided decal is affixed to the vehicle which has been purchased with EMS Fund Act funds pursuant to Paragraph (8) of Subsection F of 7.27.4.12 NMAC no later than 120 calendar days following delivery of vehicle.

(2) At a minimum, this report will include the name of the county or municipality, address, phone and contact person, the date submitted, the names of the local recipients involved in the project, the year the project was awarded, a brief description of the project, a fiscal accounting or summary of expenditures, total expenditures and any funds remaining, the project achievements and any changes from the originally submitted application.

(3) The bureau may require a special report from an applicant funded on the appropriate use and maintenance of any eligible item acquired with funds distributed

under section for local EMS system improvement projects, EMS vehicle purchase projects or statewide EMS system improvement projects.

L. BUDGET ADJUSTMENTS: For local EMS system improvement projects, EMS vehicle purchase projects and statewide EMS system improvement projects, the following will apply:

(1) an applicant or a local recipient may request a budget adjustment for any of the following reasons or other good cause shown:

(a) to permit the expenditure of any balance of funds subsequent to the purchase of an approved item;

(b) to change priorities or change requested items and;

(c) to permit expenditure of all or part of an approved project in the following fiscal year; the deadline to request the bureau's approval to carry over funds shall be made in writing by October 31;

(2) each proposed budget adjustment shall be stated in writing to the bureau and shall receive the bureau's approval prior to expending or encumbering the reallocated funds.

[7.27.4.12 NMAC - Rp, 7.27.4.12 NMAC, 8/13/2004]

7.27.4.13 STATEWIDE TRAUMA CARE SYSTEM PROGRAM:

A. STATEWIDE TRAUMA CARE SYSTEM PROGRAM: The statewide trauma care system program shall provide for the support, development and expansion of the statewide trauma care system in accordance with rules adopted by the department. No more than four percent (4%) will be set aside from the fund for the purpose of supporting the statewide trauma care system program.

B. PROGRAM: The program mission shall include but not be limited to the continued support of the trauma registry database, statewide trauma system leadership, and the development, implementation, expansion, monitoring and support of the statewide trauma care system.

C. BUDGET: Each fiscal year, the bureau, with consultation from the trauma advisory committee, a subcommittee of the advisory committee, will propose a budget for the statewide trauma care system program to the advisory committee for review no later than it's summer meeting. Following this review, the bureau will formally budget these funds. The bureau with concurrence from the advisory committee, may make budget adjustments to permit expenditure of all or part of a given fiscal year's budgeted amount for trauma in the following fiscal year.

D. REPORT: The bureau will submit a final report to the advisory committee on the program by the end of the fiscal year. At a minimum the report will include current activities, improvements, evaluation of areas in need and future plans for the continued enhancement of the state trauma care program.

[7.27.4.13 NMAC - Rp, 7.27.4.13 NMAC, 8/13/2004]

7.27.4.14 ADMINISTRATION:

A. ADMINISTRATION: From the fund, three percent (3%) may be used by the bureau and EMS regional offices for administrative costs, including monitoring and providing technical assistance, as set forth in this section.

B. INSPECTION - STATUTORY REQUIREMENT: Inspections, pursuant to Section 24**-**10A**-**9, NMSA 1978 are to be constructive and informative to the local recipient to insure the highest possible standards of equipment and training are instituted by the local recipient and to identify any areas which could be of danger or harmful to the health, safety and welfare of staff and the public for whom service is provided.

(1) Applicants and local recipients shall be subject to reasonable visitation by authorized representatives of the bureau. Vehicle maintenance records, records of service under warranties, continuing education records, training certificates, and similar records shall be open for inspection, as well as tariff billings and fiscal and expenditure records relative to an area for which full or partial funding was made under the act.

(2) Upon completion of an inspection, the findings shall be discussed with the applicant’s and/or local recipient’s representative.

(3) If deficiencies are indicated, the applicant and/or local recipient shall submit a report stating how the deficiencies will be corrected and the estimated date of completion. In most cases corrections should be completed within thirty (30) calendar days.

C. LOSS OF FUNDING ELIGIBILITY - STATUTORY REQUIREMENT: A municipality, county or local recipient that the bureau finds has expended money in violation of the act including misrepresentation on the EMS Fund Act application, may be ineligible to receive funding from the bureau for a period of not less than one year or more than three years, through the process set forth below.

(1) When a violation is suspected, the bureau will notify the applicant and/or local recipient in writing identifying the concerns and requesting an explanation or response.

(2) The applicant and/or local recipient shall respond in writing within twenty (20) working days.

(3) The bureau may initiate a formal investigation, including a formal audit, if deemed necessary.

(4) Based upon their findings, the bureau will notify the applicant and/or local recipient in writing of their determination and associated penalty, which can range from one to three years of ineligibility.

(5) The bureau may refer the matter to appropriate law enforcement agencies.

D. OVERSIGHT OF MUTUAL AID: The bureau shall encourage the development of appropriate mutual aid agreements between local recipients to ensure compliance with the act and this rule.

E. COORDINATION: The bureau shall facilitate the coordination of services between state agencies, EMS regional offices, applicants, and local recipients to execute the requirements of the act and this rule for the efficient and effective use of these funds.

F. EVALUATION AND AUDIT OF PROGRAMS: The bureau shall be responsible for the periodic evaluation of all programs and projects receiving funds under the act. This evaluation may include initiation of an objective audit, if deemed necessary.

G. TECHNICAL ASSISTANCE: The bureau shall be responsible to provide, as needed, technical assistance to counties, municipalities, EMS regional offices, state and local agencies and any other parties involved in any of the programs funded through the act and this rule.

[7.27.4.14 NMAC - Rp, 7.27.4.14 NMAC, 8/13/2004]

PART 5: CERTIFICATION OF AIR AMBULANCE

7.27.5.1 ISSUING AGENCY:

New Mexico Department of Health, Epidemiology and Response Division, Emergency Medical Systems Bureau.

[7.27.5.1 NMAC - Rp, 7.27.5.1 NMAC, 01-01-06]

7.27.5.2 SCOPE:

This regulation applies to any air service within New Mexico that transports persons requiring medical care including, but not limited to: basic life support (BLS), advanced life support (ALS), critical care, or specialty care. Out-of-state services that fly into New Mexico to pick up and/or deliver medical patients shall also be certified in accordance with these rules, or through reciprocity in accordance with these rules. The United

States department of defense and the New Mexico department of military affairs are exempt from this rule when conducting official military operations. Public safety agencies that routinely provide air ambulance services shall be certified.

[7.27.5.2 NMAC - Rp, 7.27.5.2 NMAC, 01-01-06]

7.27.5.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: 1) the Department of Health Act, section 9-7-6.E. NMSA 1978, which authorizes the secretary of the department to "... make and adopt such reasonable and procedural rules and rules as may be necessary to carry out the duties of the department and its divisions," and; 2) the Emergency Medical Services Act, Section 24-10B-4-H, NMSA 1978, which authorizes the department to adopt regulations for the certification of air medical transport. Administration and enforcement of these regulations is the responsibility of the emergency medical systems bureau of the epidemiology and response division, department of health.

[7.27.5.3 NMAC - Rp, 7.27.5.3 NMAC, 01-01-06]

7.27.5.4 DURATION:

Permanent.

[7.27.5.4 NMAC - Rp, 7.27.5.4 NMAC, 01-01-06]

7.27.5.5 EFFECTIVE DATE:

January 1, 2006, unless a later date is cited at the end of a section.

[7.27.5.5 NMAC - Rp, 7.27.5.5 NMAC, 01-01-06]

7.27.5.6 OBJECTIVE:

The purpose of this document is to inform the public and air ambulance services about the requirements and standards for the certification of air ambulance services operating within New Mexico, and the process and procedures to become certified as specified below.

A. These rules provide the minimum criteria and process for the certification of both fixed and rotor wing air ambulance services that operate within the state of New Mexico, based upon the recommendations of the air medical transport advisory committee; to provide minimum standards for certified services to abide by; and, to assist in the provision of a comprehensive system of emergency medical services in the state of New Mexico.

B. These rules are designed to assist air ambulance services in preparing for, achieving, and maintaining certification as a certified air ambulance service in the state of New Mexico. Air ambulance services that have and maintain the commission on accreditation of medical transport systems (CAMTS) accreditation meet the standards for air ambulance certification in the state of New Mexico. The bureau shall certify an air ambulance service with CAMTS accreditation following review and approval of the application and inspection, if necessary, as determined by the bureau, and payment of necessary fees and approval by the bureau.

[7.27.5.6 NMAC - Rp, 7.27.5.6 NMAC, 01-01-06]

7.27.5.7 DEFINITIONS:

A. "Act (EMS Act)" means the Emergency Medical Services Act, [Sections 24-10B-1, et seq., NMSA 1978].

B. "Advanced life support air ambulance service" means an organization, certified by the bureau, to transport in an air ambulance, patient(s) who require basic life support (BLS) or advanced life support (ALS) care.

C. "Advanced life support (ALS)" means advanced pre-hospital and inter-facility care and treatment, as authorized by regulation, which may be performed only by a person licensed by the department as an emergency medical technician - paramedic (EMT-P), or licensed by the state at a higher level, or otherwise authorized to practice ALS.

D. "Air ambulance service" means any governmental or private service that provides air transportation specifically designed to accommodate the medical needs of a person who is ill, injured or otherwise mentally or physically incapacitated and who requires in-flight medical supervision.

E. "Air ambulance certificate" means a document issued by the department as evidence that an air ambulance service meets the requirements for certification at the advanced life support, critical or specialty care level, as found in these rules.

F. "Aircraft type" means a particular make and model of helicopter or fixed wing aircraft.

G. "Aircraft operator" means the vendor and/or owner who operates and maintains the aircraft utilized by an air ambulance service.

H. "Air medical transport advisory committee (AMTAC)" means a subcommittee of the statewide EMS advisory committee as authorized by the EMS Act, Section 24-10B-7.A., NMSA 1978. The term "air medical transport advisory committee" as used throughout these rules is synonymous with "air transport advisory committee".

I. "Bureau" means the emergency medical systems bureau of the epidemiology and response division, of the department of health.

J. "Certification evaluation team" means a team appointed by the bureau for the purpose of performing an initial or subsequent inspection of air medical services seeking certification, or of those already certified.

K. "Combination service" means any service that has more than one type of aircraft, for example, fixed wing and rotor wing.

L. "Commission on the accreditation of medical transport systems (CAMTS)" means a national accrediting organization that evaluates air ambulance services based on air ambulance industry standards established by CAMTS.

M. "Critical care air ambulance service" means an organization certified by the bureau to transport patients in an air ambulance that requires critical care.

N. "Critical care" means pre-hospital or inter-facility care and treatment, respectively, that exceeds the advanced life support level of care, as authorized by rule. The critical care mission shall consist of at least one critical care provider and at least one additional provider which shall be licensed at or above the ALS level of care, and/or specifically trained in the area of care required. Additional providers may be added as necessary.

O. "Critical care provider" means the critical care primary provider shall consist of at least one registered nurse, physician assistant, nurse practitioner and/or medical physician trained in the area of critical care.

P. "Department" means the department of health.

Q. "Emergency medical services (EMS)" means the services rendered by providers in response to an individual’s need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

R. "Federal aviation regulations (FAR)" means regulations promulgated by the federal aviation administration of the U.S. department of transportation, governing the operation of all aircraft within the United States.

S. "Level of service" means the highest level at which the air ambulance service is certified to function on a 24 hours a day, seven days a week basis.

T. "Medical control" means supervision, provided by or under the direction of physicians to providers by written protocol and/or direct communication.

U. "Medical direction" means guidance or supervision provided by a physician to a provider or emergency medical services system and which includes authority over and

responsibility for emergency medical dispatch, direct patient care and transport of patients, arrangements for medical control and all other aspects of patient care delivered by a provider.

V. "Medical direction committee" means a committee of physicians and emergency medical technicians, appointed by the secretary of health to advise the bureau on all matters relating to medical control and medical direction.

W. "Medical director" means a physician who has the responsibility for oversight of patient care of an EMS system or EMS provider service, including providing for or ensuring the medical control of emergency medical technicians, the development, implementation, and evaluation of medical protocols, and quality assurance activities.

X. "Physician" means a doctor of medicine or doctor of osteopathy who is licensed or otherwise authorized to practice medicine or osteopathic medicine in New Mexico.

Y. "Protocol" means a predetermined, written medical care plan and includes standing orders.

Z. "Provider" means a person who has been licensed by the appropriate agency to provide patient care at the ALS, critical or specialty care level.

AA. "Regional office" means an emergency medical services planning and development agency formally recognized and supported by the bureau.

BB. "Secretary" means the secretary of health.

CC. "Service" means a certified air ambulance service authorized to operate in the state of New Mexico under these rules.

DD. "Specialty care" means care and treatment that exceeds the advanced life support level of care, as authorized by regulation. The specialty care mission shall consist of at least one specialty care provider and at least one additional provider which shall be licensed at or above the ALS level of care, and/or specifically trained in the area of care required. Additional providers may be added as necessary.

EE. "Specialty care provider" means a caregiver appropriately trained and licensed to provide patient care as defined by the mission.

[7.27.5.7 NMAC - Rp, 7.27.5.7 NMAC, 01-01-06]

7.27.5.8 USE OF TERMS AND ADVERTISING:

It shall be prohibited for any air ambulance service to advertise or perform air ambulance services, or use the title "certified air ambulance service," in New Mexico, unless it is certified under these rules.

[7.27.5.8 NMAC - Rp, 7.27.5.8 NMAC, 01-01-06]

7.27.5.9 DISCLOSURE TO THE PUBLIC:

At the initiation of contact with a potential client, patient or the public, the certified air ambulance service shall disclose the current level of state of New Mexico certification and what level of service can be provided.

[7.27.5.9 NMAC - Rp, 7.27.5.9 NMAC, 01-01-06]

7.27.5.10 FULL CERTIFICATION PERIOD:

The certification period for all air ambulance services shall be for a 3-year period. Once a certified air ambulance service becomes accredited by CAMTS, the certification period shall be adjusted by the bureau to correspond with the CAMTS accreditation period.

[7.27.5.10 NMAC - Rp, 7.27.5.10 NMAC, 01-01-06]

7.27.5.11 REPORTING:

Certified air ambulance services shall complete a patient run report for each patient that is transported by air. The minimum data elements identified by the bureau shall be compiled and submitted to the bureau on a quarterly basis, or as determined by the bureau. Certified services shall provide as a minimum, an annual number of runs of patients picked up in New Mexico including location and patient complaint. Review of completed patient care reports may be required during initial and/or subsequent inspections.

[7.27.5.11 NMAC - Rp, 7.27.5.11 NMAC, 01-01-06]

7.27.5.12 EMERGENCY INFORMATION REQUIRED:

Certified air ambulance services shall provide, during initial/renewal of certification, emergency information about the service to the bureau. This information shall be used by the bureau to provide effective communications and resource management, in the event of a statewide or localized disaster/emergency situation. The information is included in the initial/renewal application for certification of air ambulance services.

[7.27.5.12 NMAC - Rp, 7.27.5.12 NMAC, 01-01-06]

7.27.5.13 CERTIFICATION PROCESS AND PROCEDURES:

A. General: Prior to beginning air ambulance operations within the state of New Mexico, either a temporary or full air ambulance certification is required for the levels of service, as outlined below.

(1) Levels of service: the following levels of service are authorized in New Mexico:

(a) advanced air ambulance service: the air medical crew shall at all times consist of at least 2 licensed health care providers, one of which, shall be licensed at the advanced life support (ALS) level or above (minimum licensed EMT-paramedic or above);

(b) critical care air ambulance service: the critical care mission shall consist of at least one critical care provider and at least one additional provider which shall be licensed at or above the ALS level of care, and/or specifically trained in the area of care required; additional providers may be added as necessary;

(c) specialty care air ambulance service: the specialty care mission shall consist of at least one specialty care provider and at least one additional provider which shall be licensed at or above the ALS level of care, and/or specifically trained in the area of care required; additional providers may be added as necessary;

(d) generally, services certified to provide critical care are certified to perform advanced air ambulance service care; in all such cases, the minimum level of certified/licensed health care provider staffing, for each level of certification, shall be aboard the aircraft;

(e) services that provide care at the advanced, critical or specialty air ambulance level care are required to remain with the patient until someone of equal or higher training assumes care of the patient.

(2) Temporary certification: a temporary certification for a maximum period of three years may be issued by the bureau for non-CAMTS accredited services, upon successful completion of the application process, a preliminary inspection and approval by the bureau, and payment of all required fees.

(a) A preliminary inspection includes an on site visit with the air ambulance service, aircraft, and crew. The certification evaluation team (CET) will normally consist of a bureau representative, the state EMS medical director or a designated physician, state aviation officer, EMS communications manager, and additional personnel as determined by the bureau.

(b) Once a temporary certification is issued, and within the three year certification, the service shall obtain and maintain CAMTS accreditation in order to become fully certified by the bureau. All non-CAMTS accredited air ambulance services shall submit a program information file (PIF) to CAMTS and the bureau within 16 months of acquiring a temporary certification from the bureau as outlined in Subsection B of 7.27.5.13 NMAC.

(3) Full certification: after successfully completing the CAMTS accreditation process, and upon approval by the bureau, a three year air ambulance service certificate for the approved level shall be issued to the service. To be fully certified, an air ambulance service shall:

(a) comply with applicable federal, state, and local laws and rules to operate a business in New Mexico;

(b) submit a copy of CAMTS accreditation certificate;

(c) complete a service application and submit it along with the required application fee to the bureau;

(d) may be required to complete an air ambulance service inspection, as determined by the bureau.

B. Application for certification of non-CAMTS accredited services: Prior to transporting patients within the state of New Mexico, an air ambulance service:

(1) shall submit to the bureau a completed bureau approved New Mexico air ambulance application with appropriate fees;

(2) shall insure compliance with all federal and state requirements, such as proof of insurance, aircraft inspection certificates, FAA Part 135 certificate, board of pharmacy permit(s), and drug enforcement agency permits;

(3) shall complete the initial bureau inspection process; and

(4) upon successful completion, the bureau shall issue a temporary air ambulance certificate for a period of up to three years for one of the approved levels of service:

(a) by the end of the first (16) sixteen months of the temporary certification period, the service shall provide to the bureau with a copy of the initial CAMTS program information form (PIF) and a letter from CAMTS acknowledging receipt of the PIF;

(b) failure to complete the CAMTS accreditation process during the temporary certification period shall be reviewed by the bureau and may result in initiation of action to suspend the air ambulance service temporary certification; this includes, but is not limited to:

(i) failure to submit a complete PIF to the bureau or CAMTS within the first sixteen months of the temporary certification period; or

(ii) submitting an incomplete PIF; or

(iii) failure to pay appropriate fees to the bureau; or

(iv) failure of a bureau inspection or CAMTS accreditation inspection;

(5) upon receipt of proof of CAMTS accreditation and approval of the bureau, the bureau may issue a full air ambulance certification.

C. Application for certification of CAMTS accredited services: Prior to transporting patients within the state of New Mexico, an air ambulance service shall:

(1) submit to the bureau a completed bureau approved New Mexico air ambulance application with appropriate fees; and

(2) ensure compliance with all federal and state requirements such as proof of insurance, aircraft inspection certificates, FAA Part 135 certificate, board of pharmacy permit(s), and drug enforcement agency permits; and

(3) submit proof of current CAMTS accreditation; services that maintain CAMTS accreditation shall notify the bureau immediately of any CAMTS accreditation status changes;

(4) upon successful completion the bureau shall issue a full New Mexico air ambulance certification at the appropriate level of care.

D. Certification evaluation team (CET): The CET shall typically consist of the membership listed below. The bureau shall convene the membership of the CET as necessary to perform either the initial, temporary service inspections, or whenever the bureau deems necessary.

(1) The CET membership is composed of the following individuals, as determined by the bureau:

(a) bureau representative - team leader;

(b) state EMS medical director or a designated physician;

(c) state aviation representative;

(d) EMS communications representative;

(e) other members as deemed necessary by the bureau.

(2) Services shall be given advanced notice, in writing, of those personnel selected for the CET. A service which has a good faith belief that selected individual(s) on the CET may be biased or have a possible conflict of interest, may request that the

bureau select a new member. In all such cases, the bureau shall make the final determination of CET membership.

(3) Other inspections: Inspections of non-CAMTS accredited, out-of-state services shall follow the certification process, as outlined. When out-of-state travel is required of the CET, the service applying for certification shall be responsible for reimbursement of travel expenses.

E. Changing the level of service: Changing a level of service shall require the service to submit an initial application for that level of service, along with certification fees. Changing from a rotor or fixed wing service to a combination service will also require a new application and fee. Changing from a combined rotor wing and fixed wing service to a single type of aircraft service will require a new application and fee for the service(s) involved.

F. Renewal of certification and inspection: Services shall retain state certification by renewing their certification every three years, concurrent with CAMTS accreditation. This is accomplished by submitting the required renewal application, fee, and proof of current CAMTS accreditation. Normally, the certification for air ambulance services that maintain national accreditation according to the standards of the CAMTS do not require a renewal inspection by the bureau to maintain certification, but, shall meet all other requirements, including the submission of a renewal application and payment of fees. The bureau may perform an inspection of a certified air ambulance service, as determined by the bureau. The renewal application contains general air ambulance service information and is used in conjunction with the initial certification application standards when applying for renewal to update the bureau on the air ambulance service.

[7.27.5.13 NMAC - Rp, 7.27.5.13 NMAC, 01-01-06]

7.27.5.14 FEES:

A. A fee shall be assessed by the bureau for certification to operate an air ambulance in the state of New Mexico. The bureau, with the advice of the air medical transport advisory committee and the statewide EMS advisory committee, shall set the amount of the fee. Exceptions: fees shall not apply to:

(1) an air ambulance service from another state assisting in the response to a major disaster, mass casualty incident or other emergency;

(2) an air ambulance service transferring patients to or from New Mexico less than two times per month.

B. Fees for upgrading the level of service will be the same fee that is required for initial application. Fees for changing from fixed wing or rotor wing to a combination service will be the same as for a new service. Fees for changing from a combination

rotor wing and fixed wing service to a single type of service will be the same as a new service.

C. Fees Table:

(1) Initial certification fees for CAMTS accredited services: The $625.00 base fee for initial certification of single aircraft type includes one aircraft or $925.00 initial certification fee for combination service includes two aircraft. An additional $200.00 is required for each additional assigned/operating aircraft and/or base, not to exceed $1825.00 per service.. Additional fees may be assessed if additional travel is required to accommodate out-of-state applicants:

Type of Service	**In-State Fee**	**Out-of-State Fee**	**Additional Aircraft Fee**
Rotor Wing Service	$625.00	$1,125.00	$200.00 per aircraft
Fixed Wing Service	$625.00	$1,125.00	$200.00 per aircraft
Combination Service	$925.00	$1,425.00	$200.00 per aircraft

(2) Initial Certification Fees for Non-CAMTS Accredited Services: The $1250.00 base fee for initial certification of single aircraft type includes one aircraft or $1850.00 initial certification fee for combination service includes two aircraft. An additional $200.00 fee is required for each additional assigned/operating aircraft and/or base, not to exceed $3,250.00 per service. Additional fees may be assessed if additional travel is required to accommodate out-of-state applicants.

Type of Service	**In-State Fee**	**Out-of-State Fee**	**Additional Aircraft Fee**
Rotor Wing Service	$1,250.00	$2,250.00	$200.00 per aircraft
Fixed Wing Service	$1,250.00	$2,250.00	$200.00 per aircraft
Combination Service	$1,250.00	$2,250.00	$200.00 per aircraft

(3) Renewal Certification Fees: The following fees are to be submitted along with the air ambulance service renewal application whether based in-state or out-of-state:

Type of Service	Fee
Rotor Wing Service	$500.00
Fixed Wing Service	$500.00
Combination Service	$500.00

(4) Changes to Air Ambulance Service After Certification:

Type of Service	In-State Fee	Out-of-State Fee
Rotor or Fixed Wing Service to Combination Service	$625.00	$625.00
Combination Services to Rotor or Fixed Wing Service	$625.00	$625.00
Adding Additional Aircraft After Certification	$200.00 per aircraft	$200.00 per aircraft

[7.27.5.14 NMAC - Rp, 7.27.5.14 NMAC, 01/01/06]

7.27.5.15 ENFORCEMENT:

A. Complaint/Incident Procedures: Any person may communicate a complaint or knowledge of an incident to the bureau. Complaints shall be submitted in signed written form to the bureau as soon as practical. The bureau may begin an investigation if there is sufficient cause.

(1) When a complaint is received by the bureau, written acknowledgement shall be made within 10 working days and the staff shall decide whether or not a preliminary or formal investigation of the complaint shall be initiated.

(2) If no investigation is warranted, the service or person filing the complaint will be notified, as determined by the bureau.

(3) Services being formally investigated shall receive written notification within ten (10) working days after a decision is made to begin a formal investigation, unless extenuating circumstances exist which would reasonably preclude notification.

(4) At the conclusion of the bureau's formal investigation, the bureau may report its findings to the investigated service in written form. If the bureau investigation warrants disciplinary action against a service, the service will be given a notice of contemplated action (see right to appeal and hearing in 7.27.15.D NMAC).

(5) If the bureau makes a good faith judgment that the health and/or safety of the public would be jeopardized, it may take immediate action to suspend an air

ambulance service's certification to prevent a service from operating within New Mexico. The suspended service shall be afforded an expedited appeal and hearing process.

B. Investigations: Investigations shall normally be conducted by the bureau.

(1) Preliminary Investigations: When the bureau receives information that might form the basis for disciplinary action against a service, it shall begin a preliminary investigation. This is a fact finding/information gathering investigation that will attempt to determine for the bureau whether justification exists to initiate an action or to conduct a formal investigation.

(2) Formal Investigations: Formal investigations are for the purpose of obtaining additional information to allow the bureau to determine if it will initiate an action. Notice will be given to the service that is the subject of the formal investigation, unless extenuating circumstances exist which would reasonably preclude notification.

(3) Confidentiality: The bureau will take every precaution to insure that investigations are conducted in a confidential manner.

(4) Records: An official record is maintained for every New Mexico air ambulance service, certified under these rules. If the bureau begins an investigation, a separate confidential record will be created containing all investigation material. If the bureau initiates an action, all records not exempt from disclosure under the inspection of public records act, sections 14-2-1, et seq., NMSA 1978, will be placed in the service's official record. Any request for records maintained by the bureau will be processed in accordance with the inspection of public records act.

C. Grounds For Denial, Suspension, and Revocation: Air ambulance certification may be denied, suspended or revoked based on the following grounds:

(1) fraud, deceit, misrepresentation in obtaining certification, including misrepresentation during the initial or renewal certification process;

(2) failure to meet any certification/accreditation requirements including failing to acquire and/or maintain accreditation with the commission on accreditation of medical transport systems (CAMTS) as outlined in these rules;

(3) negligence in the delivery of air ambulance medical services, including, but not limited to:

(a) malpractice and/or substandard medical care or treatment; or

(b) using non-licensed personnel or personnel performing outside the standard of care/scope of practice; or

(c) failure to have operational equipment and failure to carry the required equipment, or inappropriate use of equipment during a flight; or

(d) unauthorized disclosure of medical or other confidential information;

(4) loss of federal aviation administration certification or failure to notify the bureau of such loss of certification;

(5) loss of CAMTS accreditation or failure to notify the bureau of such loss of accreditation;

(6) failure to report revocation, suspension, denial, or other adverse actions taken in any other state or jurisdiction affecting the ability to provide air ambulance services;

(7) performing air ambulance operations without being certified by the department to perform the authorized level of service, including providing service after expiration of a certification;

(8) the use of any false, fraudulent, or deceptive statement in any document connected with the operation of an air ambulance service;

(9) failure to cooperate with an investigation or to furnish the bureau with requested information;

(10) failure to report required documentation, including patient run report data;

(11) failure of a service to comply with the rotor wing response protocol or the fixed/rotor wing inter-facility transportation protocol as outlined in these rules.

D. Right to Appeal: Any service may appeal a decision by the department to deny, suspend or revoke air ambulance certification as provided below:

(1) denial of initial certification: any air ambulance service applying for certification may appeal to the department a denial of an application for certification;

(2) suspension or revocation of an existing certification: any certified air ambulance service may appeal to the department the proposed suspension or revocation of certification;

(3) denial for renewal of certification: any certified air ambulance service may appeal to the department the denial of a renewal application for certification.

E. Notice of Contemplated Action: When the bureau contemplates taking any action specified in Subsection C of 7.27.5.15 NMAC, it shall serve upon the applicant or

certified service a written notice containing a statement of the grounds or subject upon which the proposed action is based, and rule(s) violated.

F. Right to Hearing: The applicant or certified service may request a hearing before a hearing officer appointed by the Secretary to contest the proposed action, by mailing a certified return receipt letter addressed to the bureau within twenty (20) days after service of the notice.

G. Hearing: Upon receipt of a timely request for a hearing, the department shall appoint a hearing officer and schedule a hearing, to be held in Santa Fe, New Mexico, within forty five (45) working days of receipt of the timely request for a hearing. Exception: in the event of an immediate suspension by the bureau to protect the safety and health of the public, the air ambulance service will be afforded an expedited hearing within twenty (20) days of the date of the receipt of appeal.

H. Notice of Hearing: The department shall notify the applicant or certified service of the date, time, and place of the hearing, the identity of the hearing officer, and the subject matter of the hearing, not less than thirty (30) days prior to the date of the hearing. Exception: in the event of an immediate suspension to protect the safety and health of the public, notice will be provided of an expedited hearing within ten (10) days of receipt of appeal.

I. Hearing Officer Duties: The hearing officer shall preside over the hearing, administer oaths, take evidence and decide evidentiary objections and rule on any motions or other matters that arise prior to the hearing.

J. Discovery: Upon written request to another party, any party is entitled to:

(1) obtain the names and addresses of witnesses who will or may be called by the other party to testify at the hearing; and

(2) inspect and copy any documents or items which the other party will or may introduce in evidence at the hearing.

K. Conduct of Hearing: Hearings are open to the public unless a request for closed meeting is made by either party.

L. Hearing Officer Written Report and Recommendation(s): The hearing officer shall make a written report and recommendation(s) to the secretary containing a statement of the issues raised at the hearing, proposed findings of fact, and conclusions of law, and a recommended determination. The hearing officer or designee shall record the hearing by means of a mechanical sound recording device provided by the department for a record of the hearing. The hearing officer written report shall be submitted to the secretary no later than 30 working days after the close of the hearing.

M. Secretary's Determination: The secretary shall render a final determination within 10 working days of the submission of the hearing officer's written report. A copy of the final decision shall be mailed to the appealing party by certified mail, return receipt requested. A copy shall be provided to legal counsel for the bureau.

[7.27.5.15 NMAC - Rp, 7.27.5.15 NMAC, 01/01/06]

7.27.5.16 STANDARDS:

The most recent standards for air ambulance services published by the CAMTS are incorporated by reference, with the written permission of CAMTS. Air ambulance services shall meet the standards outlined in the CAMTS *accreditation standards*, with following exceptions:

A. Rotor Wing Scene Response Protocol (Rotor Wing): All rotor wing air ambulance services certified to operate in the state of New Mexico shall adhere to the response and transportation policy outlined below. Failure to adhere to the response protocol policy may be investigated by the department and may result in disciplinary action against the service(s) involved in the non-compliance. The department recognizes that air ambulance services may need to occasionally deviate from this policy in the best interest of patient care.

(1) Response: When a request from a EMS provider, law enforcement officer, or the incident commander for a rotor wing air ambulance is received by telephone or radio at a dispatch center to respond to a scene, the dispatcher or air ambulance service shall ensure that the closest available service shall respond. If another rotor wing service is closer to the scene and their aircraft is available to respond, the request shall be transferred and communicated to that service, without delay.

(2) Transportation: All patients shall be transported by the rotor wing air ambulance service to the closest appropriate facility. For trauma patients, the regional or local trauma transportation protocols/guidelines should guide the destination decision. Regional or EMS system transportation protocols/guidelines shall also guide transportation decisions.

B. Inter-facility Transportation Protocol (Rotor Wing and Fixed Wing): The department follows the federal Emergency Medical Treatment and Labor Act (EMTALA) for inter-facility transfers.

(1) For inter-facility transfers, it is the responsibility of the physician at the sending facility to arrange an "appropriate transfer" under the EMTALA requirements. The EMTALA requirements include as part of arranging an "appropriate transfer" that the sending physician secure an appropriate method of transportation that is consistent with the patient's needs. (It is recommended that the sending physician and the receiving physician consult when making the decision about the appropriate method of transportation.)

(2) Physicians arranging inter-facility transfers must remain current on available EMS transportation options within their area. In New Mexico, the following options are available in many geographical areas; Regular ground ambulance (BLS and ALS), critical care ground ambulance, fixed wing air ambulances (BLS, ALS, and critical care), and rotor wing air ambulances (critical care).

C. Specific Exceptions to the CAMTS Accreditation Standards.

(1) Throughout the standards, the words "should be" means "shall" for the purpose of certification in New Mexico.

(2) In the far right hand column, "RW" applies to "rotor wing" and "FW" applies to "fixed wing". Both "RW" and "FW" apply for certification of air ambulance services in New Mexico.

(3) In the far right hand column, "G" refers to "ground transport" and "ME" refers to "medical escort". These do not apply for air ambulance certification in New Mexico.

(4) In section 01.10.02, the minimum "general liability insurance" required for rotor wing services is 50 million dollars in New Mexico.

(5) In section 01.10.01, if an accredited program refers a flight to another service, it shall follow the rotor wing scene response protocol and the inter-facility transportation protocol as found in section 7.27.5.16 NMAC.

(6) In section 01.12.00, all air ambulance services shall report aviation incidents and accidents to the CONCERN network and the bureau, as well as all appropriate other government agencies. See the CAMTS standards glossary for a definition of incident and accident. The CONCERN network provides information regarding accidents and incidents in the air medical and critical care transport community. This information is provided by the transport service involved and then distributed via email by the CONCERN network. The purpose of the CONCERN network is to increase awareness of safety hazards in the medical transport community. It is accessible via the world wide web at http://www.concern-network.org.

(7) In section 01.12.00, air ambulance services shall report all aviation incidents and accidents to the CONCERN network and the bureau, in addition to all other appropriate government agencies required by law.

(8) In section 02.03.00, a clinical care supervisor shall be an EMT-P or higher level of licensure.

(9) In section 02.04.01, on site shifts scheduled for greater than twenty-four hours are discouraged.

[7.27.5.16 NMAC - Rp, 7.27.5.16 NMAC, 01/01/06]

7.27.5.17 RADIO COMMUNICATION FREQUENCIES:

A. The following UHF medical frequencies are required in all air ambulance vehicles to communicate with the New Mexico EMS system and to conduct medical communication in the state of New Mexico.

(1) Transmit 463.000, receive 468.000.

(2) Transmit 463.235, receive 468.025.

(3) Transmit 463.050, receive 468.050.

(4) Transmit 463.075, receive 468.075.

(5) Transmit 463.100, receive 468.100.

(6) Transmit 463.125, receive 468.125.

(7) Transmit 463.150, receive 468.150.

(8) Transmit 463.175, receive 468.175.

(9) Transmit 462.950, receive 467.950.

(10) Transmit 462.975, receive 467.975.

[7.27.5.17 NMAC - Rp, 7.27.5.17 NMAC, 01/01/06]

7.27.5.18 STANDARDS AND REQUIREMENTS CHECKLISTS:

Standards and requirements are outlined in the CAMTS accreditation standards incorporated by reference, with the written permission of CAMTS, with the noted exceptions in section 7.27.5.16 NMAC.

[7.27.5.18 - Rp, 7.27.5.18 NMAC, 01/01/06]

7.27.5.19 APPLICATION FOR AIR AMBULANCE CERTIFICATION:

All applications for certification as an air ambulance shall contain the following:

A. service name;

B. ownership structure: sole proprietor, partnership, corporation, etc.;

C. service mailing address;

D. physical location of facilities: use additional sheets as necessary;

E. communications;

(1) business telephone;

(2) facsimile number;

(3) dispatch center telephone;

(4) emergency point of contact;

(5) operations telephone;

(6) cellular telephone;

(7) pager number;

F. communications center: physical location of the communications center;

G. medical service management personnel:

(1) program administrator: name, telephone, facsimile, and other contact information as applicable;

(2) medical director: name, license number, telephone, facsimile, and other contact information as applicable;

(3) clinical care supervisor: name, telephone, facsimile, and other contact information as applicable;

H. hours of operations: 24 hour, 7 days a week, other (please explain);

I. type of air ambulance certificate requested:

(1) fixed wing only;

(2) rotor wing only;

(3) combination service;

J. level of service requested:

(1) advanced life support;

(2) critical care;

(3) specialty care;

K. service affiliation:

(1) private or government service;

(2) hospital, police, independent, or municipal;

L. aircraft certificate holder:

(1) service name;

(2) contact person;

(3) address;

(4) business telephone;

(5) facsimile;

(6) certificate number;

M. type of aircraft: for fixed and rotor wing, the following information is required:

(1) make of aircraft(s);

(2) model of aircraft(s);

(3) tail number(s);

N. level of staffing: For both fixed and rotor wing, please attach a copy of your staffing plan to include the following:

(1) EMS personnel: EMT-P and the number of each;

(2) nursing personnel: number and type;

(3) physician(s): number and type;

(4) other personnel: number and type;

O. emergency information: emergency contact information shall be provided for the service director, clinical care supervisor, medical director, and dispatch agency;

P. all applicants shall meet the CAMTS accreditation standards for the level of service of the air ambulance service; some CAMTS accreditation standards may be waived by the bureau for initial certification since new start-up air ambulance services cannot achieve CAMTS accreditation without being in service for a period of time; some CAMTS accreditation standards have exceptions that are listed in 7.27.5.16 NMAC; in general the initial application for air ambulance certification shall include the following:

Standards	**Reference Number**
Medical Section	
Capabilities and Resources of the Medical Transport Service and receiving hospitals	01.00.00
Medical Personnel	02.00.00
Medical Director	02.01.00
Medical Control Physician	02.02.00
Clinical Care Supervisor	02.03.00
Staffing	02.04.00
Mission Types	02.05.00
Training and Continuing Education	02.06.00
Aircraft/Ambulance Section	
Medical Configuration	03.00.00
Operational Issues	04.00.00
Aircraft/Ambulance Equipment	05.00.00
Communications	06.00.00
Management and Administrative Responsibilities	
Management Policies	07.00.00
Utilization Review	07.01.08
Quality Management	08.00.00
Infection Control	09.00.00
Rotor Wing Standards	
Certificate of the Aircraft Operator	10.00.00
Weather and Weather Minimums	11.00.00
Pilot Personnel	12.00.00
Maintenance	13.00.00
Helipad	14.00.00
Refueling	15.00.00
Community Outreach	16.00.00
Fixed Wing Standards	
Certificate of the Aircraft Operator	17.00.00

Standards	Reference Number
Aircraft	18.00.00
Weather	19.00.00
Pilot Personnel	20.00.00
Policies	21.00.00
Maintenance	22.00.00
Refueling	26.00.00
Community Outreach	27.00.00
Ground Inter-facility Standards: Not Applicable.	N/A
Addendums	
Addendum A - Rationale for Change - Critical Care Alternative	
Addendum B - Education Matrix	
ALS-BLS Ground Standards: Not Applicable	N/A
Medical Escort Standards: Not Applicable	N/A

[7.27.5.19 NMAC - Rp, 7.27.5.19 NMAC, 01/01/06]

7.27.5.20 AIRCRAFT EQUIPMENT STANDARDS:

Standards and requirements are outlined in the CAMTS accreditation standards incorporated by reference, with the noted exceptions in section 7.27.5.16 NMAC.

[7.27.5.20 NMAC - Rp, 7.27.5.20 NMAC, 01/01/06]

7.27.5.21 TRAINING STANDARDS:

Standards and requirements are outlined in the CAMTS accreditation standards incorporated by reference, with the noted exceptions in section 7.27.5.16 NMAC.

7.27.5.21 NMAC - Rp, 7.27.5.21 NMAC, 01/01/06]

PART 6: EMERGENCY MEDICAL SERVICES ADVANCE DIRECTIVES

7.27.6.1 ISSUING AGENCY:

New Mexico Department of Health (DOH), Epidemiology and Response Division (ERD), Emergency Medical Systems Bureau (EMSB).

[7.27.6.1 NMAC - Rp, 7.27.6.1 NMAC, 12/12/2017]

7.27.6.2 SCOPE:

This regulation applies to all people of New Mexico who have capacity, or by a person duly appointed under a durable power of attorney for health care, physicians, advanced practice nurses, or physician assistants, and emergency medical services personnel.

[7.27.6.2 NMAC - Rp, 7.27.6.2 NMAC, 12/12/2017]

7.27.6.3 STATUTORY AUTHORITY:

These regulations are promulgated pursuant to the following statutory authorities:

A. the Department of Health Act, Section 9-7-6. E NMSA 1978, which authorizes the secretary of the department of health to make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions"; and

B. the Emergency Medical Services Act (as amended by Laws of 2003, Chapter 243), Section 2410B-4I NMSA 1978, which authorizes the department of health to adopt "regulations pertaining to authorization of providers to honor advance directives to withhold or terminate care in certain pre-hospital or inter-facility circumstances, as guided by local medical protocols".

[7.27.6.3 NMAC - Rp,7.27.6.3 NMAC, 12/12/2017]

7.27.6.4 DURATION:

Permanent.

[7.27.6.4 NMAC - Rp, 7.27.6.4 NMAC, 12/12/2017]

7.27.6.5 EFFECTIVE DATE:

December 12, 2017, unless a later date is cited at the end of a section.

[7.27.6.5 NMAC - Rp, 7.27.6.5 NMAC, 12/12/2017]

7.27.6.6 OBJECTIVE:

These regulations will inform the public and New Mexico emergency medical services providers of the procedures to authorize the use of advance directives in pre-hospital and inter-facility settings.

[7.27.6.6 NMAC - Rp, 7.27.6.6 NMAC, 12/12/2017]

7.27.6.7 DEFINITIONS:

A. "Advance directive" means a written instruction, such as a living will, durable power of attorney for health care or emergency medical services do not resuscitate form recognizable under state law and relating to the provision of health care when an individual is incapacitated.

B. "Advanced Practice Nurse" means a registered nurse who has completed the required education and training and received state of New Mexico approval to practice as a certified nurse midwife or advanced practice registered nurse.

C. "Authorized health care decision maker" means a person authorized under a durable power of attorney to make health care decisions on behalf of another, a court-appointed guardian or the parent of a minor or any other person authorized by law to make health care decisions for another.

D. "Bureau" means the emergency medical systems bureau of the epidemiology and response division of the department.

E. "Capacity" means an individual's ability to understand and appreciate the nature and consequences of proposed health care, including its significant benefits, risks and alternatives to proposed health care and to make and communicate an informed health-care decision.

F. "Designee" means a registered nurse, social worker, or other person who is designated and authorized by a physician, advanced practice nurse, or physician assistant to explain an EMS DNR order to a person who may execute the order.

G. "Durable power of attorney" means a document executed according to the provisions of Sections 45-5-501 through 45-5-502 NMSA 1978 of the New Mexico Probate Code, which designates an individual to make health care decisions for the person executing the document, or an advance health-care directive executed according to the provisions of Sections 24-7A-1 through 24-7A-18 NMSA 1978 of the New Mexico Uniform Health-Care Decisions Act, which designates an agent or surrogate to make health care decisions for an individual.

H. "Emergency medical services (EMS)" means the services rendered by emergency medical technicians or certified emergency medical services first responders in response to an individual's need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

I. "EMS bracelet" means a bracelet, medallion or some other item of personal wear, approved by the bureau for indicating in a standard, readily-recognizable manner that the person has executed an EMS DNR order.

J. "EMS do not resuscitate (DNR) order" means an order issued by a physician, advanced practice nurse, or physician’s assistant, and signed by the person or

authorized health care decision maker, on a form approved by the bureau, indicating that resuscitative measures should not be performed.

K. "EMS personnel" means persons currently licensed or certified by the bureau to practice as emergency medical technicians (EMTs) or emergency medical services first responders in New Mexico.

L. "Medical control" means supervision provided by or under the direction of physicians to EMS personnel by written protocol or direct communications.

M. "New Mexico Medical Orders for Scope of Treatment (MOST) form" is a bureau approved advanced healthcare directive/healthcare decision that may be used either in conjunction with or as an alternative to the EMS DNR order; it must be signed by a physician, advanced practice nurse, or physician's assistant and by the patient or patient's healthcare decision maker.

N. "Physician" means a doctor of medicine or doctor of osteopathy licensed or otherwise authorized to practice medicine or osteopathic medicine.

O. "Physician's Assistant (PA)" means a person who has received the education, training and approval from the State of New Mexico to practice as a PA in New Mexico

P. "Pre-hospital setting" means any setting outside of a hospital where EMS personnel are called for assistance, including but not limited to long term care facilities, private homes or during transport.

[7.27.6.7 NMAC - Rp, 7.27.6.7 NMAC, 12/12/2017]

7.27.6.8 EMS DO NOT RESUSCITATE (DNR) ORDER:

A. Execution and duration of an EMS DNR order, including Section A of the MOST form.

(1) Any physician, advanced practice nurse, or PA may execute an EMS DNR order on behalf of any person with capacity, with the person's informed consent. The physician, advanced practice nurse, or PA or designee shall explain to the person the full meaning of the order, the available alternatives, how the order may be revoked, and answer any questions the person may have about the order. The person for whom the order is being executed shall sign the document, as well as the physician, advanced practice nurse, or PA. A registered nurse may sign the EMS DNR or MOST if a verbal order for the EMS DNR or MOST has been received from a physician, advanced practice nurse, or PA; the name of the physician, advanced practice nurse, or PA must be printed beneath the signature.

(2) If the person for whom an EMS DNR order is contemplated has appointed an agent under a durable power of attorney, and the person for whom the DNR order is

contemplated lacks capacity, the physician, advanced practice nurse, or PA or designee may discuss the situation with the person's authorized health care decision maker, if any. The physician, advanced practice nurse, PA, or designee shall explain to the authorized health care decision maker the full meaning of the order, the available alternatives, how the order may be revoked, and answer any questions the authorized health care decision maker may have about the order. If the authorized health care decision maker gives informed consent to the order, the decision maker will sign the EMS DNR or MOST, as will the physician, advanced practice nurse, or PA. A registered nurse may sign the EMS DNR or MOST if a verbal order for the EMS DNR or MOST has been received from a physician, advanced practice nurse, or PA; the name of the physician, advanced practice nurse, or PA must be printed beneath the signature.

(3) An EMS DNR or MOST order shall remain in effect indefinitely unless revoked or unless an expiration date is specified in the document.

(4) An EMS DNR or MOST order shall be periodically reviewed by the person for whom the EMS DNR order is executed or by the authorized health care decision maker.

(5) A person for whom an EMS DNR order is executed may choose to wear an optional EMS bracelet indicating the existence of the order.

B. Revocation of an EMS DNR or MOST order.

(1) An EMS DNR or MOST order may be revoked at any time orally, by executing a subsequent order, or by performing an act which indicates an attempt to revoke the order, such as by burning, tearing, canceling, obliterating or destroying the order or any part of it, by the person on whose behalf it was executed or by the person's authorized health care decision maker.

(2) If an EMS DNR or MOST order is revoked, EMS personnel shall initiate appropriate resuscitation measures.

C. Execution and duration of a durable power of attorney.

(1) Any adult with decisional capacity may execute a durable power of attorney.

(2) A durable power of attorney shall remain in effect indefinitely unless revoked or unless an expiration date is specified in the document.

D. Revocation of a durable power of attorney: a durable power of attorney may be revoked at any
time by executing a subsequent durable power of attorney or by performing an act which indicates an attempt to revoke the durable power of attorney, such as by burning, tearing, canceling, obliterating or destroying the document, or any part of it, by the

person who executed it. It may also be revoked by an oral statement by the person who executed it.

[7.27.6.8 NMAC - Rp, 7.27.6.8 NMAC, 12/12/2017]

7.27.6.9 EMS PERSONNEL AND PROCEDURES:

A. Authorization of EMS personnel: EMS personnel shall follow EMS DNR orders, MOST form instructions or durable powers of attorney when encountering persons in pre-hospital settings in accordance with these regulations and local EMS medical protocols.

B. EMS procedures for verifying EMS DNR orders: EMS personnel shall comply with the following
procedures when encountering a possible EMS DNR order:

(1) primary assessment - perform initial primary assessment, i.e., assess airway, breathing and carotid pulse;

(2) verification of identification - verify by:

(a) using a driver's license or other signed photo identification; or

(b) identification by a family member; or

(c) positive third party identification by someone who knows the person;

(3) verification of existence of the appropriately completed MOST form by the steps in Subsection D of 7.27.6.9 NMAC;

(4) verification of EMS DNR or MOST order - verify the existence of an EMS DNR or MOST order for the person, using the following indicators:

(a) EMS DNR order only: if a valid EMS DNR order is immediately accessible, proceed to Subsection C of 7.27.6.9 NMAC;

(b) intact EMS bracelet: if the person is wearing an EMS bracelet that is fully intact and not defaced, proceed to Subsection C of 7.27.6.9 NMAC;

(c) non-intact or defaced EMS bracelet with an EMS DNR order: if the person is wearing an EMS bracelet that is not fully intact or is defaced, but an EMS DNR order is immediately accessible, proceed to Subsection C of 7.27.6.9 NMAC;

(d) non-intact or defaced EMS bracelet without an EMS DNR order: follow the regular resuscitation protocol and ask family member(s) or others present to locate the EMS DNR order; if the EMS DNR order is located, proceed to Subsection C of 7.27.6.9

NMAC; if the EMS DNR order is not located, continue the regular resuscitation protocol and contact medical control for consultation;

(e) no EMS bracelet and no EMS DNR order: if the person is not wearing an EMS bracelet but there are other indications that the person is on DNR status, follow the regular resuscitation protocol and ask family member(s) or others present to locate the EMS DNR order; if the EMS DNR order is located, proceed to Subsection C of 7.27.6.9 NMAC; if the EMS DNR order is not located, continue the regular resuscitation protocol and contact medical control for consultation.

(5) if there is any question about the validity of an EMS DNR order or MOST form, or there is any indication of an attempted homicide, initiate resuscitation until such time that the questions have been answered; if possible, contact medical control for consultation.

C. EMS procedures for implementing EMS DNR orders or MOST form instructions: if a person has a valid EMS DNR order or MOST form as evidenced by the steps in Subsection B of 7.27.6.9 NMAC, proceed as follows:

(1) for all persons: the following procedures may be initiated for the comfort of the person if they have not been refused by the person or by the authorized health care decision maker:

(a) administering oxygen by mask or cannula;

(b) suctioning;

(c) managing airways except intubation and other advanced airway maneuvers;

(d) administering analgesics, as authorized by the New Mexico scopes of practice;

(e) controlling bleeding;

(f) other care indicated on MOST form if utilized;

(g) making patient comfortable; and

(h) comforting family.

(2) for all persons in cardiac or respiratory arrest: - the following procedures shall be withheld:

(a) external cardiac compressions;

(b) artificial ventilations, intubation or other advanced airway maneuvers;

(c) defibrillation/external cardiac pacing;

(d) administration of cardiac medications; and

(e) artificial respiration.

(3) if there is any question about the validity of an EMS DNR order, or there is evidence of an attempted homicide or suicide, initiate resuscitation until such time that the questions have been answered; if possible, contact medical control for consultation.

D. EMS procedures for implementing the instructions on the MOST form or other durable powers of attorney:

(1) EMS personnel shall comply with the following procedures when encountering a MOST form, a DNR or advance directive form from any other source, or other durable power of attorney:

(a) primary assessment - perform initial primary assessment, i.e., assess airway, breathing and carotid pulse;

(b) verification of identification - verify, using a driver's license or other signed photo identification, by family member's positive identification, or identification by a person who knows the person, that the person is the one who executed the durable power of attorney; verify the identification of the person identified in the durable power of attorney as the authorized health care decision maker; if needed, contact medical control for consultation and then follow that person's instructions as authorized by the MOST form, other DNR form, other advance directive, or durable power of attorney.

(2) if there is any question about the validity of a MOST form, other DNR form, or other durable power of attorney, initiate resuscitation until such time that the questions have been answered; if possible, contact medical control for consultation.

E. Relationship of EMS DNR orders to durable powers of attorney: Where a person has an
EMS DNR order and a MOST form or other durable power of attorney, the most recent document shall prevail for EMS treatment only.

[7.27.6.9 NMAC - Rp, 7.27.6.9 NMAC, 12/12/2017]

7.27.6.10 ENFORCEABILITY AND PROGRAM ADMINISTRATION:

A. Enforceability of DNR orders and durable powers of attorney from other states: EMS personnel may honor DNR orders and durable powers of attorney that are executed in another state or jurisdiction in compliance with the laws of that state or

jurisdiction, or in compliance with the laws of New Mexico, to the extent the document is not inconsistent with the public policy of New Mexico.

B. Program administration: the bureau shall distribute, or arrange for the distribution of, EMS DNR order forms and relevant information to interested citizens and appropriate health care providers. These materials shall include specific guidance on how to obtain additional forms and the EMS bracelet.

[7.27.6.10 NMAC - Rp, 7.27.6.10 NMAC, 12/12/2017]

PART 7: TRAUMA CARE SYSTEM

7.27.7.1 ISSUING AGENCY:

New Mexico Department of Health, Public Health Division, Injury Prevention and Emergency Medical Services (EMS) Bureau.

[7.27.7.1 NMAC - Rp 7 NMAC 27.7.1, 6/14/02]

7.27.7.2 SCOPE:

These regulations apply to all agencies providing EMS services, local EMS Medical Directors, Regional Trauma Advisory Committees, the Trauma Advisory Committee, the Injury Prevention and EMS Bureau (IPEMS), the New Mexico Department of Health and hospitals participating in the New Mexico Trauma Care System.

[7.27.7.2 NMAC - Rp 7 NMAC 27.7.2**,** 6/14/02]

7.27.7.3 STATUTORY AUTHORITY:

These regulations are promulgated by the Secretary of Health by the authority of Section 9-7-6.E. NMSA 1978, and the Emergency Medical Services (EMS) Act, Section 24-10B-4.H. NMSA 1978 (as amended by Laws of 1993, Chapter 161). Administration and enforcement of the Act is the responsibility of the Injury Prevention and Emergency Medical Services Bureau of the Public Health Division, Department of Health.

[7.27.7.3 NMAC - Rp 7 NMAC 27.7.3, 6/14/02]

7.27.7.4 DURATION:

Permanent

[7.27.7.4 NMAC - Rp 7 NMAC 27.7.4, 6/14/02]

7.27.7.5 EFFECTIVE DATE:

June 14, 2002, unless a later date is cited at the end of a section.

[7.27.7.5 NMAC - Rp 7 NMAC 27.7.5, 6/14/02]

7.27.7.6 OBJECTIVE:

The purpose of these regulations is to implement the trauma system provisions of the EMS Act (as amended by the Laws of 1993, Chapter 161).

A. These regulations set forth standards governing the statewide trauma system in order to:

(1) prevent unnecessary death and disability due to injury,

(2) develop a statewide trauma system to assure timely, quality, cost-efficient and definitive care through coordination of pre-hospital, hospital and post-acute care,

(3) provide optimal care for the trauma patient,

(4) study and identify the epidemiology of injury; and,

(5) pursue trauma prevention activities to decrease the incidence of trauma.

B. These regulations establish procedures for:

(1) statewide trauma system oversight,

(2) requirements for all participating facilities,

(3) the designation process of hospitals/healthcare facilities to provide trauma care services; and,

(4) the development and operation of a statewide trauma registry.

C. These regulations are not intended to constitute detailed procedures for implementation of the state trauma system. Procedures and guidelines are available upon request from the IPEMS Bureau, Trauma Section, Public Health Division, Department of Health, PO Box 26110, Santa Fe, New Mexico, 87502-6110.

D. Trauma system design/components: the trauma system in New Mexico will be designed with the following framework:

(1) system roles and responsibilities define the organizational structure of the people and organizations instrumental to the trauma system. These include:

(a) New Mexico Department of Health

(b) IPEMS Bureau

(c) EMS Regional offices

(d) Trauma Advisory Committee

(e) pre-hospital services

(f) Regional Trauma Councils

(g) acute care facilities

(h) other state trauma systems

(i) evaluation and process improvement systems

(j) injury prevention professionals

(2) system structures are the tools, structure and processes of the trauma systems. These include:

(a) laws and regulations

(b) information systems

(c) evaluation and process improvement systems

E. System oversight:

(1) IPEMS Bureau

(2) Trauma Advisory Committee

(3) Regional Trauma Advisory Councils

(4) system process improvement program

(5) designated trauma centers (levels I-IV)

(6) state and hospital trauma registry

(7) coordinated linkages with pre-hospital care services, rehabilitation facilities and long term care providers

(8) support programs (e.g., public education, prevention, system finance)

F. The system will emphasize an inclusive approach with optimal participation by all providers in the continuum of trauma care.

[7.27.7.6 NMAC - Rp 7 NMAC 27.7.6, 6/14/02]

7.27.7.7 DEFINITIONS:

Unless a different meaning is plainly required by the context, the following words and phrases used in these regulations shall have the meanings indicated.

A. "ACLS" means advanced cardiac life support, a course developed by the American Heart Association.

B. "activation of the trauma system" means procedures whereby a pre-hospital provider of hospital/healthcare facility identifies the major trauma patient by trauma triage criteria and pre-hospital and hospital resources are mobilized to care for the patient in accordance with the regional trauma plan and the trauma center's policy and procedures for trauma team activation.

C. "approved" means approved by the IPEMS Bureau.

D. "ATLS" means advanced trauma life support, a course developed by the American College of Surgeons.

E. "board certified or board eligible" means completion of the examination and award of certification by the appropriate certifying body for the physician specialty. Eligible means meets the standards to sit for the appropriate certifying board and actively pursuing certification.

F. "BP" means blood pressure.

G. "Bureau" means the Injury Prevention and EMS Bureau of the Public Health Division of the Department of Health.

H. "certified ambulance service" means any provider of ambulance service subject to the jurisdiction of the Public Regulation Commission.

I. "continuum of care" means all services available to the population of persons either at risk of injury or who have incurred an injury, beginning with injury prevention and progressing to long term care services and including the return to the highest level of wellness and functioning.

J. "CME" means continuing medical education.

K. "Department" means the New Mexico Department of Health.

L. "designated trauma center" means a hospital identified by the Department as a Level I, II, III, or IV trauma care services provider.

M. "designation" means a formal determination by the Department that a hospital/healthcare facility is capable of providing special resources and care as a designated trauma center.

N. "Emergency Medical Services (EMS) Provider" means Emergency Medical Technicians (EMT) or trained EMS first responders who render care in response to a need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

O. "ENPC" means Emergency Nursing Pediatric Course, developed by the Emergency Nurses Association.

P. "E-Code" means external cause code, an etiology included in the International Classification of Diseases (ICD).

Q. "ED" means emergency department.

R. "facility patient care protocols" means the written procedures adopted by the medical staff of a participating facility that directs the care of the patient. These procedures shall be based upon the assessment of the patient's medical needs and shall follow minimum statewide standards.

S. "hospital" means a facility with an emergency department and physician(s) available, licensed under state statute, or a comparable facility operated by the federal government or located and licensed in another state.

T. "hospital trauma registry" means a computerized trauma data base maintained by a hospital/healthcare facility.

U. "hospital trauma registry policy manual" means a written guideline used by New Mexico trauma data collection personnel to ensure uniform, complete and accurate trauma data.

V. "ICD" means the international classification of diseases, a coding system developed by the World Health organization.

W. "ICU" means intensive care unit.

X. "immediately available" means the immediate and rapid response upon notification and the physical presence of the health professional in the stated location at the time of need by the trauma patient which is continuously monitored by the process improvement plan.

Y. "inclusive trauma system" means a trauma system that encourages optimal participation by all providers in the continuum of trauma care as well as injury prevention, rehabilitation and long-term care service providers.

Z. "indicator" means a process improvement tool or process measure used to monitor the quality of important governance, management, clinical, and support processes and outcomes.

AA. "interfacility transfer criteria" means the criteria established to indicate the need for a level of care for the trauma patient that is not available at the transferring facility.

BB. "letter of intent" means a written document executed by a hospital/healthcare facility's administration indicating their intention to participate in the New Mexico Trauma System.

CC. "level I trauma center" means a hospital which is designated by the Department as having met the hospital/healthcare facility resource standards for a level I trauma center as described in the most recent version of the Resources for Optimal Care of the Injured Patient, published by the Committee on Trauma of the American College of Surgeons. A level I trauma center is capable of providing immediately available comprehensive care on a twenty-four (24) hour basis for acutely injured patients of all ages. The hospital is committed with resources for the evaluation, stabilization, and definitive care of all injured patients as well as committed to trauma-related research, training, and community outreach. A level I trauma center shall satisfy the requirements for outreach, training and public education as specified in Appendix D, Table 1, Outreach, Training and Public Education Section.

DD. "level II trauma center" means a hospital which is designated by the Department as having met the hospital resource standards for a level II trauma center as described in the most recent version of the Resources for Optimal Care of the Injured Patient, published by the Committee on Trauma of the American College of Surgeons. A level II trauma center is capable of providing promptly available major trauma care on a twenty-four (24) hour basis for acutely injured patients of all ages. The hospital has the capability to provide subspecialty care in most areas and is committed with resources for the evaluation, stabilization, and definitive care of all injured patients. A level II trauma center shall satisfy the requirements for outreach, training and public education as specified in Appendix D, Table 1, Outreach, Training and Public Education Section.

EE. "level III trauma center" means a hospital which is designated by the Department as having met the hospital resource standards for a level III trauma center as described in Appendix D, Table 1 of these regulations. A level III trauma center is capable of providing promptly available trauma care on a twenty-four (24) hour basis, including on-call general surgery and select specialty coverage. The hospital is capable of providing evaluation, initial stabilization, limited ongoing care and for the transfer of

acutely injured patients of all ages to level I or level II facilities which can provide further definitive surgical care.

FF."level IV trauma center" means a hospital or other healthcare facility that is designated by the Department as having met the hospital/healthcare facility resource standards for a level IV trauma center as described in Appendix D, Table1 of these regulations. A level IV trauma center is capable of providing physician-directed basic services for the evaluation, initial stabilization, and early transfer of acutely injured patients of all ages to a higher level of care. Such facilities may have limited on-call general surgical and subspecialty services.

GG. "local EMS medical director" means a physician who is responsible for all aspects of patient care of a local EMS system or EMS provider service, including providing for or ensuring the medical control of EMTs; the development, implementation, and evaluation of protocols and oversight of process improvement activities as described in the Medical Direction for Emergency Medical Services, 7.27.3 NMAC, or such other regulations as may be adopted by the Public Health Division of the Department.

HH. "local trauma transport protocols" means protocols, developed and approved by the Regional Trauma Advisory Councils, to define destination procedures for major trauma patients.

II. "major trauma" means serious injury caused by external forces which may result in death or disability.

JJ. "mid-level practitioner" means an advance practice nurse or physician assistant.

KK. "New Mexico Trauma Foundation" means an organization established to conduct trauma related research, to develop and coordinate trauma injury prevention programs, to coordinate and facilitate the financial viability activities of the designated trauma centers and trauma team participating physicians and other trauma system related activities and purposes.

LL."Office of the Medical Investigator (OMI)" means the office designated by the State of New Mexico to determine the causes of sudden or unexplained death.

MM. "PALS" means pediatric advance life support, a course developed by the American Heart Association.

NN. "participating facility" means any hospital that treats or admits trauma patients and that is an active participant in their Regional Trauma Advisory Council.

OO. "pediatric trauma patient" means a trauma patient known or estimated to be less than fourteen (14) years of age.

PP. **"physician"** means a doctor of medicine or osteopathy who is licensed or otherwise authorized to practice medicine or osteopathy in the State of New Mexico.

QQ. **"PI"** means process improvement, an organized method of monitoring, evaluating and improving care provided throughout the trauma system.

RR. **"pre-hospital patient care protocols"** means the written procedures adopted by the local EMS medical director or adopted by the Regional Trauma Council which directs the pre-hospital emergency care of a patient.

SS. **"promptly available"** means the physical presence of the health professionals in the stated location within a specified period of time, which is defined in the local or regional trauma plan and the hospital's trauma center designation application.

TT."qualifying trauma patient" means a patient who meets the statewide and approved regional pre-hospital trauma triage criteria and the Bureau approved criteria for statewide trauma registry inclusion.

UU. **"recognized"** means written acknowledgement by the Bureau.

VV. **"region"** means a geographic area served by local emergency medical service(s) and/or hospital(s)/healthcare facilities for the purpose of planning a local system which provides care for persons with injuries.

WW. **"Regional Trauma Advisory Council (ReTrAC)"** means a TAC and Bureau approved group from each recognized trauma region that develops and implements trauma plans that address the particular needs of the trauma service area.

XX. **"regional trauma plan"** means a document created by a Regional Trauma Advisory Council and approved by the Bureau with the advice of the Trauma Advisory Committee that identifies goals, objectives, guidelines, and standards for the oversight, management and operation of a regional trauma program.

YY. **"Secretary"** means the Secretary of the New Mexico Department of Health.

ZZ."trauma" means a major single or multi-system injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.

AAA. **"Trauma Advisory Committee (TAC)"** means the subcommittee on trauma of the Statewide EMS Advisory Committee established pursuant to the EMS Act.

BBB. **"trauma center"** means a hospital/healthcare facility designated by the Department to receive and provide services for trauma patients under these regulations.

CCC. **"trauma clinical services"** means the pre-hospital coordination, hospital resuscitation, hospital inpatient treatment, rehabilitation and follow-up medical care services for trauma patients which are the responsibility of the designated trauma center and the appropriate physician specialist, as defined by these regulations.

DDD. **"trauma committee"** means a multi-disciplinary, hospital-sponsored committee that meets regularly to provide input to the trauma program and to the hospital's administrative and medical staff.

EEE. **"trauma nurse coordinator"** means a registered nurse with experience, special training and certification who is assigned by the trauma center to manage the requirements as provided for in these regulations and to provide trauma program coordination, leadership and direction according to a hospital-approved job classification.

FFF. **"trauma program"** means an administrative unit of a trauma center that includes the medical director, trauma nurse coordinator, and trauma program support staff, for the ongoing management and coordination of the hospital's trauma program.

GGG. **"TTP"** means the approved prehospital trauma transport protocols, developed by the local/regional EMS medical director, that utilize the trauma triage guidelines to determine primary and alternative transport destinations for prehospital providers.

HHH. **"trauma registry"** means a database which documents and integrates medical and system information related to the provision of trauma care by hospitals/healthcare facilities.

III. **"trauma surgeon"** means a physician who is Board certified or Board eligible in general surgery, and who has trauma surgery privileges delineated by the hospital/healthcare facility's medical staff.

JJJ. **"trauma system"** means an organized approach to providing personnel, trauma centers, and equipment for the coordinated and effective treatment of patients with an injury with the potential of requiring immediate medical or surgical intervention to prevent death or disability. The trauma care system includes prevention activities, pre-hospital care, hospital care, and rehabilitation. The components of a trauma system include:

(1) provision of manpower

(2) training of personnel

(3) communications

(4) transportation

(5) hospitals/healthcare facilities

(6) critical care units

(7) use of public safety agencies

(8) use of private agencies

(9) consumer participation

(10) accessibility to care

(11) transfer of patients

(12) standard medical record keeping and reporting

(13) public information/education and prevention

(14) independent review and evaluation, including formal total process improvement programs

(15) disaster linkages

(16) mutual aid agreements

KKK. "trauma system plan" means the State Trauma Plan that develops the infrastructure needed to support an inclusive statewide trauma system that recognizes the unique geo-political attributes of the regions and empowers the Regional Trauma Councils (ReTrACs) to meet the needs of their regions.

LLL. "trauma team" means personnel assigned for involvement with trauma resuscitation.

MMM. "trauma team physician" means a physician who has been identified by the designated trauma center and its trauma surgeon(s) as a member of the center's trauma team.

NNN. "trauma triage criteria" means the parameters established to identify the high-risk patients for major injury and/or critically injured trauma patients for treatment in accordance with the local trauma transport protocols. The criteria shall include such considerations as the anatomic components, physiologic conditions, and mechanism of injury.

OOO. "triage" means the sorting of trauma patients in terms of disposition, destination, or priority requiring and identifying injury severity and patient risk, so that the appropriate care level can be readily accessed according to patient care guidelines.

[7.27.7.7 NMAC - Rp 7 NMAC 27.7.7 & 7 NMAC 27.7.13, 6/14/02]

7.27.7.8 SYSTEM ADMINISTRATION:

A. General Responsibilities of the IPEMS Bureau:

(1) the Bureau shall administer the process, to designate and re-designate hospitals/healthcare facilities to provide trauma care services in accordance with these regulations.

(2) the Bureau shall establish and manage the Statewide Trauma Registry.

(3) the Bureau shall approve and periodically review statewide and regional pre-hospital trauma triage criteria guidelines, inter-facility transfer criteria for adult and pediatric patients, trauma center standards and the trauma register data set with the advice of the Trauma Advisory Committee (TAC).

(4) the Bureau may recognize the establishment of Regional Trauma Councils (ReTrACs) as appropriate.

(5) the Bureau shall develop and update the State Trauma System Plan periodically with advice from the TAC.

(6) the Bureau shall review, recommend changes to, and approve any proposed regional plans submitted by a ReTrAC, through TAC and shall take into account recommendation from the TAC. This approval shall be based upon consideration of the needs of trauma patients whose care may require resources from more than one (1) region and/or from adjacent states.

(7) the Bureau shall provide technical assistance and support to the TAC, ReTrACs and to hospitals/healthcare facilities and EMS providers as necessary to carry out the Trauma System Plan.

(8) the Bureau shall exercise, as necessary, the right to review, inspect, evaluate and audit all trauma patient records, trauma process improvement plans and committee minutes, physical facilities, and any other documents relevant to trauma care in any designated trauma center to verify compliance with trauma center standards. The Bureau shall maintain the confidentiality of such records in accordance with state and/or federal law.

(9) the Bureau shall facilitate the establishment of a statewide "inclusive" trauma system by encouraging participation of all agencies, facilities and services that treat or admit trauma patients in the statewide trauma data collection process, or in injury prevention programs, or in ReTrAC or in any other manner deemed by the Bureau to improve trauma care.

(10) the Bureau may periodically conduct special studies on the Statewide Trauma System to determine system coverage, quality and extent of care, and financial effect of the system components.

(11) the Bureau may develop other trauma regulations, with advice from TAC, and as necessary, to ensure the quality of the Statewide Trauma System.

(12) the Bureau shall facilitate, and where necessary, develop and maintain public information/education and prevention programs as an integral component of the trauma system.

B. Trauma Advisory Committee: Trauma Advisory Committee (TAC), a subcommittee of the Statewide EMS Advisory Committee established pursuant to the EMS Act, shall:

(1) adopt guidelines, with concurrence of the Statewide EMS Advisory Committee and Bureau, for its operations, including membership, attendance, maintenance of minutes and other guidelines necessary to assure the orderly conduct of business;

(2) periodically review and comment on the Department's regulations, policies, and standards for trauma;

(3) review and comment annually on the Statewide EMS Advisory Committee's budget for the trauma system;

(4) advise the Bureau regarding trauma system needs and progress throughout the state;

(5) review and comment on regional trauma plans;

(6) periodically review local/regional pre-hospital trauma triage guidelines and inter-facility transfer criteria; and,

(7) advise the Bureau on injury prevention and public information/educational programs.

C. Regional trauma advisory councils (ReTrACs):

(1) Regional Trauma Advisory Councils (ReTrACs) may be established by application made to the Bureau.

(2) the application shall be in a manner and format prescribed by the Bureau.

(3) such applications shall be reviewed and commented on the TAC prior to approval by the Bureau.

(4) ReTrAC, in order to be recognized, shall submit to the Bureau a membership list which includes a balance of representation from EMS providers, hospital(s)/healthcare facilities and other interested parties.

(5) an approved ReTrAC shall develop, update as appropriate, and implement a regional trauma plan that identifies particular regional needs and sets goals for special regional trauma needs. Additionally, a ReTrAC shall:

(a) seek and consider the recommendations of trauma system providers, governmental entities and consumers,

(b) consider the regional and state analyses provided by the Bureau based on trauma registry data and other appropriate sources; and,

(c) develop and implement regional trauma triage and treatment protocols bypass and diversion plans, process improvement methods and patient care protocols.

(d) the approved ReTrAC shall establish a medical review committee to conduct the regional process improvement program, as defined by the Bureau's approved process improvement plan, including the review of patient outcome and regional system issues.

(e) the approved ReTrAC shall annually, identify and analyze system and patient care trends and outcomes, based on trauma registry data provided by the Bureau, to evaluate effectiveness of regional trauma system and its component subsystems.

(f) the approved ReTrAC shall advise the Bureau and TAC on other matters relating to the delivery of trauma care within the region; and,

(g) accomplish other purposes as approved by the Bureau.

(6) an approved ReTrAC shall adopt pre-hospital patient care protocols in consultation with the local EMS medical directors, EMS providers, trauma service providers, and emergency communication centers. These protocols shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma centers to receive the patient should an inter-facility transfer be necessary. Procedures on inter-facility transfer of patients shall be consistent with the inter-facility transfer criteria and guidelines as provided for in Appendix B.

D. Trauma System Process Improvement Program:

(1) an overall Process Improvement (PI) program shall be developed for the State Trauma System. The PI program shall include patient care outcomes and compliance with these regulations. The PI program shall consist of:

(a) an approved state PI system plan,

(b) system trauma registry,

(c) Bureau and approved ReTrAC review of:

(i) trauma system trends/needs,

(ii) key indicators ad defined by the State Trauma PI Plan, and

(iii) patient care and other outcome issues and needs of the trauma system.

(d) trauma center review of:

(i) trends/needs,

(ii) key indicators as defined by the trauma center PI plan, and,

(iii) patient care and outcome studies as needed to verify compliance with standards of care and the needs of the trauma center.

(2) the Bureau shall:

(a) develop and maintain a Statewide Trauma System PI Plan with input from the TAC; and,

(b) provide guidelines for and review of regional trauma PI plans to evaluate regional trauma care delivery, patient care outcomes, and compliance with these standards.

(3) each ReTrAC shall:

(a) develop a written regional trauma PI plan, which includes policies for confidentiality of records and recordings of committee actions, including a requirement that each attendee of the trauma PI committee meeting is informed in writing of the confidentiality requirement. Information identifying individual patients shall not be publicly disclosed without the patient’s consent in accordance with applicable state and federal laws;

(b) include in its regional trauma PI plan, the process for informing the Bureau of the results of the PI review;

(c) appoint, at a minimum, one member for each designated trauma center, licensed medical staff, trauma coordinator/or nurse, licensed EMS provider, a local EMS pre-hospital provider medical director, and a member of the EMS regional office to participate on the regional PI subcommittee. Other healthcare providers and hospital/healthcare facilities providing trauma care in the region, including non-designated hospital/healthcare facilities and EMS providers and pre-hospital services, may be invited to participate in the PI process.

(d) implement the written regional trauma PI plan including periodic assessment of performance of the regional EMS and trauma care system, including area training plans, based on date supplied by the trauma registry and other sources, including:

(i) trauma care delivery,

(ii) patient care outcomes, including pediatric and adult patients,

(iii) all trauma deaths, and

(iv) compliance with these regulations.

(e) provide assessment of data governing all aspects of patient care; and

(f) establish the process for communication to and from the Bureau on identified trauma system issues and concerns.

(4) each designated trauma center shall:

(a) develop an internal trauma plan which, based on data supplied by the trauma registry and other sources, will provide for the ongoing assessment and improvement of performances of the trauma center, including;

(i) trauma care delivery,

(ii) all trauma deaths,

(iii) identification and analysis of injury trends, patient care outcomes, and other information,

(iv) periodic assessment of data governing aspects of patient care,

(v) policies regarding confidentiality of data elements related to identification of provider and trauma center care outcomes, in accordance with applicable state and/or federal law,

(vi) policies regarding confidentiality of records and committee minutes, including a requirement that each attendee of the trauma PI committee meeting is informed in writing of the confidentiality requirement. Information identifying individual patients shall not be publicly disclosed without the patient's consent in accordance with applicable state and federal laws.

(vii) provision for feedback to the Bureau and the approved ReTrAC on identified trauma issues and concerns, and

(viii) compliance with these regulations.

(b) implement the hospital-wide PI program in compliance with the trauma center plan to reflect and demonstrate continuous process improvement in the delivery of trauma care. The trauma center PI program shall include regular in-house, multi-disciplinary trauma conferences, which address:

(i) comprehensive review of patient care throughout the patient's stay,

(ii) participation of members of the trauma team,

(iii) participation of the person responsible for coordination of trauma registry activities,

(iv) participation of the trauma center's designated rehabilitation coordinator, as appropriate,

(v) feedback to staff and services areas that are involved with trauma care, and

(vi) provision of appropriate reports to the state and regional process improvement program.

(c) document the trauma center's PI program proceedings, conclusions, actions taken, results of the actions taken and follow through, demonstrating that relevant findings are used to study and improve processes that affect trauma patient care;

(d) evaluate the results of the trauma PI program and include them with the trauma center's process improvement program;

(e) participate in the System Trauma Registry by:

(i) identifying a person to be responsible for coordination of trauma registry activities,

(ii) downloading required trauma data as stipulated by the Bureau,

(iii) submit aggregate reports as stipulated by the Bureau, and

(iv) participate in the trauma registry workshops.

(f) participate in the appropriate ReTrAC PI program that may be required in these regulations.

[7.27.7.8 NMAC - Rp 7 NMAC 27.7.8, 6/14/02]

7.27.7.9 TRAUMA CENTER DESIGNATION PROCESS:

A. Levels of trauma centers: the Bureau shall identify trauma centers by levels of care capability as defined in these regulations. The levels are as follows:

(1) level I trauma center

(2) level II trauma center

(3) level III trauma center

(4) level IV trauma center

B. Phases of Designation:

(1) phase one (1), letter of intent: the first phase of the designation process is an invitation issued by the Bureau to all hospitals/healthcare facilities in the State that applications for designations are initiated by a letter of intent.

(2) phase two (2), application: the hospital shall submit an application, that has been developed by the Bureau, to the Bureau identifying the desired level of trauma center designation.

(3) phase three (3), review: the third phase is the review phase which begins with the on-site review of the hospital/healthcare facility and ends with the Bureau's recommendation to the Secretary to designate the hospital/healthcare facility as a trauma center.

(4) phase four (4), final: the fourth phase is the final phase which begins with the Secretary reviewing the Bureau's recommendations and ends with a final decision as to the level of trauma center designation by the Department. This phase also includes an appeal procedure for the denial of a designation application in accordance with these regulations.

C. Application Process:

(1) the Bureau shall develop and issue an application packet to hospitals or healthcare facilities, which have submitted a letter of intent in seeking initial designation as a trauma center.

(2) the application packet shall describe the information required from an applicant to be considered for trauma center designation. Such information shall include:

(a) application requirements,

(b) system standards for the level at which the hospital/healthcare facility is applying together with the current status on each standard and category of designation sought,

(c) evaluation criteria,

(d) statement and documentation of attendance and participation in the area ReTrAC and a commitment to serve the trauma care needs of their desired trauma services area and as a partner in the Statewide Trauma System,

(e) geographic area proposed to be covered, and appropriate utilization of data, and

(f) evidence of financial viability compliance.

(3) if there is a designated trauma center or centers at the same or higher level of designation in the proposed geographical area to be served by the applicant, the applicant shall include in its application the following:

(a) a statement of the proposed role of the applicant hospital assuring that the applicant's trauma program and activities would not have a negative financial or operational impact on the existing designated trauma center(s) program or services, and

(b) a statement by the area ReTrAC that the proposed trauma program of the applicant is consistent with and addresses the needs of the regional trauma program as described in the approved regional trauma plan.

(4) the Bureau shall:

(a) conduct a review of each applicant's submitted proposal for completeness. If any proposal is incomplete, the applicant shall be notified by the Bureau and afforded the opportunity to complete the application at least within twenty (20) working days of the Bureau's notification; and,

(b) evaluate applications for potential multiple hospital designation following the same criteria as for a single-facility application. Applications for multiple hospital designation must demonstrate that the goals of these regulations are met as defined in their applications.

D. On-Site Review for Designation:

(1) the Bureau shall conduct an on-site review of an applicant hospital/healthcare facility for levels I, II, III, and IV trauma centers, prior to designation.

(2) the Bureau shall establish multi-disciplinary on-site review teams composed of individuals knowledgeable in trauma care and systems, appropriate to the level of designation requested.

(3) for the initial designation for a level I and II trauma center, the team shall include but not be limited to a:

(a) trauma surgeon,

(b) emergency physician, and

(c) trauma nurse coordinator.

(4) for the designation for a level III and IV trauma center, the team shall include a:

(a) trauma surgeon or emergency physician, and

(b) trauma nurse coordinator.

(5) the composition of subsequent survey teams shall be determined by the Bureau.

(6) such teams shall consist of professionals who do not live or work:

(a) in the same state as the applicant for the designation of levels I and II trauma centers, or,

(b) in the same county as the applicant for designation of level III or IV trauma centers.

(7) the Bureau will consider the allegation of conflict of interest of an on-site review team member if a hospital or healthcare facility can demonstrate a reasonable basis for concern as determined by the Department. Concerns accompanied by the proof upon which the hospital or healthcare facility relies on must be submitted in writing

within ten (10) working days of the Bureau's announcements of proposed on-site review team members.

(8) the applicant's administration, faculty, medical staff, employees and representatives are prohibited from having any contact with any on-site review team member after the announcement of the team members and before the on-site review, except as authorized by the Bureau. A violation of this provision may be grounds for denying that applicant's proposal, as determined by the Bureau.

(9) the on-site review team shall evaluate the appropriateness and capabilities of the applicant to provide trauma care services, and validate the hospital/healthcare facility's ability to meet the responsibilities, equipment, and performance standards for the level of designation sought and to meet the overall needs of the trauma system in that region by:

(a) familiarizing themselves with the hospital or healthcare facility's proposal;

(b) inspecting the hospital or healthcare facility's physical plant and interviewing of key staff,

(c) examining hospital or healthcare facility trauma related documents, including patient care records;

(d) interviewing other appropriate individuals;

(e) reviewing past applicant or similar proposals for the regions; and, reviewing other materials as deemed appropriate by the Bureau.

(10) the on-site review team shall:

(a) make a verbal summary of preliminary findings to the applicant upon completion of the on-site review; and,

(b) make written recommendations to the Bureau of the on-site review.

(11) the Bureau and the members of the on-site review team shall maintain confidentiality of information, records, and reports developed pursuant to on-site reviews as permitted by state and federal laws. Information obtained by the on-site team, their oral and written reports, and deliberations shall be kept confidential by the Bureau.

(12) the applicant's application will become the property of the Bureau and shall be considered public information at the end of the designation process, subject to state and federal laws.

(13) hospitals applying for level I or level II may, at their discretion, request a verification site survey by representatives of the American College of Surgeons. The Bureau will accept the findings of the verification site visit and incorporate a copy of the findings in its report to the Secretary recommending or not recommending designation at the level applied for.

E. Designation of Trauma Center:

(1) as soon as practical, but no later than forty five (45) days after receipt of the on-site report survey document, the Bureau shall make recommendations to the Secretary based on:

(a) evaluation of pre-review documentation submitted as part of the application,

(b) recommendations from the on-site review team,

(c) ability of each applicant to comply with goals of the State and regional trauma plans, and,

(d) compliance with agreements with the Bureau, including compliance with regional review criteria as applicable during the previous designation period.

(2) after completion of the on-site review, the Bureau:

(a) may recommend to the Secretary approval at the level of designation proposed by the hospital or healthcare facility; or,

(b) may recommend to the Secretary a lower designation, if, according to the site surveyor's evaluation, the hospital or healthcare facility is unable to meet the standards of the designation for which the applicant applied; or,

(c) may require the hospital or healthcare facility to submit an application for the lower designation, to be followed by an on-site review.

(3) upon approval of the recommended level of designation by the Secretary, the Bureau shall require the hospital or healthcare facility, after receiving notification of the Secretary's decision, to respond within ten (10) working days to accept or decline the proposed designation.

(4) hospitals or healthcare facilities designated as a trauma center shall comply with applicable standards as set forth by the Bureau.

F. Categories of Designation:

(1) provisional: the Bureau may initially designate a trauma center as "provisional" for a term not to exceed one (1) year except for good cause shown as granted by the Bureau;

(a) shall require all provisional trauma centers to have a written work plan of objectives to rectify deficiencies and to demonstrate progress on the work plan throughout the twelve (12) month time period; and,

(b) shall, at the end of the provisional period, grant full designation, extend the provisional period, or suspend the trauma center for cause.

(2) full designation: the Bureau may grant full designation to any hospital or healthcare facility in full compliance with these regulations, subject to the review process described, for a period not to exceed three (3) years.

G. Agreement Process: the Bureau and the designated trauma center shall enter into a written agreement. The agreement shall:

(1) authorize the hospital or healthcare facility to function and identify itself as a designated trauma center for either provisional or full designation;

(2) identify the requirements and responsibilities of both the trauma center and the Bureau, including attendance requirements at local, regional, state and national meetings;

(3) allow the Bureau to monitor compliance with regulations and standards during the designation period, including access to:

(a) patient discharge summaries

(b) patient care logs

(c) patient care records

(d) hospital trauma process improvement program records, including minutes, and,

(e) other relevant documents as determined by the Bureau, and

(4) require confidentiality of information relating to individual patient, provider, and hospital/healthcare facility’s care outcomes in accordance with state and federal laws.

H. Denial, Revocation or Suspension of Designation:

(1) the Bureau may deny the application for designation if it finds that the hospital/healthcare facility:

(a) is not the most qualified applicant within a geographic area;

(b) is unable to meet the requirements of these regulations for the level of designation sought;

(c) makes a false statement of a material fact in the hospital/healthcare facility's application for designation;

(d) refuses to allow representatives of the Bureau to inspect any part of the hospital/healthcare facility, records, documentation, or files pertaining to the designation process;

(e) is unable to meet or comply with the requirements as stated in **Paragraph (5) of Subsection C of 7.27.7.8 NMAC** for participation in the activities of an area ReTrAC and the requirements of an approved regional trauma plan.

(f) engages in unauthorized contact with any on-site review team member.

(2) the Bureau may revoke or suspend a trauma center designation if the trauma center:

(a) fails, refuses to comply or violates the provisions of the State hospital licensure requirements of the State trauma regulations or provisions of applicable federal law; or the trauma center agreement;

(b) fails to provide data to the Trauma Registry;

(c) makes a false statement of a material fact in the application for designation, or in any record required by these regulations, or in a matter under investigation;

(d) prevents, interferes with, or attempts to impede in any way, the work of a representative of the Bureau in the lawful enforcement of these regulations or any other applicable state law;

(e) uses false, fraudulent, or misleading advertising, or makes any public claims regarding the hospital/healthcare facility's ability to care for non-trauma patients based on its trauma center designation status;

(f) misrepresents or is fraudulent in any aspect of conducting business;

(g) is substantially out of compliance with the requirements of these regulations, and has been unable or refused to comply as required by the Bureau.

(3) the following procedures will be used for any investigation of a designated trauma center by the Bureau:

(a) any person or entity may communicate a complaint or knowledge of an incident of any alleged violation of these regulations to the Bureau. Complaints shall be submitted in signed written form to the Bureau. The Bureau may begin an investigation without a signed written complaint if there is sufficient cause.

(b) trauma centers being investigated shall receive written notification within ten (10) working days after a decision is made to begin a preliminary investigation.

(c) at the conclusion of the Bureau's preliminary investigation, the Bureau shall report its findings to the trauma center in written form, including any requirements for corrective action.

(d) if the trauma center does not respond, the corrective action is insufficient, or if the complaint is of such serious nature as to warrant suspension or revocation of designation, as determined by the Bureau, the Bureau shall proceed to the procedure as outlined in **Paragraph (4) of Subsection H of 7.27.7.9 NMAC below.**

(4) preliminary and further investigations shall be conducted by the Bureau.

(a) preliminary investigations shall be initiated when the Bureau receives information, which might form the basis for action against a trauma center. This fact finding/information gathering investigation will determine for the Bureau whether justification exists to initiate an action or to conduct a further investigation.

(b) further investigations shall be undertaken when additional information is required to allow the Bureau to determine if it will initiate an action. Notice will be given to the trauma center, which is the subject of the investigation unless extenuating circumstances exist which would reasonably preclude notification.

(c) the Bureau will take every precaution to ensure that preliminary and further investigations are conducted in a confidential manner.

(d) an official record is maintained for every designated trauma center in New Mexico under these regulations. If the Bureau begins a preliminary or further investigation, a confidential record will be created containing all investigatory material. If the Bureau initiates an action, all records not exempt from disclosure under the Inspection of Public Records Act, Section 14-2-1, et seq, NMSA 1978, will be placed in the designated trauma center's official record. Any request for records maintained by the Bureau will be processed in accordance with the Inspection of Public Records Act.

(5) the following process shall be used when designation is contemplated to be denied, revoked, or suspended:

(a) the Bureau shall notify a hospital/healthcare facility in writing of contemplated denial of designation, revocation, or suspension of designation by issuing a Notice of Contemplated Action (NCA). Such NCA shall include:

(i) the reasons for the action, and,

(ii) rights of the hospital/healthcare facility, which include a right to a hearing, and may, for contemplated suspension or revocation actions, at the discretion of the Bureau, include authorization to submit a plan of correction.

(b) the Bureau shall notify the recognized ReTrAC (if applicable) of the action taken.

(c) should a plan of correction be authorized by the Bureau pending contemplated revocation or suspension of designation of a trauma center, the following procedure shall be followed:

(i) the Bureau shall specify a deadline for submission of the plan of correction in the NCA. The plan shall include steps, which the trauma center intends to take in order to correct deficiencies and projected date of completion.

(ii) the Bureau shall approve or disapprove the plan within fifteen (15) calendar days of receipt. If the plan is disapproved by the Bureau, the hospital/healthcare facility shall have twenty (20) days to request a hearing in accordance with **Paragraph (6) of Subsection H of 7.27.7.9 NMAC** below.

(iii) upon notification that the plan of correction is approved by the Bureau, the trauma center shall begin implementation of the plan immediately and notify the Bureau upon completion of the plan.

(iv) upon satisfactory evidence of compliance, which may include an on-site review, the trauma center shall retain the designation status.

(6) the following process of appeal will be available to any hospital/healthcare facility which has received a Notice of Contemplated Action (NCA) to deny, suspend or revoke a trauma center designation.

(a) within twenty (20) calendar days of receipt of the contemplated action to deny, suspend or revoke a trauma center designation,

(b) a hospital/healthcare facility may formally appeal by requesting a hearing in writing, by certified return receipt letter to the Secretary of the Department, PO Box 26110, Santa Fe, New Mexico, 87502-6110.

(c) upon receipt of a timely appeal, and request for a hearing, the Secretary shall appoint a Hearing Officer and schedule a hearing, to be held in Santa Fe, New

Mexico within forty five (45) working days. If no timely request for hearing is received, the Bureau will take the action contemplated in the NCA.

(d) the Department shall notify the hospital/healthcare facility of the date, time, and place of the hearing, the identity of the Hearing Officer, and the subject matter of the hearing, not less than thirty (30) days prior to the date of the hearing.

(e) the Hearing Officer shall preside over the hearing, administer oaths, take evidence and decide evidentiary objections and rule on any motions or other matters that arise prior to the hearing.

(f) the hearing is open to the public unless requested to be closed by the hospital or the Department.

(g) the Hearing Officer shall make a written report and recommendation(s) to the Secretary containing a statement of the issue raised at the hearing, proposed findings of fact, conclusions of law, and a recommended determination.

(h) The Hearing Officer, or designee, shall record the hearing by means of mechanical sound recording device provided by the Department.

(i) The Hearing Officer's written report shall be submitted to the Secretary no later than thirty (30) working days after the close of the hearing.

(j) the Secretary shall render a final determination within ten (10) working days of the submission of the Hearing Officer's report. A copy of the final decision shall be mailed to the appealing hospital/healthcare facility by certified mail, and a copy shall be provided to the Office of General Counsel of the Department of Health.

I. Change in Trauma Center Designation Status:

(1) a designated trauma center shall have the right, with ninety (90) days notice, to withdraw as a trauma center or to request a designation lower than their current designated level.

(2) a designated trauma center shall:

(a) notify the Bureau and the approved ReTrAC within five (5) calendar days if temporarily unable to comply, and the reasons, with designation standards;

(b) notify the Bureau and the ReTrAC if it chooses to no longer provide trauma services commensurate with its designation level; and,

(c) if the trauma center chooses to apply for a lower level of designation, the Bureau, at its discretion, may repeat all or part of the designation process as described in these regulations.

J. Renewal of Trauma Centers Designation:

(1) all trauma centers shall repeat the designation process as described in these regulations every three (3) years prior to the trauma center's expiration of designation. The trauma center shall apply to the Bureau for re-designation for a period of three (3) years. A designated trauma center, in good standing, shall remain designated until the application process is completed.

(2) each level I, II, and III trauma center shall be resurveyed as described in the designation process in Section M of these regulations. Each level IV trauma center may be resurveyed, at the discretion of the Bureau.

(3) at the discretion, and for good cause, the Bureau may extend for up to one year the current designation status of any trauma center.

K. Trauma System Fees: the Bureau shall establish and publish a fee structure for trauma centers applicants for designation as a trauma center to help defray the costs associated with review of the application, the on-site review process and ongoing trauma system management.

L. Prohibition of the Use, Advertising or Marketing of Terms: to protect against public misconception of the capabilities of individual institutions and the usage of misleading terms, the following are prohibited:

(1) after January 1, 1996, no person, emergency medical service, hospital/healthcare facility shall, by any means, advertise, assert, represent, offer, provide or imply that such person, service, clinic or facility is a trauma center or use the terms; "trauma center", "trauma facility", trauma hospital", "trauma care hospital" or similar terminology or state in any manner that the person, organization or facility has the capabilities for providing treatment to major trauma patients except as permitted within the scope of the trauma center designation as provided herein.

(2) no trauma center shall, in any manner, advertise or publicly assert that its trauma designation affects the hospital/healthcare facility's care for non-trauma patients, nor that the designation should influence the referral of non-trauma system patients.

M. Trauma Center Fiscal Viability Requirement: in order to assure that each designated trauma center has adequate financial and facility resources and a qualified medical workforce to provide optimal care to the injured patient and to meet the requirements of these regulations, each designated trauma center shall:

(1) establish a trauma program fee and charge schedule for services rendered to qualifying trauma patients that accurately reflect the cost of services rendered to qualifying trauma patients and the financial risk associated with rendering trauma services as a designated trauma center;

(2) enter into reimbursement agreements or contracts with all third party payer organizations including, but not limited to, managed care organizations, Blue Cross and Blue Shield and preferred provider organizations. These reimbursement agreements are intended to:

(a) adequately reimburse the designated trauma center the cost for rendering emergency and in-hospital care to qualifying trauma patients, and

(b) adequately reimburse the hospital employed or contracted trauma team physicians the cost of rendering care to qualified trauma patients and the cost of trauma team alerting and trauma team activation.

(3) the designated trauma center, or an organization acting in its behalf such as the New Mexico Trauma Foundation, with the contractual authority to negotiate payment and reimbursement agreements and/or to perform other financial and collection services for the designated trauma center shall not discount or otherwise attempt to collect charges and fee less than the trauma program fee and charge schedule developed by the designated trauma center.

(4) a designated trauma center hospital may request from the Bureau a waiver of the financial viability requirements enumerated in this Section. The waiver request shall specify that the applicant's trauma program generates sufficient revenue to cover the cost of the trauma program and the financial risk associated with trauma center designation.

N. Trauma Team Physician Fiscal Viability Requirement: in order to assure that each trauma team physician participating on the trauma teams at the designated trauma centers has the financial resources needed to provide optimal care to the injured patient and to meet the requirements of these regulations, each trauma team participating physician shall:

(1) establish a trauma fee and charge schedule for physician services rendered to qualifying trauma patients that accurately reflect the cost of physician services rendered to qualifying trauma patients and the financial risk associated with rendering trauma care services as a trauma team physician; and

(2) enter into reimbursement agreements or contracts with all third party payer organizations including, but not limited to, managed care organizations, Blue Cross and Blue Shield and preferred provider organizations. These reimbursement agreements shall adequately reimburse the physician for physician services rendered to qualifying trauma patients.

(3) the trauma team physician or, an organization acting in his or her behalf such as the New Mexico Trauma Foundation, with the authority to negotiate payment and reimbursement agreements and/or to perform other financial and collection services

for the physician shall not discount or otherwise attempt to collect charges and fee less than the trauma fee and charge schedule developed by the physician.

(4) a physician participating on the trauma team at a designated trauma center hospital may request from the Bureau a waiver of the financial viability requirements enumerated in this Section. The waiver request shall specify that the physician generates sufficient revenue to cover the cost of the trauma program participation. "

O. Trauma Managed Care Patients: each designated trauma center shall:

(1) facilitate the transfer of a member of a health maintenance organization or system when the medical condition of the patient permits as defined by the patient's attending trauma physician and trauma center's trauma protocols.

(2) develop written policies, in cooperation with managed care healthcare systems and hospitals owned or contracted to provide care to the managed care providers, to:

(a) notifying the healthcare plan within forty-eight (48) hours of a trauma patient's admission,

(b) coordinate discharge planning of plan patients, and,

(c) facilitate transfer of patients.

[7.27.7.9 NMAC - Rp 7 NMAC 27.7.9, 6/14/02]

7.27.7.10 TRAUMA SYSTEMS DATA COLLECTION:

A. Bureau Responsibilities: the bureau shall:

(1) establish a statewide trauma data registry to collect and analyze data on the incidence, severity, and causes of trauma, including traumatic brain and spinal cord injury for the purposes of:

(a) monitoring and providing information necessary to evaluate qualifying trauma patient care, outcome and cost,

(b) assessing compliance of pre-hospital providers, designated trauma centers, and other hospital/healthcare facilities with the standards of the state trauma system operation and designation,

(c) providing information necessary for resource planning and management,

(d) providing data for injury surveillance, analysis, and prevention programs, and

(e) providing a resource for research and education.

(2) establish criteria to identify patients to be included in the State trauma system data collection from:

(a) all EMS providers,

(b) hospital/healthcare facilities, both designated and non-designated,

(c) Office of Medical Investigator reports,

(d) other sources outside of the trauma system which may include, but not be limited to:

(i) death certificates,

(ii) Hospital Inpatient Discharge Data (HIDD), and

(iii) law enforcement agency records.

(3) establish, publish, and periodically review the required data elements to be submitted to provide information regarding injury, trauma care, and system operation, in the following categories:

(a) demographic,

(b) anatomic,

(c) physiologic,

(d) severity,

(e) epidemiologic,

(f) resource utilization,

(g) Process Improvement,

(h) outcome, and

(i) financial.

(4) require a case specific patient identifier common to all data sources used in the trauma registry;

(5) provide procedures and specifications for electronic and hard copy submission of data;

(6) develop a system for, and report mechanism on process improvement through:

(a) establishing protocols for quality control, consistent with the Bureau's most current data quality guidelines,

(b) completing studies to assess the completeness and accuracy of case identification and data collection, and

(c) assuring the completeness and accuracy of data submitted for each provider submitting data to the trauma registry.

(7) evaluate requests from appropriate ReTrAC for collection of voluntarily submitted additional data elements from agencies and facilities in that region.

B. Provider Responsibilities:

(1) all certificated ambulance services shall:

(a) provide pre-hospital run reports for inclusion of trauma patient data on:

(i) trauma victims dead at scene,

(ii) all patients meeting local/regional trauma triage criteria who are transported to a hospital or healthcare facility and,

(iii) all patients transported in accordance with inter-facility transfer policies to a higher level of care or for special resources.

(b) submit data by electronic transfer or, if authorized in writing, to the EMS database as required, on approved forms.

(c) the transporting service shall be responsible for submitting to the receiving hospital/healthcare facility data, described in Appendix A, sub paragraph B (1), on all trauma patients.

(2) designated trauma centers shall use the following patient criteria to identify trauma patients for submission of data as defined in Appendix D, Table 1 as follows:

(a) discharge diagnosis ICD-0-CM codes of 800.0-904.99, including 940.0 - 949.00 (burns) when associated with major trauma,

(b) meets local, regional or state trauma triage criteria,

(c) emergency admissions (less than twenty-four (24) hours after arrival) for traumatic injuries,

(d) transferred to another hospital for trauma evaluation and/or definitive care by a trauma service,

(e) trauma patients who are pronounced dead on arrival at a hospital/healthcare facility,

(f) all trauma patients who are pronounced dead after admission to a hospital/healthcare facility, and

(g) submit required trauma system trauma registry data as indicated in Appendix C, via electronic transfer or, if authorized, in writing by the Bureau on approved paper forms.

(3) the Office of Medical Investigator (OMI) shall submit data to the Systems Trauma Registry, and appropriate hospital facility trauma registry, on all patients with injury listed as an underlying cause or contributing factor to death on the death certificate.

C. Trauma Registry Reports:

(1) the Bureau shall report:

(a) annually on all patient data entered into the System Trauma Registry;

(b) on trends, patient care outcomes, and other data, for each trauma region and for the state, for the purpose of regional evaluation as required in the State and Regional PI Plan; and,

(c) periodically on financial trends and needs.

(2) the Bureau shall provide:

(a) periodic reports to all providers submitting data to the System Trauma Registry;

(b) provider-specific raw data to the provider that originally submitted the data, upon request;

(c) aggregate regional data semiannually to the appropriate ReTrAC, excluding any confidential or identifying data; and,

(d) aggregate state trauma system data for hospitals, public or private, agencies and other interested parties for prevention activities, epidemiologic/demographic studies, and education and research projects.

D. Access and Release of Systems Trauma Registry Information:

(1) data elements related to the identification of individual patient's, provider's, and hospital/healthcare facility's outcomes shall be confidential.

(2) persons with access to information collected under these regulations shall use the information for only those purposes stipulated.

(3) the Bureau may approve requests for data and other information from the Trauma Registry for special studies and analyses, consistent with requirements for confidentiality of patient and quality management records. The Bureau may require requestors to pay any or all of the reasonable costs associated with special preparation of such requests, which may be approved. In accordance with those provisions, confidential information shall not be disclosed, except:

(a) on request, to an approved regional process improvement program which is bound by the same confidentiality guidelines as the Bureau;

(b) on request, to a scientific research professional associated with a scientific research organization, providing:

(i) the research professional's written research proposal has been reviewed and approved by the Bureau with respect to the scientific merit and confidentiality safeguards;

(ii) the Bureau has given administrative approval for the proposal; and,

(c) data does not provide specific hospital/healthcare facility or patient identification.

[7.27.7.10 NMAC - Rp 7 NMAC 27.7.10, 6/14/02]

7.27.7.11 PRE-HOSPITAL TRANSPORT GUIDELINES:

A. Each pre-hospital EMS provider shall: ensure, upon arrival at the location of an injury, a trained first responder or EMT assessment of the condition of each trauma patient using the local/regional trauma triage criteria to determine the transport destination according to local trauma transport protocols (TTPs).

B. The local TTPs will take into consideration the following exceptions:

(1) EMS Air Ambulance; when transporting by ground is not appropriate due to distance, terrain, traffic or other reasons, activation of an EMS air ambulance should be considered as provided for in the local TTPs. Consideration for EMS air ambulance activation shall include:

(a) multiple trauma patients,

(b) disaster situations,

(c) poorly accessible terrain,

(d) excessive or impeding traffic,

(e) transport time greater than thirty (30) minutes, or,

(f) potential to overload the closest hospital or EMS service.

(2) pediatric trauma: pediatric trauma patients shall be transported to the nearest designated trauma center that meets essential pediatric guidelines pursuant to these regulations, as provided for in the local TTPs.

(3) special needs: if a designated trauma center is farther from the location of the incident, has special resources that the nearest designated trauma care hospital does not have (such as burn capability), which is needed for the immediate condition of the trauma patient, the pre-hospital EMS provider may transport to the designated trauma center having the needed resource based on a specific approved local TTP. Special needs may include:

(a) burns,

(b) re-implantation,

(c) pregnancy,

(d) spinal cords/head injuries,

(e) hazardous material exposure, or,

(f) age less than two (2) years or greater than sixty (60) years and,

(g) other medical conditions requiring specialized services that may be included in the local TTP specific and appropriate to the patient's needs.

(4) other circumstances: if a designated trauma center is greater than thirty (30) minutes away by ground transport, a trauma patient may be transported to a hospital other than a trauma center only if the hospital is closer to the incident and the patient's immediate condition is such that the patient's life would be endangered if care was delayed by proceeding directly to the nearest trauma center. Transport of patients shall be based on approved local TTPs.

C. Pre-hospital EMS providers shall: have an approved TTP that requests alternative transport destinations as provided for in this paragraph. The local TTP shall specify specific exceptions and define the Process improvement (PI) plan to monitor protocols.

D. Where a pre-hospital EMS provider intends to transport a trauma patient to a facility, as provided for in the approved local TTPs: the pre-hospital EMS service and the medical director in collaboration with the Bureau shall ensure that the hospital meets all of the following:

(1) is staffed twenty-four (24) hours per day with a physician or at least a mid-level practitioner who is qualified in emergency airway management, ventilatory support, and control of life threatening circulatory problems which shall include, but not be limited to:

(a) placement of endotracheal tubes,

(b) establishment of intravenous access, and

(c) insertion of chest tubes.

(2) has equipment and staff to conduct chest and cervical/spinal radiological exams.

(3) has laboratory facilities, equipment and staff available to analyze and report patients blood and chemistry results;

(4) has equipment and staff promptly on call to initiate definitive care required by a trauma patient within thirty (30) minutes of the patient's arrival at the hospital, or can initiate procedures within thirty (30) minutes of the patient's arrival to transfer the trauma patient; and

(5) has written transfer agreements with a designated trauma center which identifies specific procedures to ensure the timely transfer of the trauma patient to the designated trauma care hospital.

E. A hospital/healthcare facility licensed in another state: which meets the above criteria may be identified in the local TTPs as a hospital/healthcare facility to which the EMS provider may transport a trauma patient.

F. These transport guidelines are considered in conjunction with all applicable laws and regulations. The Bureau may request copies of the local TTPs

[7.27.7.11 NMAC - Rp 7 NMAC 27.7.11, 6/14/02]

7.27.7.12 APPENDIX A TRAUMA PATIENT TRIAGE CRITERIA GUIDELINES:

A. Trauma Patient Triage Criteria Guidelines. The following guidelines were developed by the TAC standards committee and presented to the TAC for review in January 2001. It was subsequently brought before the JOE (Joint Organization on EMS Education) and the EMS Medical Direction Committee for discussion.

(1) purpose: To present for consideration by the TAC a standardized framework of Statewide Prehospital Trauma Triage Guidelines for use by all levels of EMS providers using clear text communications. This criteria does not affect the ability of a local area to further define specific triage criteria. Rather it establishes a common language for EMS to communicate regarding patient condition. It is not meant to replace local area triage, treatment and transport guidelines.

(2) history: In the early 1990's EMS training programs adopted the definitions of critical patients as defined by University Hospital, function as the only Level I Trauma Center in the state. Level I, II and III criteria for trauma patients were subsequently taught to all New Mexico EMS providers. As local triage criteria changed and was further defined, the changes were not reflected in EMS training statewide.

(3) goal of this guideline:

(a) create a statewide minimum trauma triage criteria guideline for all EMS personnel.

(b) assist regional trauma centers with educating EMS personnel to better understand trauma patient triage criteria.

(c) use as a tool by non-designated facilities to better understand trauma patient triage criteria.

(d) adopt (and further clarify as appropriate) within area existing trauma plan(s) in conjunction with ReTrAC's.

(4) approval will require review and approval by the ReTrAC's, Statewide Trauma Advisory Committee, EMS Medical Direction Committee and the Joint Organization on EMS Education (JOE).

(5) impact:redefining of learning objectives, scenarios, test questions and educational related information for all levels of EMS providers. Current EMS providers

will be taught the revised criteria during the 2001-2002 EMS refresher cycles. New EMS providers will begin to be taught the revised criteria effective July 2001.

(6) target implementation date: July 1, 2002.

(7) patient status: based on information obtained by physical examination and history, patients are classified according to stability as follows:

(a) stable - patient is stable, with no apparent risk of developing a life threatening or disabling condition. Non-emergent transport is appropriate.

(b) serious - patient is at moderate risk of developing a life threatening or disabling condition. Most circumstances will merit non-emergent transport.

(c) Critical - Patient has a severe & acute life threatening or disabling condition. Immediate intervention is required. Emergency transport at EMS providers' discretion. Examples include penetrating and/or blunt trauma injuries to chest and/or abdominopelvic cavity with unstable vitals, or if patient presents with vitals indicating they are likely to deteriorate

(8) transport destination decisions

(a) stable status patients will be transported to the nearest appropriate facility of the patient's choice only when that destination does not compromise the patient and the destination location does not result in the transport vehicle moving outside of the established EMS response area. If the patient is a minor, incapable of making an informed decision, incarcerated, or subject to the guardianship of another, Medical Control will be contacted when the decision of the responsible party, is not, in the EMS provider's opinion, in the best interest of the patient.

(b) serious status patients will be transported to the closest appropriate facility within the transporting vehicle's service area. The destination decision process will fall on the EMS providers and in some cases Medical Control.

(c) critical status patients will be transported to the most readily accessible facility that is staffed and equipped to provide initial stabilization care upon arrival. The destination decision process will fall on the EMS providers and in some cases Medical Control.

B. Institutional Trauma Team Activation Criteria

(1) pre-hospital guidelines for requesting trauma team activation.

(a) systolic BP < 90 mm Hg with clear evidence of hemodynamic instability

(b) decreased level of consciousness secondary to trauma (GCS < 10)

(c) all non-superficial penetrating injuries to head, neck or torso

(d) evidence of airway compromise not manageable in the field

(e) significant respiratory compromise of traumatic origin

(f) suspected pelvic fracture with hemodynamic instability

(g) burns > 10% of body surface, or burns involving face and/or airway

Special considerations should be given for all patients <5 or >65 years of age, pregnancy greater than 20 weeks, or other related co-morbid factors (Coumadin, Beta Blockers, etc.)

(2) EMS notification of significant MOI: Mechanism of Injury (MOI) should be a consideration for adoption in each area trauma activation criteria. It is recognized that the inclusion of MOI has different advantages and disadvantages for urban and rural communities. As a minimum, EMS should report all incidents involving high evidence of significant MOI:

(a) falls greater than two times the patient height

(b) incidents involving rapid deceleration

(c) passenger space vehicle intrusion greater than twenty inches.

(d) death of another occupant from same vehicle.

(e) vehicle ejection

(f) high speed rollover

[7.27.7.12 NMAC - Rp 7 NMAC 27.7.14, 6/14/02]

7.27.7.13 APPENDIX B TRAUMA PATIENT INTERFACILITY TRANSFER CRITERIA:

A. Transfer Criteria: All patients from the following categories are at high risk for death or disability and should be considered for transfer to a Level I or Level II Trauma Center.

(1) Central Nervous System

(a) head injury: penetrating injury or depressed skull fracture

(i) open injury with or without CSF(Cerebral Spinal Fluid) leak

(ii) Glasgow Coma Score (GCS) < 12 or GCS deterioration of 1 point or more

(iii) lateralizing signs

(b) spinal cord injury

(2) chest

(a) widened mediastinum

(b) major chest wall injury

(c) cardiac injury

(d) patients who may require protracted ventilation

(3) pelvis

(a) unstable pelvic ring disruption

(b) pelvic ring disruption with shock and evidence of continuing hemorrhage

(c) open pelvic injury

(4) multiple system injury

(a) severe face injury with head injury

(b) chest injury with head injury

(c) abdominal or pelvic injury with head injury

(d) burns with associated injuries

(e) multiple fractures

(5) co- morbid factors

(a) age < 2 years or > 60 years

(b) pregnancy

(c) known cardio-respiratory or metabolic diseases

(6) secondary deterioration (late sequelae)

(a) protracted ventilation required

(b) sepsis

(c) single or multiple organ system failure

(d) major tissue necrosis

B. Transfer Guidelines: prior to transport, the following minimal patient care standards are to be met:

(1) establish and assure an adequate airway and ventilation.

(2) establish and maintain adequate access routes for fluid administration.

(3) initiate adequate fluid and/ or blood replacement.

(4) assure that the patient's vital signs are sufficient to sustain organ perfusion.

(5) initiate control of hemorrhage.

(6) stabilize and splint suspect spinal and extremity fractures.

(7) provide pain management.

(8) establish physician acceptance of patient at receiving facility.

(9) assure personnel are appropriately trained for level of care for transfer.

(10) provide pre- transfer report between nursing staff.

[7.27.7.13 NMAC - Rp 7 NMAC 27.7.15, 6/14/02]

7.27.7.14 APPENDIX C: TRAUMA DATA COLLECTION/ DOCUMENTATION CRITERIA:

A. Prehospital

(1) scene calls, first responders, licensed ground or certified air ambulance services data shall include:

(a) pre-hospital incident run number

(b) name or name code, when available

(c) date of birth when available

(d) age

(e) sex

(f) social security number when available

(g) agency identification number

(h) first agency on scene (yes/ no)

(i) transporting agency identification

(j) level of transporting agency (BLS/ ALS)

(k) incident county code

(l) date of incident

(m) time

- **(i)** call received
- **(ii)** dispatched
- **(iii)** arrived at scene
- **(iv)** departed scene

(n) initial systolic blood pressure (if obtainable, palpable or best pulse)

(o) respiratory rate

(p) Glasgow coma score- (eye, verbal, and motor when applicable)

(q) narrative description of the mechanism of injury

(r) meets trauma triage criteria (yes/ no)

(s) extrication required

(t) safety restraint or device used

(u) field interventions done

(v) additional information if patient died at scene

(i) patient home zip code

(ii) patient race when available

(2) for interfacility transfers, the transporting service shall include:

(a) agency identification number

(b) pre-hospital run sheet number

(c) inter-facility transfer (yes/ no)

(d) mode of transportation

(e) level of transportation (BLS/ ALS)

(f) patient name or name code

(g) date of birth, when available

(h) social security number, when available

(i) age

(j) sex

(k) agency incident number

(l) name of first hospital

(m) name of receiving hospital

(n) time

(i) depart first hospital

(ii) arrive at receiving facility

B. Designated Trauma Centers

(1) for designated trauma centers, the data shall include:

(a) *indicates a data element currently included in the HTR (Hospital Trauma Registry)

(b) **indicates a data element to be downloaded to the STR (State Trauma Registry)

(c) **identification of facility

(d) **unique patient identification number assigned to the patient by the facility

(e) level of transporting agency (BLS/ALS)

(f) *pre-hospital run sheet number

(g) **date of ED arrival

(h) *time of ED arrival

(i) **date of incident

(j) **initial hospital

(k) **facility patient was transferred from

(2) for designated trauma centers, patient information shall include:

(a) *name or name code

(b) **date of birth

(c) **sex

(d) **race

(e) **patient's trauma identification number (same as b above in section 1)

(f) **social security number

(g) home zip code

(3) **mechanism of injury (narrative)

(4) **E Code, including E Code 849

(5) **occupational injury (yes/ no)

(6) **safety restraint/ device used

(7) time of patient radio report

(8) **trauma team activated (yes/ no)

(9) activation response times

(a) time of activation

(b) time of call to surgeon

(c) *time of arrival of surgeon in ED

(d) *time of arrival of subspecialist

(10) initial vital signs in ED

(a) **systolic blood pressure

(b) **respiratory rate

(c) first temperature

(d) ** Glasgow coma score (eye, verbal, and motor)

(11) **ED respiratory status (spontaneous/ intubated)

(12) **ED procedures performed

(13) *time of ED discharge

(14) **ED discharge disposition

(15) *admitting service

(16) CT scan of head done (yes/ no)

(a) date of head CT scan

(b) time of head CT scan

(17) for initial surgery

(a) **date and time patient arrived or

(b) date/ time operation started

(c) **ICD-9- CM procedure code

(d) *total cc's PRBC infused

(18) **length of primary stay in ICU

(19) *co- morbidity complications

(20) disability at acute care discharge

(a) **feeding

(b) **locomotion

(c) **expression

(d) **rehabilitation potential

(21) **date of facility discharge

(22) **discharge disposition

(23) **extended care facility identification number

(24) autopsy done (yes/ no)

(25) **date of death

(26) **organ/tissue donor (yes/ no)

(27) **final ICD-9 discharge code

(28) *unplanned readmission

(29) **payer source

(30) **total billed charges

C. Office of Medical Investigator- data may include:

(1) name or name code

(2) **date of birth

(3) **social security number

(4) **sex

(5) **race

(6) **date of incident

(7) **date of death

(8) **place of death

(9) home zip code

(10) **medical examiner identification number

(11) **medical examiner facility identification number

(12) **autopsy done

(13) **mechanism of injury

(14) **organ donor

(15) **cause of death

(16) most recent ICD diagnosis code or equivalent description

[7.27.7.14 NMAC - Rp 7 NMAC 27.7.16, 6/14/02]

7.27.7.15 APPENDIX D:

Table 1

STATE OF NEW MEXICO **Trauma Care System Regulations/ Standards for Designation**		
Organization/ Management **(E) Essential (D) Desirable (N/A) Not Applicable**		
	Level III	**Level IV**
(1) A Trauma Center must demonstrate substantial medical, administrative and financial commitment for the level of designation requested. Commitment must be demonstrated and include documentation from hospital's:		
a. Board of Directors;	E	E
b. Medical Staff; and	E	E
c. Administrative team.	E	E

(2) For the purpose of administrating trauma care, a designated Trauma Center shall have a trauma program. The trauma program includes a management team, which oversees the trauma program. The trauma program shall:		
a. Be organized and directed by a trauma program medical director who is proficient in, and committed to the care of the injured. The trauma program medical director shall be:		
(i) Board certified or eligible in general surgery, or other surgical specialties or emergency medicine as justified by the applicant and approved by the State.	E	E
(ii) With training in trauma services and care.	D	D
(iii) Responsible for overall clinical direction, management and administration of the hospital's trauma program.	E	D
(iv) Currently certified in ATLS (Advanced Trauma Life Support)	E	E
(v) Demonstrate a commitment to trauma research; and	D	D
(vi) Must agree to actively participate in a defined trauma related continuing education program on an annual basis.	E	D
b. Define a program for providing care to the trauma patient to include coordination with the departments of surgery and emergency medicine and other hospital departments.	E	E
c. Provide ongoing coordination of the trauma program by a Trauma Nurse Coordinator who:		
(i) In collaboration with the trauma program medical director, monitors and coordinates trauma programs and system elements, including:		
(A) Clinical Activities;	E	E
(B) Trauma education and prevention activities;	E	E
(C) Research;	D	D
(D) Management activities per hospital needs;	E	E
(E) Trauma Registry; and	E	E
(F) Quality Improvement	E	E
(ii) Is a full-time position	E	D
(iii) Is licensed in State of New Mexico as a Registered Nurse	E	E
(iv) Has appropriate resources/staff to meet the requirements of these regulations and commitments of the hospital.	E	E

(v) Has demonstrated expertise in trauma care as identified by a minimum of 5 years recent nursing experience in one of the following areas:		
(A) Trauma systems/care	D	D
(B) Emergency department	D	D
(C) Critical Care	D	D
(D) Trauma Program	D	D
(vi) Minimum current/continuing education:		
(A) 5 hours/year trauma	E	E
(B) 2 hours/year pediatric	E	E
(C) TNCC (Trauma Nurse Core Curriculum) or equivalent	E	E
(vii) Participates in the development, implementation or continuation of trauma care systems at their appropriate ReTrAC (Regional Trauma Advisory Council)	E	E
d. Provide a multidisciplinary trauma committee, which provides input to the trauma program and to hospital administration as needed. The Trauma Committee shall demonstrate coordination between the Departments of Surgery and Emergency Medicine and be responsible for, but not limited to, the trauma program's Process Improvement process. Membership shall include:		
(i) An emergency physician;	E	E
(ii) Trauma medical director;	E	D
(iii) A neurosurgeon;	D	D
(iv) An orthopedic surgeon;	D	D
(v) A pediatrician;	D	D
(vi) An anesthesiologist/CRNA;	D	D
(vii) The trauma rehabilitation coordinator, trauma social worker and discharge planner; and input from physiatrist; (if available)	D	D
(viii) Trauma Nurse Coordinator;	E	E
(ix) Other appropriate nursing disciplines;	E	E
(x) Radiology; and	D	D
(xi) Administration.	E	D
e. Include a trauma resuscitation team which shall be;		
(i) Directed by an emergency medical physician who is proficient in the care of the injured, and who assumes responsibility for the overall care and coordination of the trauma patient until the care is formally turned over to the trauma/general surgeon (as appropriate per Level of designation)	E	N/A

(ii) The team shall be organized and directed by an in-house ED physician	E	D
(iii) All members of the team shall be promptly available upon notification. (Trauma PI process must verify prompt availability, outcome driven)	E	D
(iv) The trauma resuscitation team shall be activated in accordance with the hospital's trauma program and consistent with the regional trauma plan.	E	E
(v) Members of the trauma team shall:		
(A) Be oriented to the trauma care system;	E	D
(B) Participate in the trauma PI (Performance/Process Improvement) program;	E	D
(C) Participate in ongoing CME/CE in trauma;	E	D
(D) Be oriented to the internal trauma patient clinical management system at the hospital;	E	E
(E) Be oriented to the trauma program policies and procedures to include all operations of the trauma program including internal written triage, treatment and transfer protocols and procedures to identify which patients are triaged in and out of trauma program's clinical service.	E	E
(3) A Trauma Center shall have an Emergency Department with established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patients and a designated trauma resuscitation and treatment space with the capacity to meet the needs of the expected volume.	E	E
(4) A Trauma Center shall have a surgery department, including:		
a. General surgery on call and promptly available as requested.	E	D
b. Trauma/general surgeons must be Board certified or eligible in general surgery.	E	D
c. Trauma/general surgeons must have received ATLS (Advanced Trauma Life Support) once in their career (note: if surgeon is available)	E	E

d. A minimum of 6 hours per year or 18 hours over a three year period of continuing education related to trauma. (note: if surgeon is available)	E	E
e. Neurosurgery, Board certified and promptly available on-call.	D	N/A
f. The following surgical services on-call and available promptly:		
(i) Gynecological surgery;	D	D
(ii) Hand surgery;	D	D
(iii) Microsurgery;	D	D
(iv) Obstetric surgery;	D	D
(v) Orthopedic surgery;	D	D
(vi) Otorhinolaryngologic/maxillofacial surgery and capable of managing upper airway trauma;	D	D
(vii) Plastic surgery;	D	D
(viii) Thoracic surgery; and	D	D
(ix) Urologic surgery;	D	D
(x) General surgery for trauma service backup.	D	D
(xi) Pediatric surgeon available for consultation.	D	D
(5) A Trauma Center shall have other specialties including:		
a. Anesthesiology, with an anesthesiologist or CRNA who is on-call and promptly available and current in ACLS (Advanced Cardiac Life Support).	E	D
b. The following services on-call and available promptly:		
(i) Cardiology;	D	D
(ii) Gastroenterology;	D	D
(iii) Hematology;	D	D
(iv) Internal medicine;	E	D
(v) Nephrology;	D	D
(vi) Pathology;	D	D
(vii) Pediatrics;	E	D
(viii) Pulmonology/Intensivist	D	D
(ix) Psychiatry; and	D	N/A
(x) Radiology.	E	D
c. Other physician specialists on-call and available to the trauma as defined by their protocols.	E	D
Note: Internal Trauma PI process must verify "promptly" available services; outcome driven		
(6) A Trauma Center shall have approved policies to divert/redistribute and transfer patients to other designated facilities, based on it's ability each patient at	E	E

a particular time and collaborative work with their respective ReTrAC.		
(7) A Trauma Center shall		
a. Have a PI program, which includes quality improvement principals and an outcome orientation as provided for in this chapter.	E	E
b. Participate in regional trauma PI programs via their respective ReTrAC	E	E
Resources and Capabilities/Interhospital Transfer Guidelines		
(1) A Trauma Center shall have an Emergency Department with:		
a. A physician director who is:		
(i) Board certified or eligible in emergency medicine; and/or	D	D
(ii) If not Board certified in emergency medicine;		
(A) Current with ATLS and PALS (Pediatric Advanced Life Support)	E	E
(B) Must have 5 years or 7,000 hours experience in emergency medicine	E	D
b. Emergency physicians;		
(i) With 50% Board certified or eligible in emergency medicine, with the remainder practicing emergency medicine as their primary practice with special competency in the care of trauma patients and Board certified in pediatrics, family practice, internal medicine, or general surgery.	D	D
(ii) In-house and immediately available upon the patient's arrival to the ED.	E	D
(iii) If not emergency medicine Board certified:		
(A) Current with ATLS;	E	E
(B) Current with PALS; or	E	E
(iv) If not Board certified in any of the above specialties, they must be/have;		
(A) Current with ATLS;	E	E
(B) Current with PALS; and	E	E
(C) Five (5) years or seven thousand (7,000) hours experience in emergency medicine.	E	D
(v) A minimum of 6 hours per year or 18 hours over a three year period of continuing education related to trauma.	E	E

(vi) Must have had ATLS once in their career	E	E
c. Trauma resuscitation/ED nurses:		
(i) In the ED 24 hours per day	E	D
(A) At least two trauma resuscitation nurses	D	D
(B) At least one trauma-trained nurse	E	D
(ii) Currently RN licensed;	E	E
(iii) TNCC provider verification or an approved equivalent;	E	E
(iv) Orientation to their nurse role (trauma resuscitation nurse)	E	D
(v) Participates in a formal trauma PI program by representation;	E	D
(vi) Minimum of 6 hours per year continuing education related to trauma which may include credit for the TNCC;	E	E
(vii) Collaborates with health care professional and families in donor identification and care, the organ and tissue procurement process and recipient care.	E	E
d. An ED nurse manager		
(i) Is currently RN licensed;	E	E
(ii) TNCC provider verification or an approved equivalent;	D, Note	D, Note
(iii) Participates in a formal trauma PI program;	E	D
(iv) Minimum of 6 hours per year continuing education related to trauma which may include TNCC	E	D
Note: The ED nurse manager who routinely staffs to provide patient care, shall meet the requirements of the trauma resuscitation/ED nurse (as described above)		
e. Equipment for resuscitation and life support of adult trauma patients, including:		
(i) Airway control and ventilation equipment including:		
(A) Airways;	E	E
(B) Laryngoscopes, including curved and straight;	E	E
(C) Endotracheal tubes of all sizes;	E	E
(D) Bag-valve mask resuscitator, with full range of mask sizes	E	E

(E) Sources of oxygen;	E	E
(F) Mechanical ventilation;	E	E
(ii) Suction devices, including:		
(A) Back-up suction source;	E	E
(B) Suction catheters; and	E	E
(C) Tonsil suction tip.	E	E
(iii) Electrocardiograph;	E	E
(iv) Cardiac monitor;	E	E
(v) Defibrillator, including internal and external paddles;	E	D N/A for internal paddles
(vi) All standard apparatus to establish central venous pressure monitoring;	E	E
(vii) All standard intravenous fluids and administering devices	E	E
(viii) Sterile surgical sets for procedures standard for ED trauma care such as thoracotomy, vascular access, chest decompression;	E	D
(ix) Gastric lavage equipment;	E	E
(x) Drugs and supplies necessary for emergency care;	E	E
(xi) Capability for the rapid infusion of fluids;	E	E
(xii) Capability for rapid fluid recovery and transfusion;	E	E
(xiii) Thermal control equipment for;		
(A) Patient;	E	E
(B) Blood;	E	E
(xiv) Two-way radio linked with prehospital vehicles;	E	E
(xv) Cervical injury immobilization devices;	E	E
(xvi) Long-bone stabilization devices.	E	E
f. Trauma social services or crisis intervention services based on an approved hospital protocol.	D	D
(2) A Trauma center shall have an Operating Room (OR) that:		
a. Assures prompt availability of an OR suite 24 hours per day; and	E	D
b. Staffs with at least one RN in-house for the anticipated volume of patients and the remainder		

of the OR team and support staff on-call and promptly available.	D	D
c. Has OR nurses who:		
(i) Are currently licensed as RNs;	E	E
(ii) Can demonstrate trauma preparedness for the care of the trauma patient in the OR through hospital approved competencies and/or formal training course;	E	D
(iii) Complete a structured orientation program related to the perioperative care of the trauma patient;	E	D
(iv) Minimum of 6 hours per year continuing education related to the perioperative care of the trauma patient;	E	D
(v) Participates in the multidisciplinary trauma committee by representation including patient care conferences;	E	E
(vi) Participates in trauma PI activities by representation.	E	E
d. Has a documented method for prompt mobilization of consecutive surgical teams for trauma patients;	E	D
e. Collaborates with health professionals and families in donor identification and care, the organ and tissue procurement process and recipient care.	E	E
f. Includes equipment or capabilities including;		
(i) Cardiopulmonary bypass;	D	D
(ii) Operating microscope;	D	N/A
(iii) Thermal control equipment for patients;	E	E
(iv) Thermal control for blood;	E	E
(v) Rapid infusion capability;	E	E
(vi) Rapid fluid recovery capability;	E	D
(vii) Radiology capability;	E	E
(viii) Bronchoscope in operating room;	E	D
(ix) Endoscopes available	E	D
(x) Monitoring equipment; and	E	E
(xi) Instruments for external and internal fixation of fractures;	D	D
(xii) Instruments and equipment appropriate for pediatric trauma care;	D	D

g. Designated operative treatment space with the capacity to meet the needs of the expected patient volume.	E	D
(3) A Trauma Center shall have a post-anesthesia care unit or an acceptable surgical intensive care unit designated for surgical patient recovery with:		
a. Essential personnel, including at least one nurse with critical care and post-anesthesia care training, readily available 24 hours a day;	E	D
b. Can demonstrate trauma preparedness for the care of the post-anesthesia trauma patient through approved competencies and/or formal training courses;	E	D
c. Completes a structured orientation program related to the post-anesthesia perioperative care of the trauma patient;	E	D
d. Appropriate monitoring and resuscitative equipment.	E	D
(4) A Trauma Center shall have an intensive care unit (ICU) with:		
a. A medical director who is Board certified or eligible in critical care, internal medicine, pulmonary medicine, cardiology, or surgery;	E	D
b. A physician on duty in the ICU 24 hours a day, or who is immediately available; Note: May be met by an ED physician meeting the requirements of these regulations	E	D
c. A physician-directed code team;	E	D
d. Intensive care registered nurses who:		
(i) Are currently RN licensed;	E	D
(ii) TNCC verified or an equivalent course;	E	D
(iii) Completes a structured orientation and competency program which includes content related to the care of a trauma patient;	E	D
(iv) Minimum of 6 hours per year continuing education related to trauma;	E	D
(v) Participates in a multidisciplinary trauma committee including patient-care conferences by representation;	E	D
(vi) Participates in trauma PI activities;	E	D
(vii) Collaborates with health care professionals and families in donor identification and care, the organ and tissue procurement and recipient care.	E	E
e. Equipment appropriate for adult including:		

(i) Airway control and ventilation devices;	E	E
(ii) Oxygen source with concentration controls;	E	E
(iii) Cardiac emergency cart;	E	E
(iv) Temporary pacemaker;	E	D
(v) Electrocardiograph-cardiac monitor-defibrillator;	E	E
(vi) Cardiac output monitoring;	D	D
(vii) Electronic pressure monitoring	D	D
(viii) Mechanical ventilator devices;	E	D
(ix) Patient weighing devices;	E	E
(x) Pulmonary function measuring devices;	D	D
(xi) Temperature control devices;	E	D
(xii) Drugs, intravenous fluids, and supplies; and	E	E
(xiii) Intracranial pressure monitoring devices.	D	D
f. Designated trauma critical care and treatment space with the capacity to meet the needs of the expected patient volume.	E	D
(5) A Trauma Center shall have a clinical laboratory immediately available based upon the expected volume of patients, including:		
a. Standard analysis of blood, urine, and other body fluids;	E, Note	E, Note
b. Coagulation studies;	E, Note	E, Note
c. Blood gases and pH determination;	E, Note	E, Note
d. Serum and urine osmolality;	E, Note	D
e. Microbiology;	E, Note	D
f. Alcohol determination;	E, Note	D
g. Drug screening; and	D	D
h. Microtechnique.	E, Note	D
Note: Shall be promptly available		
(6) A Trauma Center shall have transfusion services including:		
a. Blood and blood components available from in-house or through community services, to meet patient needs in a timely fashion;	E	D
b. Ability to have non-crossmatched blood available on patient arrival to the ED;	E	D
c. Procedures and ability to perform massive transfusions and autotransfusion; and	E	D
d. Blood storage capability;	E	D
(7) A Trauma Center shall have radiological services including:		

a. The following services in-house and immediately available:		
(i) Computerized tomography	E, Note	D
Note: Shall be promptly available		
(ii) Radiology capability;	E, Note	E, Note
Note: If not in-house 24 hours per day, must have an approved early notification process		
(iii) In-house CT technician 24 hours a day	E, Note	D
Note: Shall be promptly available		
(iv) In-house radiology technician 24 hours a day	E, Note	D
Note: Shall be promptly available		
Note: Trauma PI process must verify promptly available services, outcome driven		
b. The following services on-call and promptly available:		
(i) Angiography	D	D
(ii) Sonography	D	D
(8) A Trauma Center shall have acute dialysis capability, or a written agreement with an appropriate facility for such.	E	E
(9) A Trauma Center shall have:		
a. A physician-directed burn unit which is staffed by nursing personnel trained in burn care and is equipped to care for extensively burned patients; and/or	D	D
b. Written transfer agreement with a burn center or hospital with a burn unit.	E	E
(10) A Trauma Center shall be able to manage Traumatic Brain Injury and/or spinal cord injury; or have written transfer agreements with a facility with such capabilities. Adherence to current management guidelines shall be considered.	E	E
(11) A Trauma Center shall have a designated trauma rehabilitation coordinator.	D	D
(12) A Trauma Center shall have:		
a. A physician-directed rehabilitation medicine service which is staffed by personnel trained in rehabilitation care and is equipped to care for the trauma patient and/or;	D	D
b. Written agreements to transfer patients to a designated rehabilitation service when medically feasible.	E	E
(13) A Trauma Center shall have a heliport or helipad meeting applicable standards and any applicable Department-approved procedures and located close	E, Note	E, Note

enough to permit the facility to receive and transfer patients by air.		
Note: May be fulfilled through a designated landing site with supporting written protocols.		
(14) In addition to all transfer agreements in this section, designated Trauma Centers shall have additional written transfer agreements for the identification and transfer of patients with special care needs who meet inter-hospital transfer criteria, to include the following patients categories:		
a. Pediatrics	E	E
b. Obstetrics	E	E
c. Other considerations based upon the specific hospital needs	E	E
(15) Transfer agreements shall include the responsibility of the transferring hospital and the receiving hospital, and shall assign medical control during inter-hospital transfer.	E	E
(16) Transferring facilities shall use Department-approved pre-hospital services for inter-facility transfer of trauma patients.	E	E
Outreach, Training, and Public Education		
(1) A Trauma Center shall have:		
a. An outreach consultation and referral program with physicians of the community, prehospital care agencies and outlying areas regarding trauma care developed through participation with their respective ReTrAC.	E	E
b. An outreach program with other designated trauma centers and hospitals developed through participation with their respective ReTrAC to include:	E	E
(i) Agreement to participate in regional trauma monitoring and PI meetings as defined by the State IPEMS Bureau;	E	E
(ii) Monitoring of the transfers in and out of the designated trauma center;	E	E
(iii) Establishing transfer agreements and referral feedback mechanisms.	E	E
c. Training, including;		
(i) Offers or participates in a formal program of continuing trauma care education for:		
(A) Staff and community physicians;	E	E

(B) Staff and community nurses;	E	E
(C) System and trauma clinical training for all allied health care professionals throughout the continuum;	E	D
(D) Prehospital personnel;	E	D
(ii) Hospital to cooperate and make available initial and maintenance training of invasive skills for prehospital personnel.	E	D
d. A public awareness/education program, developed through collaboration with their respective ReTrAC addressing:		
(i) Injury prevention and wellness issues relevant to the region;	E	E
(ii) Problems confronting the medical and nursing professions including hospitals regarding; hospital diversion, ED saturation as well as hospital capacity and access to care within their respective regions.	E	E
e. Planning and implementation policies and procedures for Mass Casualty Incidents (MCI) developed through collaboration with their respective ReTrAC.	E	E
Educational and Certification Requirements of Designated Trauma Care Personnel		
Unless otherwise stated in these regulations, all trauma personnel educational and or certification standards shall be met within six months of employment or contract.	E	E

STATE OF NEW MEXICO

Trauma Care Regulations/Standards for Designation

Pediatric Guidelines for Trauma Center Designation

(E) Essential (D) Desirable (N/A) 3.Not Applicable

	Level III	***Level IV***
(1) HOSPITAL SHALL:		

1.1 Meet the requirements of a basic 24-hour emergency facility and be licensed under the New Mexico Administrative Code.	E	E
(2) PROFESSIONAL STAFF: Physician		
2.1 All full-time Emergency Department physicians' education should consist of at least 16 hours of pediatric emergency CME credit every 2 years or have an acceptable hospital plan documenting pediatric proficiency.	E	D
(3) PROFESSIONAL STAFF: Nursing		
3.1 Emergency Department: At least one Registered Nurse (RN) per shift shall have successfully completed the ENPC or PALS provider course and be designated for providing and/or monitoring pediatric nursing care.	E	D
3.2 Intensive Care Unit (Hospital without PICU): at least one RN per shift shall be currently verified as a PALS provider or equivalent pediatric critical care course and be designated for providing and/or monitoring pediatric nursing care.	E	D
3.3 Post-Anesthesia Care Unit (PACU) or designated post-recovery area: at least one RN per shift shall be currently verified as a PALS provider or have completed competency verification in the post-operative care of the pediatric patient.	E	D
3.4 All nurses assigned to each department for providing and/or monitoring pediatric care shall complete two hours of pediatric education per year.	E	D
3.5 Pediatric Liaison Nurse: one shall be designated. This nurse works in collaboration with the Trauma Nurse Coordinator to ensure and document all pediatric data for the Hospital Trauma Registry and to assist in coordination and documenting pediatric nursing education.	E Note 4	D
3.5.1 Minimum Qualifications include: Works in the ED, ICU, PICU, Pediatric or QI Minimum of one-year experience in the care of the pediatric patient. Completion of at least two hours of education in pediatric topics (in addition to ENPC) per year.	D	D
(4) EQUIPMENT STATNDARDS, EMERGENCY DEPARTMENT		
The Emergency Department shall have:		
	E Note 1	E Note 1

4.1 Resuscitation area with dedicated pediatric equipment.		
4.2 Airway control and ventilation equipment	E	E
4.2.1 Laryngoscope blades with handles, curved, straight for infant and child	E	E
4.2.2 Pediatric airways: endotracheal tubes postoperative, cuffed with stylets (all appropriate sizes) and lubricant; pediatric McGill forceps; pediatric airways	E	E
4.2.3 Suction device with pediatric suction catheters (all appropriate sizes)	E	E
4.2.4 Pediatric cricothyroidotomy tray with set up for needle cricothyroidotomy (all appropriate sizes)	E	**SC**
4.2.5 Pediatric bag-valve-mask (BVM) resuscitation device with premature infant, infant, child and adult clear mask to use with the BVM device with over-riding pop-off valve.	E	D
4.2.6 Oxygen with oxygen-delivery device overriding for premature infant, infant, child and adult clear mask to use.	E	D
4.2.7 Pediatric chest tubes (all appropriate sizes)	E	**SC**
4.2.8 Pulse oximeter with pediatric and adult sensors	E	D
4.2.9 Equipment for needle thoracostomy for tension pneumothorax	E	D
4.3 Circulatory Support Equipment		
4.3.1 Pediatric IV supplies (all appropriate sizes) with IV rate-control devices	E	E
4.3.2 Appropriate fluids for pediatric resuscitation (ACLS/PALS Guidelines)	E	E
4.3.3 Introsseous needles or spinal needles for introsseous infusion (all appropriate sizes)	E	E
4.3.4 Monitor defibrillator and pediatric paddles with 0-400 watt/second capabilities	E	E

4.3.5 Pediatric blood-pressure cuffs; premature infant, infants, child, adult and thigh sizes	E	D
4.3.6 Doppler monitor	E	D
4.3.7 Temperature control device for IV fluids	E Note 2	E Note 3
4.3.8 Multilumen catheter (all appropriate sizes)	D	D
4.4 Special Trays		
4.4.1 Thoractomy	**SC**	**SC**
4.4.2 Thoracostomy	D	**SC**
4.4.3 Tracheostomy	D	**SC**
4.4.4 Diagnostic Peritoneal Lavage	D	D
4.4.5 Lumbar Puncture	E	D
4.4.6 Venesection	D	D
4.4.7 Obstetrical Emergency Delivery	E	E
4.5 Miscellaneous Equipment		
4.5.1 Spinal Immobilization device: backboards, head-rolls, or head immobilization devices, cervical collars to include sizes for children six years or younger	E	E
4.5.2 Pediatric patient warming devices	E Note 3	E Note 3
4.5.3 Thermometers	E	E
4.5.4 Pediatric Foley catheters (all appropriate sizes)	E	E
4.5.5 Pediatric splinting devices, femur traction device, general traction equipment	E	E
4.5.6 Casting capabilities	E	E
4.5.7 Sterile dressings for burn care	E	E
4.5.8 Nasogastric tubes/infant feeding tubes (all appropriate sizes)	E	E
4.5.9 Pediatric scales for weight measurement	E	E

4.6 Medications; all appropriate medications in pediatric dosages as required for resuscitation (ATLS/PALS recommendations)	E	E
4.7 Pediatric reference materials for drug dosage listed in kg (i.e. Broslow Tape)	E	E
4.8 Quality Management; The hospital shall:		
4.8.1 Review all pediatric deaths and transfer complications	E	E
4.8.2 Maintain a pediatric log or registry of all pediatric deaths and transfers	E	E

Notes

1. Pediatric crash carts should be utilized to maintain the proper pediatric equipment and supplies. The pediatric crash cart should be labeled or color coded for clear recognition,

2. Fluid may be warded in standard warmer if IV fluid warming devices are unavailable so long as the appropriate temperature is maintained.

3. Warming methods may be used if devices are unavailable (warmed blankets, warmed bags of IV fluids.

4. The Trauma Nurse Coordinator may meet this standard without the need for additional personnel.

SC Special Consideration: This term is applicable to items that are not essential or desired

components for designation. However, facilities wishing to meet specific criteria must

provide the appropriate documentation for certifications and ongoing training.

[7.27.7.15 NMAC - Rp 7 NMAC 27.7.12, 6/14/02]

PART 8: CARDIAC ARREST TARGETED RESPONSE PROGRAM

7.27.8.1 ISSUING AGENCY:

New Mexico Department of Health (DOH), Epidemiology and Response Division (ERD), Emergency Medical Systems Bureau (EMSB).

[7.27.8.1 NMAC - Rp, 7.27.8.1 NMAC, 12/12/2017]

7.27.8.2 SCOPE:

These regulations are applicable to all persons or entities operating an automated external defibrillator (AED) program within the state of New Mexico. The regulations also apply to all AED training organizations, trainers, and trained targeted responders affiliated with an AED Program.

Exemptions: Certain individuals and agencies are exempted from this regulation, as described below:

A. Individuals authorized by physicians: As stated in the Cardiac Arrest Response Act, 24-10C-1 NMSA 1978, nothing precludes a physician or a physician assistant, advanced practice registered nurse or certified nurse-midwife working within that person's scope of practice from prescribing an automated external defibrillator to a patient for use by the patient's caregiver on an individual patient, and the use does not require the individual to function in an approved program.

B. Health care professionals: EMS personnel or other health care professionals, who are authorized by other laws, regulations, and scopes of practice to use and perform defibrillation in the out-of-hospital environment, while performing official duties or within the scope of their employment.

C. Military services, other federal entities, and AED programs on tribal land: The United States department of defense, other federal agencies, AED programs on tribal lands, and the New Mexico department of military affairs are exempt from this rule.

[7.27.8.2 NMAC - Rp, 7.27.8.2 NMAC, 12/12/2017]

7.27.8.3 STATUTORY AUTHORITY:

These regulations are promulgated pursuant to the following statutory authorities:

A. The Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to "make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions".

B. The Cardiac Arrest Response Act, Subsection B of Section 24-10C-4 NMSA 1978, which authorizes the department of health to approve training programs; and.

C. The Emergency Medical Services Act, Subsection M of Section 24-10B-4 NMSA 1978, which authorizes the department of health to adopt "rules to establish a cardiac arrest targeted response program pursuant to the Cardiac Arrest Response Act."

[7.27.8.3 NMAC - Rp, 7.27.8.3 NMAC, 12/12/2017]

7.27.8.4 DURATION:

Permanent.

[7.27.8.4 NMAC - Rp, 7.27.8.4 NMAC, 12/12/2017]

7.27.8.5 EFFECTIVE DATE:

December 12, 2017, unless a later date is cited at the end of a section.

[7.27.8.5 NMAC - Rp, 7.27.8.5 NMAC, 12/12/2017]

7.27.8.6 OBJECTIVE:

The purpose of these regulations is to outline requirements for the New Mexico cardiac arrest targeted response program including: Establishment of a cardiac arrest targeted response program, AED program registration, medical direction, training, notification of local EMS services and public safety answering points, reporting, fees, and bureau responsibilities.

[7.27.8.6 NMAC - Rp, 7.27.8.6 NMAC, 12/12/2017]

7.27.8.7 DEFINITIONS:

A. "Act" means the Cardiac Arrest Response Act, Section 24-10C-1 NMSA 1978.

B. "Advanced life support (ALS)" means advanced pre-hospital and inter-facility care and treatment, including basic and intermediate life support, as prescribed by regulation, which may be performed only by a person licensed by the bureau and operating under medical control.

C. "AED program" means a program of trained targeted responders that is registered with the department.

D. "Basic life support (BLS)" means pre-hospital and inter-facility care and treatment, as prescribed by regulation, which can be performed by all licensed emergency medical technicians.

E. "Bureau" means the emergency medical systems bureau of the epidemiology and response division of the New Mexico department of health.

F. "Cardiopulmonary resuscitation (CPR)" means the manual application of chest compressions and ventilations to patients in cardiac arrest.

G. "Defibrillation" means the administration of a controlled electrical charge to the heart to restore a viable cardiac rhythm.

H. "Department (DOH)" means the New Mexico department of health.

I. "Emergency Medical Service (EMS)" means the services rendered by licensed emergency medical technicians, emergency medical services first responders or emergency medical dispatchers in response to a person's need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

J. "Protocols" means predetermined, written medical care plans and includes standing orders.

K. "Provider" means a person or entity delivering emergency medical services in New Mexico.

L. "Semi-automated external defibrillation (AED)" means a medical device heart monitor and defibrillator that:

(1) has received approval of its pre-market modification filed pursuant to United States Code, Title 21, Section 360(k), from the United States food and drug administration;

(2) is capable of recognizing cardiac arrest that will respond to defibrillation, ventricular fibrillation or rapid ventricular tachycardia, and is capable of determining whether defibrillation should be performed; and,

(3) upon determining that defibrillation should be performed, automatically charges and is capable of delivering an electrical impulse to an individual's heart upon activation by the equipment user.

N. "Trained targeted responder" means a person who has completed an authorized AED training program and who uses an AED. A designated trained targeted responder will be responsible for guidance or supervision for the AED program including overseeing all aspects of the defibrillation program. This includes training, emergency medical services coordination, protocol approval, AED deployment strategies, quality assurance and reporting.

[7.27.8.7 NMAC - Rp, 7.27.8.7 NMAC, 12/12/2017]

7.27.8.8 ESTABLISHMENT OF AN AED PROGRAM:

A. Purpose: The primary reason for establishing an AED program is to improve response to cardiac defibrillation of a person suffering from sudden cardiac arrest.

B. AED program locations: cardiac arrest targeted response programs may be initiated in any environment where members of the public are encountered.

[7.27.8.8 NMAC - Rp, 7.27.8.8 NMAC, 12/12/2017]

7.27.8.9 AED PROGRAM REQUIREMENTS:

Prior to submitting an application for registration, the designated supervising trained targeted responder shall ensure that the AED program incorporates the following requirements:

A. AED program supervising trained targeted responder shall:

(1) Oversee the AED program, assuming responsibility for how the AED program is planned and conducted.

(2) Select and identify other participating persons as trained targeted responders.

(3) Maintain AED training records for all trained targeted responders while they are active in the program, and for at least three years thereafter.

(4) Maintain AED program records including AED maintenance records, trained targeted responder training records, and AED usage records.

(5) Ensure that all trained targeted responders are trained using a training program which has been approved by the department.

(6) Provide evidence of coordination of the AED program with local EMS services and emergency dispatch agencies, including 911 dispatch agencies.

(7) Register the AED program with the department and pay registration fees, as detailed in this regulation.

(8) Report all operational uses of the AED to the department.

(9) Perform quality assurance review of all operational defibrillations; and.

(10) Ensure AED equipment is maintained in accordance with the manufacturer’s guidelines.

B. Trained targeted responders: Individuals selected by the supervising trained targeted responder that are trained in CPR and use of an AED and understand how to activate the local emergency medical system for any sudden collapse or cardiac arrest victim:

(1) Prior to participating in an AED program, trained targeted responders shall complete an initial AED training course from a Department approved training program. The course shall include both cardiopulmonary resuscitation (CPR) and AED training.

(2) At least every two years, trained targeted responders shall recertify in CPR and AED training, by successfully completing a department approved AED training course.

(3) Activate the emergency medical system during any operational response to a victim of cardiac arrest, and advise that AED is being used.

(4) Comply with program protocols for operational response to victims of cardiac arrest.

(5) Report all operational responses to victims of cardiac arrest to the supervising trained targeted responder and complete a defibrillation report. A copy of the report shall be submitted to the department within 20 calendar days.

(6) Ensure AED's are maintained and used in accordance with the manufacturer's guidelines, and inspect AED equipment at least monthly.

C. Registration: All AED programs shall be registered with the department:

(1) Initial registration: The initial registration period shall be for a period of four years. The supervising trained targeted responder for the AED program shall complete the application provided by the bureau and submit it to the department, along with the appropriate fees.

(2) Renewal: AED programs shall renew the AED program every four years, with a renewal application provided by the bureau submitted to the department, along with the appropriate fees.

(3) Notification of changes in registration: The department shall be notified when there is a:

(a) change in AED supervising trained targeted responder;

(b) change in physical address or telephone number; or

(c) stoppage or cancellation of the AED program.

D. Fees: The bureau shall establish a fee schedule for AED programs. Seventy-five ($75) dollars shall be paid by the AED program to the department for initial registration. For renewal, AED programs shall pay a fee of fifty ($50) dollars to the department.

E. Notification: Local EMS services and emergency dispatch agencies shall be notified of the activation and existence of the AED program. The notification shall include the name of the AED program supervising trained targeted responder, location of the program, telephone number, a copy of the program protocols, location of the placement of AED(s), and the operational area where the AED(s) will be used. The local emergency services and dispatch agencies shall also be notified if an existing AED program stops or cancels the AED program.

F. AED Selection and Maintenance:

(1) AED Selection: AED programs shall acquire and use semi-automated cardiac defibrillators. These devices require the responder to deliver the shock by pushing the shock button. AED programs that want a fully automated defibrillator (analyzes and shocks without operator input) may petition the bureau for a waiver to use an automated defibrillator.

(2) Maintenance: AED programs shall maintain the AED(s) and associated supplies and batteries in accordance with the manufacturer's suggested guidelines.

G. Record Keeping: Establish and maintain a record keeping system. Include the following information:

(1) List of trained targeted responders.

(2) Dates of training for trained Targeted Responders including CPR training and AED training.

(3) Copy of program protocols.

(4) Copy of registration and EMS service notification forms.

(5) AED usage reports/Data collection forms; examples may be obtained from the bureau.

(6) Quality assurance review documentation.

(7) AED equipment purchase and maintenance records.

[7.27.8.9 NMAC - Rp, 7.27.8.9 NMAC, 12/12/2017]

7.27.8.10 [RESERVED]

7.27.8.11 LIMITED IMMUNITY PROTECTIONS:

Limited immunity protections are provided for persons or entities associated with an AED program, as described in the Cardiac Arrest Response Act, 24-10C-7 NMSA 1978.

These protections are provided when the AED program is established and operated in accordance with that statute and these regulations.

[7.27.8.11 NMAC - Rp, 7.27.8.11 NMAC, 12/12/2017]

7.27.8.12-15 [RESERVED]

PART 9: TRAUMA SYSTEM FUND

7.27.9.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.27.9.1 NMAC - N, 02/29/2008]

7.27.9.2 SCOPE:

The Trauma System Fund Authority shall apply to requests made for funds available pursuant to the Trauma System Fund Authority Act, Sections 24-10E-1, et seq, NMSA 1978.

[7.27.9.2 NMAC - N, 02/29/2008]

7.27.9.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to the following statutory authorities 1) the Department of Health Act, Section 9-7-6E., NMSA 1978, which authorizes the secretary of the department of health to "make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions", and 2) the Trauma System Fund Authority Act, Section 24-10E-7., NMSA 1978, which authorizes the department of health to adopt rules to carry out the provisions of the act.

[7.27.9.3 NMAC - N, 02/29/2008]

7.27.9.4 DURATION:

Permanent.

[7.27.9.4 NMAC - N, 02/29/2008]

7.27.9.5 EFFECTIVE DATE:

02/29/2008, unless a later date is cited at the end of a section.

[7.27.9.5 NMAC - N, 02/29/2008]

7.27.9.6 OBJECTIVE:

The objective of Part 9, Chapter 27 is to establish standards and procedures for funding programs under the Trauma System Fund Authority Act. These standards and procedures are designed for the purpose of making funds available to sustain existing trauma centers, support the development of new trauma centers, and develop a statewide trauma system. This rule will inform New Mexico hospitals and other trauma system stakeholders of the procedures to access funds. The department of health through the emergency medical systems bureau, will administer the fund pursuant to the Trauma System Fund Authority Act and this rule.

[7.27.9.6 NMAC - N, 02/29/2008]

7.27.9.7 DEFINITIONS:

A. "Accumulation" defined as the prior approved expenditure or disposition in the current fiscal year of funds distributed in the fiscal year.

B. "Act" defined as the Trauma System Fund Authority Act, Section 24-10E-1, et seq, NMSA 1978.

C. "Authority" defined as those individuals, representing specific agencies, organizations and individuals appointed by the governor to serve on the Trauma System Fund Authority pursuant to Section 24-10E-4, B., NMSA 1978.

D. "Bureau" defined as the emergency medical systems bureau of the epidemiology and response division, New Mexico department of health.

E. "Chief" defined as the chief of the emergency medical systems bureau.

F. "Department" defined as the New Mexico department of health.

G. "Designated trauma centers" defined as those hospitals or other healthcare facilities designated by the department as having met the requirements of the rule 7.27.7 NMAC, "Trauma Care System" as a level I, II, III, or IV trauma center.

H. "Director" defined as the director of the epidemiology and response division.

I. "Division" defined as the epidemiology and response division.

J. "Emergency medical services (EMS)" defined as the services rendered by emergency medical technicians, licensed emergency medical services first responders or emergency medical dispatchers in response to an individual’s need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

K. "Fiscal year" defined as the state fiscal year that runs from July 1 through June 30 each year.

L. "Fund" defined as the trauma system authority fund.

M. "Injury prevention program" defined as a planned activity with a defined purpose, stated objectives, implementation schedule and an evaluation component that seeks to prevent or reduce illness or injury. Examples include but not limited to bicycle helmet promotion, seat belt awareness campaign, child care seat distribution program, driving while intoxicated (DWI) prevention and first aid training.

N. "Secretary" defined as the secretary of the New Mexico department of health.

O. "Trauma registry" defined as a database that documents and integrates medical and system information related to the provision of trauma care by hospitals or healthcare facilities.

P. "Trauma advisory system stakeholders committee (TAC)" defined as the statewide committee on trauma comprised of pre-hospital, hospital, rehabilitation, injury prevention and system support staff involved in trauma care established pursuant to the EMS Act.

Q. "Uncompensated trauma care" defined as the difference between the costs incurred by a hospital in providing the service and the amount that the hospital has been paid for providing the service.

[7.27.9.7 NMAC - N, 02/29/2008]

7.27.9.8 DUTIES OF THE BUREAU:

On behalf of the department, the bureau shall provide administrative and staff support to the authority, including the administration and distribution of the fund, pursuant to oversight by the authority in conformance with the act and this rule.

[7.27.9.8 NMAC - N, 02/29/2008]

7.27.9.9 DUTIES OF THE AUTHORITY:

The authority shall:

A. develop criteria by which distribution of funds to existing trauma centers and potential new centers will occur;

B. receive applications and determine and monitor the actual distribution of money from the fund that will support the development of a statewide system of trauma care;

C. oversee the department's administration of the fund and development of a trauma system;

D. report annually to the interim legislative health and human services committee and the legislative finance committee.

[7.27.9.9 NMAC - N, 02/29/2008]

7.27.9.10 ANNUAL REPORT:

The authority shall prepare an annual written report that includes a summary of the current fiscal year distribution from the fund, including the number of approved applications and amount awarded to sustain existing trauma centers, support the development of new trauma centers, and develop a statewide trauma system. In addition, the report will include an assessment of progress and remaining challenges to achieve the purposes of the act. The report shall be made to the interim legislative committees and made available to public entities and the public on request.

[7.27.9.10 NMAC - N, 02/29/2008]

7.27.9.11 EXISTING TRAUMA CENTER FUNDING PROGRAM:

The purpose of this program is to sustain existing New Mexico trauma centers to ensure optimal care for those who suffer traumatic injuries.

A. Eligibility: subject to the availability of the funds in the trauma system fund, facilities that are currently designated by the department as trauma centers may apply for financial support under this rule.

B. Application process: annually, prior to the start of each state fiscal year, eligible trauma centers may apply to participate in the existing trauma center funding program by submitting the application forms in a timely manner, as prescribed by the authority and distributed by the bureau. Such application forms will include, but not be limited to:

(1) identifying information;

(2) assurances from the trauma center's governing authority;

(3) de-identified data regarding trauma patients served during a specified previous time period according to the case-inclusion criteria of the trauma registry;

(4) financial data associated with those trauma patients including charges, collections, and uncompensated trauma care;

(5) a plan of expenditure for the amount requested from the fund.

C. Funding amounts: Based upon the allocation decision by the authority in 7.27.9.12 NMAC, the following formula will be applied to determine the annual funding for each existing trauma center with an approved application:

(1) an allocation will be made to each trauma center based on their level of designation subject to the availability of funds;

(2) additionally, level I, II, and III trauma centers will receive their share of the remaining dollars in the existing trauma center funding program, based upon their relative share of uncompensated trauma care for these centers as determined by the authority.

D. Award of funds: The authority shall approve the applications and the funding amounts for each existing trauma center no later than July 31st. The department shall prepare a written agreement with each existing trauma center awarded funding under this rule that reflects the term and amount of the award, and the expectations and conditions for receiving the award, including fiscal accountability and reporting requirements.

E. Use of funds: Funds awarded under the existing trauma center funding program must be used to support, sustain, or enhance the trauma program including support for trauma-related clinical and administrative personnel on-call costs for trauma program as determined by the authority.

F. Accumulation: It is anticipated that the entire amount of the annual award to each existing trauma center will be spent during the fiscal year in which it is awarded. In the event that the entire amount cannot or will not be expended, the trauma center must return the unexpended balance to the department, unless it submits an accumulation and expenditure plan that is approved by the authority prior to the close of the fiscal year in which it was awarded. The authority may approve up to one additional fiscal year to expend the balance.

G. Change in trauma center designation status: If an existing trauma center fails to maintain its level of trauma center designation following an award under this rule, the authority shall review all the pertinent information and determine what amount, if any, the department shall recover from the trauma center.

[7.27.9.11 NMAC - N, 02/29/2008]

7.27.9.12 DEVELOPING TRAUMA CENTER FUNDING PROGRAM:

The purpose of this program is to support the development of new trauma centers to enhance the overall statewide trauma system.

A. Eligibility: Any facility that has submitted a letter of intent to the bureau to become a designated trauma center under 7.27.9 NMAC prior to the issuance of the

application for this developing trauma center funding program shall be deemed eligible to apply.

B. Application process: Annually prior to the start of each state fiscal year, hospitals or healthcare facilities that have submitted a timely letter of intent to become a designated trauma center and desired level of designation, may apply to participate in the developing trauma center funding program. Such hospitals/healthcare facilities shall submit the application forms in a timely manner, as prescribed by the authority and distributed by the bureau. Such application forms will include, but not be limited to:

(1) identifying information;

(2) assurances from the trauma center's governing authority;

(3) a detailed plan to become a designated trauma center with time frames. milestones, and an associated budget which specifically indicates how funding under the program will be utilized in the coming fiscal year.

C. Funding amounts: Based upon the allocation decision by the authority in 7.27.9.2 NMAC, the authority will annually establish an award for each developing trauma center. The authority will consider the merits of each application under the developing trauma center funding program and will determine the actual award for each applicant.

D. Award of funds: The authority shall approve the applications and the funding amounts for each developing trauma center no later than July 31st. The department shall prepare a written agreement with each developing trauma center awarded funding under this rule that reflects the term and amount of the award, and the expectations and conditions for receiving the award, including fiscal accountability and reporting requirements.

E. Use of funds: Funds awarded under the developing trauma center funding program must be used to support the developing trauma program as determined by the authority.

F. Accumulation: It is anticipated that the entire amount of the annual award to each developing trauma center will be spent during the fiscal year in which it is awarded. In the event that the entire amount cannot or will not be expended, the developing trauma center must return the unexpended balance to the department, unless it submits an accumulation and expenditure plan that is approved by the authority, prior to the end of the fiscal year in which it is awarded. The authority may approve up to one additional fiscal year to expend the balance.

G. Eligibility limit: Under the developing trauma center program there is a limit of two fiscal years during which designation as a trauma center must be achieved by a developing trauma center. If designation is not achieved during this time period, the

authority shall review the circumstances and all pertinent information determining what amount if any, the department shall recover, from developing trauma center.

[7.27.9.12 NMAC - N, 02/29/2008]

7.27.9.13 TRAUMA SYSTEM DEVELOPMENT PROGRAM:

The purpose of this program is to provide financial support to various statewide system development activities, initiatives, agencies, or programs, as prioritized annually by the authority. The amount of funds available in a given fiscal year will be based upon the allocation decision by the authority in 7.27.9.11 NMAC.

A. System development priorities: Prior to each fiscal year, the authority shall establish priorities for statewide system development activities and initiatives. These priorities shall be communicated to the (TAC) and to the bureau.

B. Proposals solicited and reviewed: Early each fiscal year, the bureau, with guidance from the TAC, will widely distribute a request for applications to meet the system development priorities as specified by the authority. All applications received in a timely manner on the forms specified by the bureau will be reviewed and considered by the TAC.

C. Recommendations to the authority: Based upon their review, the TAC will make written recommendations to the authority for which system development applications warrant funding and at what levels.

D. Funding decisions: The authority will review the system development applications and the recommendations from the TAC, in making their funding decisions under the trauma system development program.

E. Award of funds: The authority shall approve the trauma system development applications and the funding amounts no later than July 31st.

[7.27.9.13 NMAC - N, 02/29/2008]

7.27.9.14 GENERAL PROVISIONS:

A. Spending flexibility: If in any fiscal year, the authority decides not to spend the entire amount allocated under any of the three trauma system funding programs as initially decided in 7.27.9.12 NMAC, the authority, at their discretion, may re-allocate that amount to either or both of the remaining funding programs for expenditure in that fiscal year.

B. Procedures for reconsideration: Applications applying for and funding under this rule may request a reconsideration of their funding amount by notifying the bureau in writing within ten (10) working days after notification to the applicant of the authority's

funding determination. The authority must review the reconsideration request within thirty (30) working days and issue a final written determination within ten (10) working days of their review.

C. Oversight, inspection, and audit: The authority, working with and through the department, is responsible for the oversight of expenditures from the fund and the development of the statewide trauma system. All recipients of trauma funds under the act shall be subject to reasonable oversight and as needed, visitation by authorized representatives of the bureau or the authority. Records of purchases, training programs, or personnel expenditures accomplished with awards from the fund shall be open for inspection. This oversight may include an objective audit if deemed necessary. Findings from all oversight activities will be shared with the fund recipient and as appropriate a written deficiency correction report may be requested.

D. Monitoring and accountability: The bureau will be responsible for monitoring the trauma system development program and for periodically, but no less than annually, reporting the progress or results to both the TAC, and the authority.

[7.27.9.14 NMAC - N, 02/29/2008]

PART 10: CERTIFICATION OF EMERGENCY MEDICAL SERVICES AGENCIES

7.27.10.1 ISSUING AGENCY:

New Mexico Department of Health, Division of Epidemiology and Response, Emergency Medical Systems Bureau.

[7.27.10.1 NMAC - N, 3/15/2010]

7.27.10.2 SCOPE:

A. This rule applies to any emergency medical service (EMS) agency that provides emergency medical services within the state of New Mexico, including but not limited to special event EMS agencies; emergency medical dispatch agencies, and transport and non-transport medical rescue agencies. This rule also applies to out-of-state EMS agencies (including but not limited to seasonal agencies) that routinely respond within or transport patients into or out of the state of New Mexico to provide emergency medical care or to pick up or deliver patients.

B. This rule does not apply to ambulance services regulated by the transportation division of the New Mexico public regulation commission or its successor agency (see 18.3.14 NMAC); federal agencies; the NM department of military affairs; tribal agencies and organizations that provide EMS entirely within the boundaries of tribal lands; ski patrols providing first aid pursuant to the Ski Safety Act, NMSA 1978, Section 24-15-1; search and rescue operations conducted pursuant to the Search and Rescue Act,

NMSA 1978, Section 24-15A-1; private businesses providing emergency response teams and initial first aid solely for their employees; or EMS agencies from adjoining states (properly licensed in their respective jurisdictions) that are either 1) responding into New Mexico to assist in a mass casualty or disaster situation that exceeds the capacity or capability of the NM EMS agency in an affected area, or 2) responding into New Mexico on a non-routine basis for emergency mutual aid assistance when requested to do so by a certified EMS agency whose service area includes areas along a mutual state border.

[7.27.10.2 NMAC - N, 3/15/2010]

7.27.10.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to the New Mexico Department of Health Act at NMSA 1978, Section 9-7-6 E, and the Emergency Medical Services Act at NMSA 1978, Section 24-10B-4 L.

[7.27.10.3 NMAC - N, 3/15/2010]

7.27.10.4 DURATION:

Permanent.

[7.27.10.4 NMAC - N, 3/15/2010]

7.27.10.5 EFFECTIVE DATE:

3/15/2010, unless a later date is cited at the end of a section.

[7.27.10.5 NMAC - N, 3/15/2010]

7.27.10.6 OBJECTIVE:

The purpose of this rule is to establish standards for the certification of EMS agencies that conduct operations within New Mexico, and to identify the process and procedures for certification and enforcement. Administration and enforcement of this rule is the responsibility of the emergency medical systems bureau of the division of epidemiology and response, department of health.

[7.27.10.6 NMAC - N, 3/15/2010]

7.27.10.7 DEFINITIONS:

A. "Air ambulance service" means any governmental or private service that provides air transportation specifically designed to accommodate the medical needs of

a person who is ill, injured or otherwise mentally or physically incapacitated and who requires in-flight medical supervision.

B. "Applicant" means an applicant for EMS agency certification under this rule.

C. "Bureau" means the emergency medical systems bureau of the epidemiology and response division, of the department of health.

D. "Call routing" means the reception of emergency calls where the purpose is to only determine the course of direction of routing (police, fire, and medical) resulting in rapid transfer of medical callers to the emergency medical dispatch agency or the emergency medical dispatch call taker for emergency medical dispatching.

E. "Certificated ambulance service" means a publicly or privately owned entity holding a current certificate from the New Mexico public regulation commission that identifies it as an emergency response ambulance service, and that is subject to the rules of the public regulation commission or its successor agency.

F. "Commission on the accreditation of ambulance services (CAAS)" means the national accrediting organization that establishes ambulance industry standards and evaluates ambulance services based upon those standards.

G. "Committee on accreditation of educational programs for the EMS professions (CoAEMSP)" means the national accrediting organization that establishes standards for educational programs for EMS professions, and that evaluates training programs based on those standards.

H. "Commission on the accreditation of medical transport systems (CAMTS)" means the national accrediting organization that establishes industry standards and evaluates air and ground ambulance services based upon those standards.

I. "Conviction" means a plea or adjudication of guilt, a plea of *nolo contendre*, an *Alford* plea, or any plea or adjudication that results in a conditional discharge or a suspended or deferred conviction.

J. "Days" means calendar days, unless otherwise specified.

K. "Department" means the New Mexico department of health.

L. "Department of transportation (DOT)" means the federal department of transportation.

M. "Emergency" means an individual’s need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

N. "Emergency medical dispatch" means the reception, evaluation, processing, and provision of dispatch life support, management of requests for emergency medical assistance, and participation in ongoing evaluation and improvement of the emergency medical dispatch process. The emergency medical dispatch process is not limited to call routing only, but includes identifying the nature of the request, prioritizing the severity of the request, dispatching the necessary resources, providing medical aid and safety instructions to the callers, and coordinating the responding resources as needed.

O. "Emergency medical dispatch agency (EMDA)" means any organization, or a combination of organizations working cooperatively, that routinely accepts calls for emergency medical assistance and employs emergency medical dispatch priority reference system (EMDPRS) techniques.

P. "Emergency medical dispatch priority reference system (EMDPRS)" means a bureau approved reference system used by an emergency medical dispatch agency (EMDA) to dispatch aid to medical emergencies, which includes systemized caller interrogation; systemized pre-arrival instructions to the caller based upon protocols matching the dispatcher’s evaluation of injury or illness severity; and prioritized vehicle response.

Q. "Emergency medical dispatcher (EMD)" means a provider who is trained and licensed pursuant to the EMS Act, NMSA 1978, Section 24-10B-4 F, to receive calls for emergency medical assistance, provide pre-arrival medical instructions, dispatch emergency medical assistance and coordinate its response.

R. "Emergency medical service(s) (EMS)" means the medical services rendered by licensed providers in response to an emergency.

S. "Emergency medical services agency (EMS agency, agency)" means an organization that provides emergency medical services. EMS agencies include emergency medical dispatch agencies, pre-hospital agencies with defined geographical boundaries for their response, inter-facility care agencies, and special event EMS agencies organized to provide emergency medical services. For the purposes of disciplinary actions taken pursuant to the enforcement provisions of this rule, unless otherwise specified, actions taken by an "EMS agency" shall include actions taken by EMS agency personnel and its medical director(s).

T. "Emergency medical technician (EMT)" means a provider who has been licensed by the department to provide patient care in accordance with the current EMS scopes of practice (7.27.2.14 NMAC).

U. "Emergency medical service agency certification (EMS agency certification, certification, certificate)" means a legal document issued to an EMS agency by the department as evidence that the applicant meets the requirements for certification to operate an EMS agency in accordance with this rule.

V. "EMS bureau (bureau)" means the emergency medical systems bureau of the epidemiology and response division of the New Mexico department of health, and includes the bureau's agents.

W. "EMS first responder (first responder)" means a provider who has been licensed by the department to provide initial patient care in accordance with the current EMS scopes of practice (7.27.2.14 NMAC).

X. "EMS Act (Act)" means the Emergency Medical Services Act, NMSA 1978, Section 24-10B-1 *et seq*.

Y. "EMS fund" means the fund established by the EMS Fund Act, NMSA 1978, Section 24-10A-1 *et seq*., that is administered by the department of health.

Z. "EMS Fund Act" means the Emergency Medical Services Fund Act, NMSA 1978, Section 24-10A-1 *et seq.*

AA. "EMS medical director (medical director)" means a physician licensed in New Mexico who is responsible for all aspects of patient care for an EMS system or EMS agency, including providing for or ensuring the medical control of EMS providers; the development, implementation, and evaluation of medical protocols; emergency medical dispatch; and oversight of quality assurance activities.

BB. "GSA standards" means the minimum standards and specifications for ambulances contained in the United States general services administration (GSA) standard KKK-A-1822F or most current GSA standard.

CC. "Level of care" means the most advanced level of emergency medical services that an emergency medical technician (EMT) is permitted to administer in accordance with the most current NM EMS scopes of practice.

DD. "Level of service" means the most advanced level of emergency medical service at which an EMS agency is certified to function in accordance with this rule.

EE. "Medical control" means EMS supervision provided by or under the direction of physicians to providers by written protocol or direct communication.

FF."Medical direction" means guidance or supervision provided by a physician to an agency, provider or emergency medical services system and includes authority over and responsibility for emergency medical dispatch, direct patient care and transport of patients, arrangements for medical control and all other aspects of patient care delivered by an EMS provider or agency.

GG. "Medical direction committee" means the committee of physicians and emergency medical technicians created under the EMS Act, at NMSA 1978, Section 24-

10B-7 C, whose members are appointed by the secretary to advise the bureau on all matters relating to medical control and medical direction.

HH. "Medical protocol" means a predetermined, written medical care plan and includes standing orders from a medical director.

II. "Mutual aid" means aid provided pursuant to a written agreement between one municipality, county or private EMS agency and one or more other municipalities, counties or private EMS agencies for the purpose of ensuring that adequate emergency medical services exist locally or throughout the state in order to assure a timely response to the call for emergency medical care. Mutual aid agreements may be utilized to address (among other things) coordinated response to catastrophic events, as well as common system demand and staffing situations.

JJ. "National EMD standard-setting and certification organization (NESSCO)" means the organization that provides and maintains a comprehensive EMD protocol and training system development process. Organizations accredited under NESSCO are required to maintain current and up-to-date emergency medical dispatch priority reference system (EMDPRS) curriculum, training, testing, certification, recertification, instructor, quality improvement and accreditation programs and standards.

KK. "Non-transport medical rescue vehicle" means any EMS agency representative vehicle (motor vehicle or watercraft) that is not a privately owned vehicle and that carries EMS equipment that is not included in the EMS agency’s medical protocols to transport patients.

LL."Non-transport medical rescue agency" means an EMS agency that does not transport patients and is organized under a New Mexico political subdivision or a private entity performing services solely for its employees.

MM. "Out-of-state EMS agency" means an EMS agency that is organized under the laws of another state, or whose principal place of business is located in another state.

NN. "Patient care report" means a medical record of an encounter between any patient and a provider of medical care.

OO. "Personnel" means any employee, agent, representative, volunteer, or intern of an EMS agency who provides emergency medical services.

PP. "Privately owned vehicle" (POV) means a privately owned vehicle not registered to a governmental entity or EMS agency.

QQ. "Physician" means a doctor of medicine or doctor of osteopathy who is licensed or otherwise authorized to practice medicine or osteopathic medicine in New Mexico.

RR. "Post-dispatch instructions" means case-specific advice, warnings, and treatments given by trained EMDs to responders whenever possible and appropriate after dispatch of field responders.

SS. "Pre-arrival instructions" means the scripted medical instructions provided to callers in emergency situations by licensed emergency medical dispatchers prior to the arrival of EMS agency personnel.

TT."Primary response area" means the specific primary geographic area designated or prescribed by a jurisdiction in which an EMS agency provides emergency medical service.

UU. "Provider" means a person who has been licensed by the department to provide patient care pursuant to the EMS Act, NMSA 1978, Section 24-10B-1 *et seq*.

VV. "Quality assurance" means a retrospective review or inspection of EMS records to determine if appropriate care is being provided.

WW. "Regional office" means an emergency medical services planning and development organization formally recognized and contracted by the bureau.

XX. "Required records" means records, logs, data sets, forms, agreements, plans, procedures, policies, titles, certificates and other documents required to be retained by an EMS agency under this rule, whether in electronic or printed form.

YY. "Scope of practice" means the skills, techniques, medications, and procedures identified by rule of the department (7.27.2.14 NMAC) that are allowed for the practice of emergency medical services in New Mexico, that apply to all EMS personnel, EMS services, and EMS medical directors.

ZZ."Secondary response area" means a geographic area in which an EMS agency provides emergency medical service beyond their primary response area, established by local jurisdictions or mutual aid agreements.

AAA. "Secretary" means the secretary of the New Mexico department of health.

BBB. "Special event emergency medical services (special event EMS)" means emergency medical services provided outside the emergency response system at scheduled, contractual events. Special event services include but are not limited to: medical services provided at movie sets, sporting events, mass gatherings, concert venues, adventure programs, religious events, guest ranches and wild-land fires.

CCC. "Special event EMS agency" means an organization that provides special event emergency medical services to the public by licensed EMS providers.

DDD. "Special skill" means a set of procedures or therapies that are beyond the usual scope of practice for a given level of licensure and that have been approved by the medical direction committee for use by a specified provider.

EEE. "Standing orders" means defined written orders for actions, techniques or drug administration, signed by the medical director, to be utilized when communication has not been made with an on-line medical control physician.

FFF. "Transport capable medical rescue" means any vehicle (motor vehicle or watercraft) that carries EMS protocols for transporting patients in a patient care compartment.

GGG. "Transport medical rescue agency" means an EMS agency that transports patients under certain circumstances and without compensation, and is organized under a New Mexico political subdivision or a private entity.

[7.27.10.7 NMAC - N, 3/15/2010]

7.27.10.8 USE OF TERMS AND ADVERTISING:

It shall be prohibited for any EMS agency to advertise or perform emergency medical services, or to use the title "certified emergency medical services agency," in New Mexico, unless the EMS agency has been certified by the bureau in accordance with this rule.

[7.27.10.8 NMAC - N, 3/15/2010]

7.27.10.9 DISCLOSURE TO THE PUBLIC:

If requested by a potential client, a patient or a member of the public, a certified emergency medical services agency shall disclose its current level of New Mexico certification and what level of service it can provide.

[7.27.10.9 NMAC - N, 3/15/2010]

7.27.10.10 EMS BUREAU CERTIFICATION REQUIRED:

An EMS agency shall, prior to beginning emergency medical services operations within the state of New Mexico, obtain either a temporary or full emergency medical services certification from the bureau. Certification by the EMS bureau shall not in itself qualify an EMS agency for EMS fund distribution.

[7.27.10.10 NMAC - N, 3/15/2010]

7.27.10.11 FULL CERTIFICATION PERIOD:

Certification periods are twenty-four months in length except for the initial period, which shall vary according to the date of initial certification. The second or subsequent period of certification shall be for a full twenty-four month period, regardless of the date of application for renewal or the date for processing of the renewal certificate. This period shall begin on January 1 of the renewal year. Requirements for renewal of licensure shall be completed by the December 1st that occurs prior to expiration of certification. The certification period for emergency medical agencies may be adjusted by the bureau to correspond with the CAMTS, CAAS or other bureau-approved accreditation period. EMS agencies may be subject to audit. EMS agencies shall complete an annual report form that contains the same elements as the annual service report required of ambulance services by PRC rule (18.3.14.22 NMAC). The bureau shall issue the annual report form to EMS agencies by November 1 of each year, and EMS agencies shall complete the form and return it to the bureau no later than January 15 of the following year.

[7.27.10.11 NMAC - N, 3/15/2010]

7.27.10.12 RECORDS AND DATA COLLECTION:

A. Patient care reports. All certified EMS agencies except special event EMS shall complete in a timely manner and keep on file a clearly written or computer-generated patient care report for each patient who is provided with emergency medical care or transported. Each patient care report shall be authored by the provider(s) actually responsible for the patient care, and shall be completed within forty-eight hours of the provision of care to the patient.

B. Submission of minimum pre-hospital data. An EMS agency shall compile and submit minimum data required pursuant to this rule on a quarterly basis, or as required by the bureau.

C. Minimum data elements; general EMS agency information. An EMS agency shall submit the following general data to the EMS bureau:

(1) EMS agency number;

(2) EMS agency state;

(3) EMS agency county;

(4) level of service;

(5) organizational type;

(6) organization status;

(7) statistical year;

(8) total service size area;

(9) total service area population;

(10) 911 call volume per year;

(11) EMS dispatch volume per year;

(12) EMS transport volume per year;

(13) EMS patient contact volume per year;

(14) EMS agency time zone;

(15) national provider identifier;

(16) EMS agency contact zip code.

D. Minimum pre-hospital data elements: An EMS agency shall compile and submit to the EMS bureau the following minimum pre-hospital data for every instance that patient care is provided by the EMS agency:

(1) vehicle type;

(2) patient care report number;

(3) software creator;

(4) software name;

(5) software version;

(6) EMS agency number;

(7) incident number;

(8) type of service requested;

(9) primary role of the unit;

(10) type of dispatch delay;

(11) type of response delay;

(12) type of scene delay;

(13) type of transport delay;

(14) type of turn-around delay;

(15) EMS unit call sign (radio number);

(16) response mode to scene;

(17) complaint reported by dispatch;

(18) EMD performed;

(19) crew member role;

(20) crew member level;

(21) PSAP call date/time;

(22) dispatch notified date/time;

(23) unit notified by dispatch date/time;

(24) unit en route date/time;

(25) unit arrived on scene date/time;

(26) arrived at patient date/time;

(27) unit left scene date/time;

(28) patient arrived at destination date/time;

(29) unit back in service date/time;

(30) unit back at home location date/time;

(31) patient’s last name;

(32) patient’s first name;

(33) patient’s home zip code;

(34) patient’s home country;

(35) patient’s social security number;

(36) patient’s gender;

(37) patient’s race;

(38) patient’s ethnicity;

(39) patient’s age;

(40) patient’s age units;

(41) patient’s date of birth;

(42) patient’s primary method of payment;

(43) patient’s insurance company ID/name;

(44) CMS service level;

(45) condition code number;

(46) number of patients at scene;

(47) mass casualty incident;

(48) incident location type;

(49) scene GPS location;

(50) incident address;

(51) incident city;

(52) incident county;

(53) incident state;

(54) prior aid;

(55) person who performed prior aid;

(56) outcome of the prior aid;

(57) possible injury;

(58) patient’s chief complaint;

(59) chief complaint anatomic location;

(60) chief complaint organ system;

(61) primary symptom;

(62) other associated symptoms;

(63) provider’s primary impression;

(64) provider’s secondary impression;

(65) cause of injury;

(66) whether injury was caused intentionally;

(67) mechanism of injury;

(68) use of occupant safety equipment;

(69) airbag deployment;

(70) height of fall;

(71) cardiac arrest;

(72) cardiac arrest etiology;

(73) resuscitation attempted;

(74) barriers to patient care;

(75) alcohol/drug use indicators;

(76) run report narrative;

(77) total Glasgow coma score;

(78) medication given;

(79) medication complication;

(80) procedure;

(81) number of procedure attempts;

(82) procedure successful;

(83) procedure complication;

(84) destination/transferred to, name;

(85) destination/transferred to, code;

(86) destination zip code;

(87) incident/patient disposition;

(88) transport mode from scene;

(89) reason for choosing destination;

(90) type of destination;

(91) emergency department disposition;

(92) hospital disposition.

E. Updates. An EMS agency shall maintain current operational information by providing regular updates to the bureau through the EMS reporting software and the application and renewal process. Review of completed patient care reports may be required during initial and subsequent inspections.

F. Location of records. An EMS agency shall maintain all required records at the agency's principal place of business within the state of New Mexico. All required records are subject to inspection by the bureau and shall be maintained so that they are reasonably accessible. The EMS bureau may, upon a showing of good cause, allow an EMS agency to maintain required records at a location outside the state of New Mexico, provided that the EMS agency demonstrates to the satisfaction of the EMS bureau that the records will be reasonably accessible for the bureau's inspection.

G. Completed patient care records. An EMS agency that transports a patient shall, upon delivery of the patient to the hospital, deliver a copy of the completed pre-hospital patient care record to the receiving facility's emergency department for inclusion in the patient's permanent medical record. In the event that the transporting unit is dispatched on another call before the pre-hospital patient care record can be transmitted, the pre-hospital patient care record shall be delivered to the receiving hospital's emergency department no later than forty-eight hours after the transportation and treatment of the patient.

H. Current records requirements.

(1) Current records for all EMS agencies. An EMS agency shall at all times maintain current copies of the following records:

(a) medical protocols signed by the EMS agency's medical director;

(b) operation plans and standard operating procedures and guidelines for the EMS agency;

(c) rosters of EMS agency personnel;

(d) applications of EMS agency employees and other personnel;

(e) copies of certification and licensure documentation for all EMS agency personnel;

(f) HIPAA documentation for all EMS agency personnel;

(g) service area maps with global positioning system (GPS) coordinates of EMS agency stations;

(h) board of pharmacy clinic license and pharmacy license, if applicable;

(i) federal drug enforcement administration (DEA) license, if applicable;

(j) driver's license and driver certification copies for each employee / volunteer; and

(k) infection control policy.

(2) Additional current records for all medical rescue agencies. Additionally, a medical rescue agency shall at all times maintain a current, valid copy of the title for each vehicle owned by the medical rescue agency.

(3) Additional current records for all emergency medical dispatch agencies. Additionally, an emergency medical dispatch agency shall at all times maintain current copies of the following documents:

(a) training records (rosters, course outlines, etc.);

(b) E-911 updates street mapping / maps; and

(c) a public safety answering points (PSAP) directory.

I. Other records required (extended retention).

(1) Medical records. An EMS agency other than special event EMS shall retain all adult medical records (including patient care reports) for at least ten years. An EMS agency other than special event EMS shall retain all medical records of minors (including patient care reports) for at least ten years, or at least one year after the person reaches the age of majority, whichever period of time is greater.

(2) Other records. An EMS agency shall retain the following records for a period of not less than seven years:

(a) a copy of the EMS agency's application for certification from the EMS bureau;

(b) certificate of insurance for the EMS agency;

(c) business license and incorporation documents for the EMS agency, as applicable, or documentation verifying the EMS agency's status as a governmental entity;

(d) all current and expired mutual aid agreements and memoranda of agreement entered into by the EMS agency;

(e) medical director contract or professional agreement;

(f) criminal background check documentation for EMS agency personnel, as applicable;

(g) copies of EMS agency certification updates; and

(h) quality assurance documentation.

(3) Additional medical rescue agency records. Additionally, a medical rescue agency shall retain the following records for a period of not less than seven years:

(a) vehicle maintenance records;

(b) annual safety inspection certificates for each vehicle operated by the EMS agency; and

(c) consultant pharmacist contract or professional agreement.

(4) Additional emergency medical dispatch agency records. Additionally, an emergency medical dispatch agency shall retain the following records for a period of not less than seven years:

(a) telephone and radio audio recordings, including magnetic tapes and digital file format recordings (DAT, CD, DVD, etc.);

(b) 911 system and call records (printed output, electronic files, etc.);

(c) CAD files; and

(d) hand-written (manual) reports.

J. Extension of retention period; contingencies. If at the end of a stated retention period an EMS agency is involved in or is aware of pending legal obligations (contractual or otherwise), litigation, administrative action, governmental investigation, insurance claims, or court orders that relate in whole or in part to a required record, the EMS agency shall continue to retain the required record for at least six months after said contingency has been resolved or concluded.

K. Protection of records. An EMS agency shall take reasonable precautions to protect required records from destruction and damage. If an EMS agency's required records are destroyed or damaged prior to the end of the retention period established in this rule, the EMS agency shall immediately notify the bureau.

[7.27.10.12 NMAC - N, 3/15/2010]

7.27.10.13 EMERGENCY INFORMATION REQUIRED:

When applying for initial certification or renewal of certification, an EMS agency shall provide to the bureau emergency contact information for the EMS agency. This information shall be used by the bureau to provide effective communications and resource management in the event of a statewide or localized disaster or emergency situation.

[7.27.10.13 NMAC - N, 3/15/2010]

7.27.10.14 GENERAL STANDARDS:

A. Personnel licensure required. An EMS agency shall ensure that EMS providers at all times maintain current EMS licensure in accordance with 7.27.2 NMAC ("Licensing of Emergency Medical Services Personnel").

B. Scopes of practice. An EMS agency providing emergency medical services shall ensure that EMS providers comply with the current EMS scopes of practice in accordance with 7.27.2 NMAC ("Licensing of Emergency Medical Services Personnel").

C. Other required personnel for emergency medical services. An EMS agency shall designate an EMS medical director, a designated training coordinator, and a service director, as provided below:

(1) training coordinator: each EMS agency shall designate a training coordinator, who shall coordinate the availability of appropriate training programs and continuing education for EMS providers;

(2) medical direction required: each EMS agency shall retain a medical director, who shall provide medical direction to the agency that is consistent with the requirements of 7.27.3 NMAC ("Medical Direction for Emergency Medical Services");

(3) service director: each EMS agency shall designate a service director who shall serve as the single point of contact for the EMS agency, who shall provide operational oversight for the entire EMS agency; the EMS agency's service director shall be responsible for the EMS agency's adherence to the standards of this rule.

D. Pharmaceutical license. An EMS agency shall comply with NM board of pharmacy requirements regarding all medications utilized and stored, including oxygen. An EMS agency shall maintain and display copies of its federal drug enforcement administration license, NM board of pharmacy clinic license, and NM board of pharmacy license in plain sight at its primary business location.

E. Proof of financial responsibility. An EMS agency shall maintain at a minimum both vehicle and general liability insurance, either through self-indemnity or an insurance company. Proof of insurance shall be filed with the bureau, along with the application for EMS agency certification as required by this rule. At any time that said insurance is required to be renewed, proof of renewal shall be submitted to the bureau.

F. Communications. An EMS agency shall maintain EMS communication capabilities sufficient to ensure interoperability and interconnectivity with dispatch centers, hospitals and other EMS and rescue providers.

G. Quality assurance review. An EMS agency shall implement a quality assurance program, which shall be planned, developed and implemented by the EMS agency's medical director in a manner consistent with 7.27.3 NMAC ("Medical Direction for Emergency Medical Services"). The quality assurance program shall include review of documentation of patient care in a pre-determined set of circumstances to ensure a feedback and training loop for the EMS providers.

H. Personnel hours and safety. An EMS agency shall adopt rules consistent with applicable federal employment standards (e.g., Fair Labor Standards Act (FLSA), 29 USC Section 201 *et seq*., Occupational Safety and Health Act (OSHA), 29 USC Section 651 *et seq*.).

I. Internships. An EMS agency may provide clinical internships only through a bureau-approved or CoAEMSP accredited EMS training program.

[7.27.10.14 NMAC - N, 3/15/2010]

7.27.10.15 DUTY TO PROVIDE SERVICE:

A. An EMS agency and any of its personnel or agents shall provide service to a person in need of emergency medical treatment or transportation.

B. An EMS agency shall, in accordance with the EMS agency's level of care, transport a patient requiring medical treatment and transport to the closest appropriate facility capable of providing appropriate care and treatment, as determined by the EMS agency's medical director.

C. An EMS agency shall give priority to emergency response calls.

D. An EMS agency shall be available 24 hours a day, 365 days a year unless the provision of services is otherwise addressed within mutual aid agreements or a memorandum of understanding. Certified special event EMS agencies may address the provision of duty hours based upon the EMS agency's contracts or agreements.

[7.27.10.15 NMAC - N, 3/15/2010]

7.27.10.16 MEDICAL RESCUE AGENCIES:

A. General requirements for all medical rescue agencies:

(1) Certification required. A medical rescue agency shall not provide treatment to any patient, nor shall a transport medical rescue agency transport any patient, unless the medical rescue agency holds a valid certificate in accordance with this rule.

(2) Level of service. Any medical rescue agency that represents itself as providing any EMS level of service shall make that level of service available.

(3) Fees prohibited. Medical rescue agencies shall not charge a fee to the patient. Nothing in this rule shall be construed to prevent a medical rescue agency from negotiating reimbursement agreements.

(4) Hygiene and cleanliness. Medical rescue agencies shall maintain clean and hygienic work environments, and shall adopt and implement reasonable infection control practices to prevent the spread of communicable diseases. Medical rescue agencies shall properly maintain and dispose of all biohazard material.

(5) Medical rescue emergency motor vehicles. Medical rescue emergency motor vehicles shall provide safe and adequate service, and shall utilize equipment, supplies and facilities that are safe and adequate for the provision of emergency medical services and otherwise consistent with the requirements of this rule. Motor vehicles shall be safe, dependable and suitable for the services rendered. Each motor vehicle shall be maintained in good mechanical and operating condition. The bureau

may remove from operation any medical rescue agency vehicle that the bureau determines to be either not road worthy or not response worthy. Transport-capable medical rescue vehicles shall be equipped with a heating, cooling and ventilation system capable of providing a reasonable level of comfort inside the motor vehicle.

(6) Documentation. EMS agencies certified under this rule shall annually submit to the bureau a certificate of safety for each of their medical rescue vehicles, to include the date, name, contact telephone number and location of the certified mechanic performing the inspection.

(7) Drivers. Any person who regularly drives a certified medical rescue (transport or non-transport) vehicle shall:

(a) be at least 18 years of age;

(b) hold a valid New Mexico driver's license or equivalent out-of-state driver's license, equivalent to a class "D" or higher;

(c) be in compliance with bureau requirements for an emergency vehicle operator's course;

(d) not have received a driving while intoxicated, driving under the influence, or reckless driving conviction within the past year;

(e) not be prohibited by law from driving without a breath alcohol ignition interlock device;

(f) not be prohibited by law from operating a motor vehicle for any other reason;

(g) annually provide to their EMS agency a copy of the person's motor vehicle driving record; the medical rescue agency shall validate and submit to the bureau a list of all drivers authorized by the agency together with the agency's annual report; all driver infractions resulting in the loss or potential loss of driving privileges shall be reported to the bureau.

(8) Safety belts. Safety belts shall be utilized by all persons in the forward compartment of emergency motor vehicles. Attending personnel shall wear seat belts when feasible. Safety belts or other safety restraining devices shall be available for patients being transported, and shall be utilized for patients at all times during patient transport, unless extenuating circumstances prevent their usage.

(9) Child restraint systems. Attending personnel shall utilize child restraint systems when feasible and necessary. Child restraint systems shall satisfy all federal and state requirements when in use.

(10) Minimum personnel requirements. All medical rescue agencies (transport and non-transport) shall maintain the following minimum personnel requirements during patient treatment and transportation:

(a) a minimum of one New Mexico licensed EMS provider shall be present at the scene of an emergency;

(b) for transport of a patient, a minimum of one qualified New Mexico-licensed EMS provider shall be present in the patient compartment of the medical rescue vehicle at all times while the compartment is occupied by a patient;

(c) healthcare personnel not licensed as an EMS provider may accompany and monitor a patient in the patient compartment of a medical rescue vehicle, provided that at least one qualified New Mexico-licensed EMS provider is also present in the patient compartment, subject to the policies of the EMS agency.

(11) Mutual aid. All medical rescue agencies (transport and non-transport) shall develop mutual aid plans with appropriate EMS agencies and PRC regulated ambulance services. A medical rescue agency may provide mutual aid to another EMS agency pursuant to a mutual aid agreement only in the event that the other agency cannot respond to a call for service, and only in the following circumstances:

(a) in mass casualty or disaster situations, when requested by state or local authorities in accordance with established local emergency plans;

(b) when requested by another EMS agency or a licensed EMS provider during an emergency and in accordance with established mutual aid agreements;

(c) when requested by a law enforcement agency or officer; or

(d) in a non-emergency, when the responsible local provider's resources are exhausted, pursuant to arrangements made by the responsible local provider for (and for the coordination of) such necessary mutual aid.

(12) Unauthorized persons. A medical rescue agency shall not transport any person who is not a patient (including but not limited to a hitchhiker), other than an on-duty employee of the medical rescue agency, a person authorized by the medical rescue agency to be transported, or a bureau representative on official business, unless the person's transport is necessitated by an emergency.

(13) Accident reports. Every medical rescue agency shall report to the bureau every accident that occurs in the course of the medical rescue agency's operations within the state on either public or private property that results in the death of a person, injury to a person that requires treatment by a physician, or damage to property belonging to either the medical rescue agency or any other person to an apparent extent of two thousand five hundred dollars ($2,500.00) or more.

(a) In the event that an EMS vehicle operated by a medical rescue agency is involved in a collision that results in a person's death, the medical rescue agency shall, within twenty-four hours of learning of the person's death, submit a copy of the police report of the collision to the bureau.

(b) Police reports of all other collisions involving an EMS vehicle operated by a medical rescue agency shall be submitted to the bureau by the medical rescue agency no later than fifteen days after the date of the collision.

(c) If a medical rescue agency learns after submitting a police report to the bureau that an individual who was involved in a collision involving an EMS vehicle operated by the agency has died, the agency shall file an amended copy of the police report with the bureau no later than fifteen days after learning of the person's death.

(d) For the purposes of this section, a medical rescue agency that has submitted a uniform accident report of the collision to the motor vehicle division of the New Mexico taxation and revenue department may submit a copy of that report to the bureau instead of a police report; provided that the deadline for the submission to the bureau of a uniform accident report shall be the same as the deadline for the submission of a police report.

B. Additional requirements for transport medical rescue agencies. Transport medical rescue agencies shall meet the following requirements in order to be certified by the bureau.

(1) All transport medical rescue vehicles shall carry appropriate supplies and equipment, including the minimum required equipment identified in this rule.

(2) Patient transport is allowed in two distinct situations:

(a) saving of life or limb: when a transport medical rescue agency is dispatched without the intent to transport, but transports patient(s) due to life or limb-saving necessity;

(b) system demand: a transport medical rescue agency may transport a patient when there is no ambulance service available, or may intercept with any air or ground ambulance service when it is beneficial for the patient.

(3) All transport medical rescue agencies shall additionally maintain the following agreements and protocols:

(a) a fully executed written agreement between the public regulation commission-certificated ambulance service serving the area and the transport medical rescue agency that describes the transport protocol to be followed;

(b) a written medical protocol that clearly specifies situations when transport is allowed and has been approved by the transport rescue agency medical director.

[7.27.10.16 NMAC - N, 3/15/2010]

7.27.10.17 MINIMUM REQUIRED EQUIPMENT FOR NON-TRANSPORT MEDICAL RESCUE VEHICLES:

All non-transport medical rescue agencies shall stock and equip non-transport medical rescue vehicles with the following minimum required equipment and supplies. Supplies shall be maintained in sufficient quantities to assure the safe and adequate provision of emergency medical services in response to one or multiple incidents.

A. Forward compartment:

(1) vehicle registration;

(2) *U. S. department of transportation emergency response guidebook* (most current edition);

(3) maps or navigational equipment;

(4) service specific protocols and resource guides;

(5) patient care reports or reporting system;

(6) hand sanitizer;

(7) flashlight (battery powered, hand crank, with mounted battery charging system);

(8) fire extinguisher (ten pounds, ABC type or functional equivalent, charged);

(9) spotlight or auxiliary lighting system;

(10) roadway warning devices (safety flares, emergency lights, safety cones);

(11) vehicle jack;

(12) spare tire; and

(13) tire wrench.

B. Communications equipment:

(1) radio communications (portable or affixed);

(2) equipment sufficient to establish and maintain direct or repeated communications with area dispatch and secondary providers; and

(3) N.M. EMSCOM radio system capable of cellular and text/data transmissions (optional), spare batteries / charger system.

C. Personal protective equipment (PPE):

(1) EMS turnout gear;

(2) helmets with face shield;

(3) gloves (work gloves or leather gloves);

(4) eye protection (glasses or goggles);

(5) hearing protection;

(6) safety vest / jacket (ANSI 2008 compliant; break-away, reflective, high visibility coloration);

(7) exam gloves (assorted sizes);

(8) disposable splash protection (gowns, scrubs, eye shielding, etc.);

(9) tyvex coveralls (optional); and

(10) N-95 mask (or a mask better than a particulate mask).

D. Diagnostic equipment:

(1) aneroid sphygmomanometer, blood pressure cuffs (with infant, pediatric, adult, and obese sizes);

(2) stethoscope (more than one);

(3) glucose monitoring instrument (portable);

(4) pulse oximeter (portable);

(5) end-tidal CO2 monitoring device (disposable, colormetric);

(6) penlights; and

(7) shears (trauma or equivalent).

E. Cardiac equipment:

(1) semi-auto external defibrillator;

(2) defibrillator pads (extra); and

(3) defibrillator batteries (extra).

F. Bandages/dressings:

(1) triangular bandages;

(2) universal dressings (approximately ten inches by thirty inches);

(3) gauze pads (four inches by four inches);

(4) bandages - soft roller (self-adhering);

(5) bandages - elastic (band aids, assorted sizes);

(6) occlusive dressings (sterile, individually wrapped);

(7) adhesive tape (various sizes: one inch, two inch, duct tape ('medical' - white);

(8) cold packs;

(9) heat packs; and

(10) burn sheets.

G. Respiratory equipment:

(1) mounted electric or manifold operation suction aspirator (that meets GSA standard);

(2) portable suction aspirator (as approved by the bureau);

(3) sterile suction catheters and tubing (rigid and soft, if applicable; assorted sizes);

(4) bag-valve-mask resuscitator (BVM) (disposable, with transparent adult mask); the BVM shall be capable of operation in cold weather, shall be capable of use with an oxygen supply and shall be capable of delivering approximately 100% oxygen;

(5) pediatric bag-valve-mask resuscitator (disposable, with transparent child and infant mask); the pediatric BVM shall be capable of operation in cold weather, shall be capable of use with an oxygen supply, and shall be capable of delivering 100% oxygen;

(6) adult oxygen masks with reservoir (non-rebreather or partial non-rebreather);

(7) adult oxygen masks (simple);

(8) pediatric oxygen masks with reservoir (non-rebreather or partial non-rebreather);

(9) pediatric oxygen masks (simple);

(10) nasal cannulas;

(11) oxygen supply tubing;

(12) oropharyngeal airways (with adult, child and infant sizes);

(13) nasopharyngeal airways (with adult, child and infant sizes);

(14) laryngeal, supraglottic, multi-lumen or laryngeal airway devices (device not intended to be placed into the trachea);

(15) oxygen: fixed system (minimum of two wall-mounted oxygen outlets and one flow meter); system shall include a yoke-type pressure reducer gauge and an approved cylinder retaining device that meets DOT standards; the system shall be capable of delivering an oxygen flow of at least 15 liters per minute; if oxygen source is of a size less than "M" cylinder, an additional full spare cylinder for the fixed system shall be carried in the ambulance; and

(16) oxygen: two portable cylinders; each unit shall consist of at least a "D" cylinder or equivalent, yoke, pressure gauge, flowmeter and cylinder wrench; the unit shall be capable of delivering an oxygen flow of at least 15 liters per minute; cylinder holders with a quick-release fitting shall be furnished to allow the use of the portable unit outside the vehicle.

[7.27.10.17 NMAC - N, 3/15/2010]

7.27.10.18 MINIMUM REQUIRED EQUIPMENT FOR TRANSPORT MEDICAL RESCUE VEHICLES:

All transport medical rescue agencies shall stock and equip transport medical rescue vehicles with the minimum equipment and supplies required in this rule to be stocked in

non-transport medical rescue vehicles by non-transport medical rescue agencies. Additionally, all transport medical rescue agencies shall stock and equip transport medical rescue vehicles with the following minimum equipment and supplies. Supplies shall be maintained in sufficient quantities to assure the safe and adequate provision of emergency medical services in response to one or multiple incidents.

A. Patient compartment:

(1) multi-level stretcher (may be power assisted, two-person);

(2) shoulder / chest and lower extremity straps (capable of securing adult and pediatric patients);

(3) pillow (disposable, with a vinyl cover or a rolled blanket);

(4) blankets;

(5) stretcher pad (bed) covers (e.g., sheets);

(6) patient restraints (two ankle and two wrist, leather or nylon);

(7) sharps container;

(8) emesis basins (emesis bags or equivalent); and

(9) body bags.

B. Pharmocological equipment for first response through ALS:

(1) appropriate medications with the contents established and approved by the service medical director, within applicable N.M. scopes of practice, with a list of contents and earliest expiration dates affixed to the outside of the kit; drug kits must be maintained in a temperate, controlled environment and shall not be left unsecured; and

(2) mark I plus kit.

C. Pediatrics:

(1) pediatric restraint system or car seat (may be a fold-down jumpseat with a child restraint system);

(2) obstetrical kit (sterile package), to include at a minimum: a receiving blanket, a sterile bulb aspirator, a wrapped sanitary napkin, a sterile pair of scissors or scalpel blade, four-inch gauze pads, one pair of sterile gloves, two cord clamps and a plastic bag for placenta; all items shall be kept in a container with an identifying label that specifies the contents;

(3) foil blanket; and

(4) pediatric drug dosage tape or chart.

D. Intravenous therapy:

(1) intravenous solution (normal saline) (1000 ml);

(2) intravenous catheters (various sizes);

(3) intraosseous needles;

(4) tubing/infusion kits;

(5) pediatric fluid volume control device (i.e., burretrol or volutrol); and

(6) arm boards (for pediatrics).

E. Immobilization devices:

(1) extremity immobilization devices (two full arms and two full legs, or equivalent);

(2) short spinal extrication device (KED or equivalent), infant or pediatric immobilization; equipment shall be identified for the safe transport of infant / pediatric patients, as approved by the EMS agency's medical director with guidelines and operating procedures provided by the agency / department;

(3) pediatric immobilization device (as approved by the department); equipment shall be identified for the safe transport of infant / pediatric patients, as approved by the EMS agency's medical director with guidelines and operating procedures provided by the agency / department;

(4) spine boards (long; at least 16" wide by 72" in length with a minimum of three straps);

(5) lateral cervical immobilization devices (commercial devices, foam blocks, blanket rolls);

(6) cervical immobilization collars (hard type, minimum two adult, two medium, two child); and

(7) traction splint (lower extremity, adjustable).

F. Rescue/extrication equipment:

(1) tarp or blankets;

(2) seatbelt cutter or trauma shears;

(3) spring loaded center punch / window punch;

(4) rescue ax or halligan tool;

(5) flathead screwdriver (minimum six inches);

(6) three-pound hammer;

(7) hacksaw with extra bimetal-type blades;

(8) duct tape;

(9) one ton "come-a-long" winch;

(10) rescue-rated chains or straps (minimum of two);

(11) hydraulic spreader / cutter / ram (combi-tool);

(12) air chisel-air cylinder, regulator, air hose (optional);

(13) air bags-air cylinder, regulator, air hose (optional);

(14) winch with recovery straps and blocking equipment; and

(15) stabilization equipment (cribbing, blocks, struts).

[7.27.10.18 NMAC - N, 3/15/2010]

7.27.10.19 SPECIAL EVENT EMS:

A. Certification required. A special event EMS agency shall not provide medical treatment or transport to any patient unless the special event EMS agency holds a valid certificate in accordance with this rule. A special event EMS agency shall not charge a fee to the patient for services provided. Nothing in this rule shall be construed to prevent a special event EMS agency from negotiating reimbursement agreements.

B. Minimum personnel requirements. The exact number and licensure of New Mexico-licensed EMS personnel to be utilized at any event shall be established and approved by the special event EMS agency and the agency’s medical director, based on estimated attendance, geography, venue and environmental factors for each event. At a minimum, one medical team consisting of two New Mexico-licensed EMS personnel equipped with a defibrillator shall be provided for every 5,000 participants and

spectators. EMS providers assigned to a patient transport unit shall not be included in the staffing levels required at an event.

C. Level of service. The highest level of care that may be practiced under the licensure of special event EMS providers shall determine the level of service provided by a medical team.

D. Special event EMS agency transport. Special event EMS may be provided by an EMS agency irrespective of whether the EMS agency is transport capable. If an EMS agency that provides special event EMS is not transport capable, transport shall be provided by a public regulation commission-certificated ambulance service for the territory where the event takes place. Medical rescue agencies performing special event EMS shall follow the appropriate section in this rule.

E. Minimum supplies, equipment, medications and kits required. All special event EMS agencies shall have available and utilize supplies and equipment appropriate to the level of service to be provided, per the direction of the EMS agency's service director and medical director. At a minimum, a medical team shall be equipped with a defibrillator and trauma and airway supplies.

[7.27.10.19 NMAC - N, 3/15/2010]

7.27.10.20 EMERGENCY MEDICAL DISPATCH:

A. Certification required. An emergency medical dispatch agency shall not operate within the state of New Mexico, nor dispatch calls within or from the state of New Mexico, nor represent itself to be an emergency medical dispatch agency operating in the state of New Mexico or dispatching calls within or from the state of New Mexico, unless the emergency medical dispatch agency holds a valid certificate in accordance with this rule.

B. Minimum requirements for medical dispatch agencies. A certified medical dispatch agency shall utilize an emergency medical dispatch priority reference system that is published by a bureau-approved source and that is used by licensed emergency medical dispatchers. A medical dispatch agency shall utilize only licensed EMDs for emergency medical dispatch.

C. Exceptions for medical dispatch agencies. In the event of a large scale emergency or mass casualty incident, emergency medical dispatch agencies may suspend emergency medical dispatch for the duration of the incident to accommodate the unusual increase in call volume.

D. Emergency medical dispatch agency performance and certification. A medical dispatch agency shall be operated in a safe, efficient, and effective manner in accordance with this rule, and shall further comply with the following minimum standards:

(1) an emergency medical dispatch agency shall, in accordance with any applicable requirements of this rule, implement and ensure that the agency's medical director reviews, approves, and oversees:

(a) an emergency medical dispatch priority reference system;

(b) an emergency medical dispatch training program;

(c) a quality assurance program;

(d) an emergency medical dispatch oversight committee; and

(e) an emergency medical dispatch continuing education program;

(2) any emergency medical dispatch priority reference system, including but not limited to its questions, instructions, codes, and protocols, shall be utilized in its entirety, rather than in limited parts;

(3) an emergency medical dispatch agency shall ensure that emergency medical dispatchers follow the questions and decision-making processes (flowcharts) within their emergency medical dispatch priority reference system in compliance with the written policies and procedures of their emergency medical dispatch agency, and as approved by the agency's medical director;

(4) an emergency medical dispatch agency shall use a bureau-approved emergency medical dispatch priority reference system on every request for medical assistance;

(5) an emergency medical dispatch agency shall ensure that each emergency medical dispatcher provides dispatch life support (including but not limited to pre-arrival instructions) in compliance with the written text or scripts and other processes within the approved emergency medical dispatch priority reference system;

(6) an emergency medical dispatch agency shall maintain and utilize policies and procedures for the safe and effective use of the agency's approved emergency medical dispatch priority reference system;

(7) an emergency medical dispatch agency shall ensure that emergency medical dispatchers maintain valid licensure in accordance with 7.27.2 NMAC ("Licensing of Emergency Medical Services Personnel");

(8) an emergency medical dispatch agency shall set minimum training requirements that meet state standards for emergency medical dispatcher certification;

(9) an emergency medical dispatch agency shall, with the written approval and supervision of the agency's medical director and with the input of the agency's

emergency medical dispatch oversight committee, establish a continuous quality assurance program that measures various areas of compliance with the emergency medical dispatch priority reference system;

(10) an emergency medical dispatch agency shall maintain and utilize the most current version of the bureau-approved emergency medical dispatch priority reference system selected for use by the emergency medical dispatch agency within six months of its publication; the most current version of the priority reference system shall also be approved in writing by the emergency medical dispatch medical director;

(11) an emergency medical dispatch agency's emergency medical dispatch oversight committee shall:

(a) establish local medical standards for dispatch procedures to assure the appropriate EMS response units are dispatched to the medical emergency scene;

(b) develop a relevant emergency medical dispatch system;

(c) develop relevant local standing orders and protocol as needed;

(d) establish and monitor training standards for initial and continuing education; and

(e) plan, develop and implement the EMS agency's quality assurance program.

E. Pre-approved EMD priority reference systems. The bureau shall identify pre-approved standardized emergency medical dispatch priority reference systems for selection and use by local emergency medical dispatch agencies.

[7.27.10.20 NMAC - N, 3/15/2010]

7.27.10.21 APPLICATION FOR CERTIFICATION:

A. Application. An EMS agency shall apply for certification using an approved application form, and shall provide completed and legible responses to every applicable element of the application form.

B. Application form. Applications for certification shall include at a minimum the following elements:

(1) name and contact information of the applicant EMS agency, including at a minimum the EMS agency's mailing and physical addresses, primary telephone number, facsimile number, and e-mail address;

(2) name and contact information of the applicant EMS agency's medical director, including at a minimum the medical director's mailing address, primary telephone number, facsimile number, and e-mail address;

(3) name and contact information of the director or chief/chief or individual primarily responsible for the operation of the applicant EMS agency, including at a minimum the person's mailing address, primary telephone number, facsimile number, and e-mail address;

(4) name and contact information of the applicant EMS agency's dispatch center, including at a minimum the dispatch center's mailing address, primary telephone number, facsimile number, and e-mail address;

(5) name and contact information of the applicant EMS agency's insurance carrier, including at a minimum the insurance carrier's mailing address, primary telephone number, facsimile number, and e-mail address;

(6) the county in which the applicant EMS agency wishes to be certified, and the number of medical rescue units operated by the applicant EMS agency; and

(7) a notarized attestation by the individual who submits the application that certifies that the information provided in the submitted application form is true and correct to the best of the individual's knowledge.

[7.27.10.21 NMAC - N, 3/15/2010]

7.27.10.22 CERTIFICATION PROCESS:

A. Temporary certification. The bureau may issue a temporary certification to an EMS agency for a period not to exceed three continuous months upon submission of a fully completed initial certification application and payment of appropriate fees. The bureau may in its sole discretion grant a temporary certification to an EMS agency in order to:

(1) allow the EMS agency to begin or continue operations while awaiting full certification;

(2) provide the EMS agency additional time to submit information requested by the bureau;

(3) provide the EMS agency additional time to meet other certification standards; or

(4) provide the EMS agency time to appeal an initial determination or denial of certification.

B. Full certification. To become fully certified, an EMS agency shall:

(1) comply with applicable federal, state, and local laws regarding the operation of a business in the state of New Mexico or the counties or municipalities thereof;

(2) if the agency is an out-of-state EMS agency, submit to the bureau a copy of a bureau-approved accreditation certificate;

(3) complete an initial or renewal certification application and submit it to the bureau along with the required application fee;

(4) submit to any inspections that may be conducted by the bureau;

(5) comply with all applicable federal and state regulatory requirements, including but not limited to insurance requirements, state board of pharmacy permitting requirements , and drug enforcement administration permitting requirements;

(6) verify the driving records of the EMS agency personnel;

(7) conduct criminal background checks of the EMS agency personnel, if requested by the bureau;

(8) furnish insurance documentation as required in this rule;

(9) if the EMS agency is an emergency medical dispatch agency, provide documentation that the agency is using the most current version of its bureau-approved EMDPRS by submitting the name, version number, and date of last revision of the EMDPRS used by the dispatch agency; and

(10) satisfy all other certification requirements applicable under this rule.

C. Renewal of certification. An EMS agency shall submit a certification renewal package to the bureau at least thirty calendar days prior to the expiration of the EMS agency's certification.

(1) To obtain renewal certification, an EMS agency shall:

(a) submit to the bureau a completed renewal certification application form;

(b) submit to the bureau the applicable certification fee;

(c) comply with all applicable federal and state regulatory requirements, including but not limited to insurance requirements, state board of pharmacy permitting requirements, and drug enforcement administration permitting requirements;

(d) if the agency is an out-of-state EMS agency, submit to the bureau a copy of a bureau-approved accreditation certificate;

(e) comply with all other certification requirements applicable under this rule.

D. Determinations regarding certification renewal. The bureau shall review a certification renewal application in the order in which it is received, provided that the application is complete and is submitted by the EMS agency in a timely manner.

(1) If there is a delay by the bureau in notifying an EMS agency of whether the agency's certification renewal application is approved or denied, and if that delay extends beyond the expiration date of the EMS agency's existing certification, that certification shall continue in effect beyond its expiration date until either:

(a) the bureau issues a written notice to the EMS agency stating that the renewal certification application has been denied; or

(b) the bureau issues a renewed certificate to the EMS agency.

(2) If an EMS agency's renewal packet is incomplete, the department shall notify the EMS agency in writing.

E. Certification updates. An EMS agency shall provide updates to the bureau of any organizational changes in the following areas within thirty days of said change:

(1) changes in management structure;

(2) changes in the EMS agency's medical direction;

(3) additions to or removals from the EMS agency's service vehicle fleet;

(4) changes of address for the EMS agency and changes in EMS agency contact information;

(5) any change that impacts the EMS agency's certification status.

F. Change of ownership. Any change of an EMS agency's ownership shall require the EMS agency to reapply with the bureau for certification, which shall require the EMS agency's submission of of any fees associated with a new certification application. The sale or exchange of fifty percent (50%) or more of the total outstanding stock of a corporation shall be deemed a change of ownership for purposes of this rule.

G. Issuance of EMS agency certificate. Upon the bureau's approval of an EMS agency's application for certification, the bureau shall provide the EMS agency with a certificate that authorizes the EMS agency to operate in New Mexico. The EMS agency

shall prominently display the certificate at the EMS agency's primary business location so that it is in full public view at all times.

H. Identification of vehicles. The bureau shall provide certification decals to the EMS agency for each of the EMS agency's vehicles, which the EMS agency shall prominently display on the vehicle(s) so that the decals are in plain sight at all times.

I. Transfer of certificate or decal prohibited. An EMS agency shall not assign, sell or otherwise transfer a bureau-issued certificate, decal or other symbol that signifies the EMS agency's certification to any other person or entity.

J. Reciprocal certification. An out-of-state EMS agency that holds a valid accreditation from the commission on accreditation of ambulance services (CAAS), the commission on accreditation of medical transport systems (CAMTS), the national EMD standard setting certification organization (NESSCO), or another organization approved by the bureau as having equivalent expertise and competency in the accreditation of EMS agencies, shall be deemed to meet the standards for EMS agency certification in the state of New Mexico under this rule.

(1) The bureau shall certify an out-of-state EMS agency that holds a bureau-approved accreditation or certification following the review and approval of the certification application, bureau verification of the EMS agency's liability insurance coverage, and payment of appropriate fees by the EMS agency.

(2) An accredited or certified out-of-state EMS agency shall attach to its initial or renewal certification application evidence of current accreditation. Accreditation of an out-of-state EMS agency shall not preclude the bureau from conducting a certification inspection or from requesting additional information from the agency to ensure compliance with this rule.

K. Exemptions to certification requirements.

(1) Federal agencies and entities, including but not limited to the United States department of defense, shall be exempt from this rule.

(2) The New Mexico department of military affairs shall be exempt from this rule.

(3) Tribal agencies and organizations that provide EMS services entirely within the boundaries of tribal lands shall be exempt from this rule.

(4) An EMS agency from any state adjoining the state of New Mexico shall be exempt from this rule if that agency responds into New Mexico to assist in a mass casualty or disaster situation that exceeds the capacity or capability of the New Mexico EMS agency in the affected area, or if that agency responds into New Mexico on a non-routine basis for emergency mutual aid assistance when requested to do so by the

certified EMS agency whose service area includes areas along the mutual state line. The out-of-state EMS agency shall hold a valid certificate or authorization issued by the EMS regulatory authority that has jurisdiction in the adjoining state where the agency is located, and may provide emergency medical care, emergency medical communication and transport commensurate with that existing authority.

(5) Ambulance services regulated by the transportation division of the New Mexico public regulation commission (see 18.3.14 NMAC) shall be exempt from this rule.

L. Inspections and audits. Inspections or audits of an EMS agency shall be conducted and reviewed by the bureau or the bureau's agent(s). Only individuals who hold valid NM emergency medical technician licensure shall be assigned to conduct an investigation of an EMS agency on behalf of the bureau.

(1) The bureau may conduct on-site inspections or audits of an EMS agency at any time, at the bureau's discretion.

(2) The bureau may investigate and inspect the land, buildings, improvements to real property, vehicles, equipment, records, or documents of an EMS agency as the bureau deems necessary to determine an EMS agency's compliance or non-compliance with this rule.

(3) An EMS agency shall provide the bureau complete access at all times to the land, buildings, improvements to real property, vehicles, and equipment owned by or within the control of the EMS agency.

(4) An EMS agency shall allow the bureau at any time to freely inspect and copy all records and documents in the agency's possession.

(5) An EMS agency that has been certified by the bureau shall submit ongoing annual reports that shall be completed via a self-assessment method, and that shall affirm that the agency meets all standards identified in this rule.

(6) Bureau investigations or audits of an EMS agency may be conducted with or without notice.

(7) An EMS agency that applies for certification from the bureau and that fails an initial inspection may be subject to additional inspections by the bureau to determine whether the EMS agency satisfies certification requirements in accordance with this rule. An EMS agency that fails an initial inspection shall reimburse the bureau for each additional inspection made by the bureau to determine the EMS agency's compliance with certification requirements, in an amount equivalent to the per diem and mileage rates permitted for nonsalaried public officers in the NM Per Diem and Mileage Act, NMSA 1978, Section 10-8-1 *et seq*. Per diem and mileage rates shall be assessed to

the EMS agency per each individual bureau employee or agent assigned to inspect the EMS agency.

M. Changes of name and address. An EMS agency shall notify the bureau of any change of the EMS agency's name or address no later than ten business days after said change is made.

[7.27.10.22 NMAC - N, 3/15/2010]

7.27.10.23 FEES:

A. Determination and assessment. The bureau shall determine and assess fees for the certification of EMS agencies. An agency shall register for only one category of EMS certification, based upon its primary scope of responsibility. However, an agency that qualifies under more than one category of EMS certification shall pay the greater of the applicable fees; for example, a fire department that has more than three vehicles and that also has an in-house dispatch center shall pay the fee applicable to an EMS agency.

B. Applicable fees.

(1) The following table identifies the certification fees applicable to EMS agencies for both initial and renewal certification. These fees are non-refundable.

DESCRIPTION	**APPLICATION FEE (INITIAL and RENEWAL)**
EMS AGENCY (transport-capable medical rescue and non-transport medical rescue) WITH:	
Up to 3 vehicles	$100.00
4-10 vehicles	$150.00
More than 11 vehicles	$200.00
SPECIAL EVENT EMS	$100.00
EMERGENCY MEDICAL DISPATCH	$100.00
LATE FEE (postmarked or hand-delivered after January 15)	25% increase over the primary fee

(2) An out-of-state EMS agency that applies for certification (reciprocal or otherwise) under this rule shall pay the same fee applicable to an in-state EMS agency.

(3) If an EMS agency adds an additional vehicle to its fleet, and if that addition increases the fee applicable to that agency, the increased fee shall not be assessed until the time of the EMS agency's next certification renewal.

(4) EMS agency vehicles that have a gross vehicle weight rating (GVWR) of less than 5,000 pounds (motor vehicles, utility carts, etc.) shall not be included among the total number of EMS agency vehicles in assessing fees under this section.

(5) Privately owned vehicles shall not be included among the total number of EMS agency vehicles in assessing fees under this section.

C. Fee exemptions and reductions.

(1) Any EMS agency seeking certification that can document that it will incur a financial hardship in meeting the fee requirements of this rule may request a fee reduction from the bureau, if either of the following criteria is met:

(a) the service is entirely staffed by volunteer EMS providers; or

(b) the total fees to be paid by the EMS agency pursuant to this rule comprise more than 5% of the EMS agency's annual EMS operational budget.

(2) The bureau may waive or reduce certification fees at its sole discretion. Requested waivers shall be considered by the bureau on a case by case basis.

D. Use of fees. Certification fees collected by the bureau under this rule shall be used expressly to improve the EMS system.

E. Payment of fees. An EMS agency shall submit payment for certification fees along with the agency's application for certification. The EMS agency shall submit payment in a form approved by the bureau. An EMS agency's certification application shall not be processed unless and until full payment of the required fees is made.

[7.27.10.23 NMAC - N, 3/15/2010]

7.27.10.24 ENFORCEMENT:

A. Complaint/incident procedures.

(1) Any person may communicate a written complaint or knowledge of an incident concerning an EMS agency or applicant to the bureau.

(2) Complaints shall be submitted in signed, written form to the bureau as soon as practical.

(3) The bureau shall notify in a timely manner an affected EMS agency or applicant that the bureau is conducting an investigation, unless extenuating circumstances reasonably preclude notification.

B. Investigations. Investigations shall be conducted by the bureau or its agent(s). The bureau shall issue to any person whom it designates as an inspector or investigator credentials to evidence the person's authority that shall bear the person's photograph. The bureau may initiate an investigation if an inspection reveals, or if the bureau otherwise becomes aware of, facts indicating a possible violation of this rule. Upon completion of the investigation, the bureau may pursue further appropriate action.

(1) Preliminary investigations. When the bureau receives information that might form the basis for disciplinary action against an EMS agency or applicant, it may begin a preliminary investigation. A preliminary investigation is a fact-finding/information-gathering investigation that will attempt to determine whether justification exists to initiate an action or to conduct a formal investigation.

(2) Formal investigations. The bureau may undertake a formal investigation for the purpose of obtaining additional information to allow the bureau to determine whether to initiate an action. The bureau shall notify the EMS agency that is the subject of the formal investigation of the pendency of that investigation, unless doing so could substantially impair the bureau’s investigation, or unless other extenuating circumstances exist that would reasonably preclude notification.

(3) Confidentiality. The bureau shall take precautions to ensure that investigations are conducted in a confidential manner.

(4) Records. An official record shall be maintained for every EMS agency certified under this rule. If the bureau begins an investigation, a separate confidential record shall be created containing all investigative material. If the bureau initiates an action, all records not exempt from disclosure under the Inspection of Public Records Act, NMSA 1978, 14-2-1 *et seq*., shall be placed in the EMS agency’s official record. Any request for records maintained by the bureau shall be processed in accordance with the Inspection of Public Records Act.

C. Waivers. The bureau, upon a showing of good cause or extenuating circumstances by an EMS agency, may waive any portion of this rule in whole or in part.

(1) An EMS agency that requests a waiver shall submit written justification to the bureau explaining what good cause or extenuating circumstances exist to grant the waiver. The EMS agency shall include any supporting documentation relevant to the request.

(2) The bureau shall determine whether to grant a requested waiver as soon as practicable. The bureau shall evaluate the request and any pertinent attached

documentation. The bureau may request additional documentation in support of the EMS agency's request as the bureau deems necessary.

(3) Upon determining whether to grant or deny a waiver request, the bureau shall notify the requesting EMS agency of the bureau's decision in writing within twenty calendar days.

D. Disciplinary action; other action. The bureau may take disciplinary action against an EMS agency or applicant, including denial, suspension, or revocation of certification, or imposition of any lesser restriction or condition upon certification, in accordance with the following:

(1) if the bureau takes final disciplinary action against an EMS agency or applicant, the bureau may publish notice of the action in a periodical, internet website, or other medium that has statewide distribution;

(2) the bureau may take immediate action to suspend an EMS agency's certification to prevent the EMS agency from operating in New Mexico if the bureau determines that the health and safety of the public would be jeopardized if it did not take such action; the suspended EMS agency shall be afforded the right to an expedited hearing in accordance with this rule;

(3) the bureau may take disciplinary action against an EMS agency, or may refuse to distribute EMS fund monies to an EMS agency, for any of the following reasons:

(a) knowingly allowing a person to perform emergency medical services in the state of New Mexico when the person is not licensed or otherwise authorized by the department of health to perform emergency medical services;

(b) any instance of inappropriate billing practices, including but not limited to the following:

(i) administering unnecessary treatment or supplies to a patient for the purpose of increasing the patient's bill;

(ii) charging for treatment or supplies not actually provided to a patient; and

(iii) engaging in medicare or medicaid fraud;

(c) financial insolvency of the EMS agency;

(d) fraud, deceit, or misrepresentation by an EMS agency in obtaining certification, including but not limited to misrepresentation during the initial or renewal certification process;

(e) expenditure of EMS fund monies in any manner or for any purpose not authorized by the bureau, or in any manner prohibited by the EMS Fund Act, NMSA 1978, Section 24-10A-1 *et seq.*, or applicable rules (see 7.27.4 NMAC);

(f) loss of federal drug enforcement administration or NM board of pharmacy licensure or failure to notify the bureau of such loss of licensure;

(g) failure to ensure that the EMS agency receives and complies with medical direction that conforms to applicable medical direction guidelines (see 7.27.3 NMAC);

(h) failure to pay required certification fees or to pay an outstanding balance owed to the bureau;

(i) operating as an EMS agency in the state of New Mexico for any period of time without holding valid certification from the bureau, unless the EMS agency previously obtained an applicable waiver from the bureau;

(j) failure to implement reasonable infection control practices, failure to maintain a clean and hygienic work environment, or failure to properly maintain and dispose of biohazard material;

(k) failure to make a required submission to the bureau, including but not limited to the submission of patient run report data;

(l) permitting an individual who is not a student at bureau-approved or CoAEMSP-accredited EMS training program to perform as an intern with the EMS agency;

(m) the conviction of an EMS agency's principals of a felony or a misdemeanor, as shown by a copy of the record of the court conviction;

(n) failure of an EMS agency's principals to notify the bureau upon learning that an EMS provider has been convicted of a felony or misdemeanor while employed by the EMS agency;

(o) failure of an EMS agency to cooperate with a bureau investigation, including but not limited to failure to furnish the bureau with requested information, or failure of agency personnel to appear at an interview as requested;

(p) attempting, either directly or through an agent, to intimidate, threaten, injure or take any adverse action against a person for providing information to the bureau;

(q) conduct on the part of EMS agency personnel that constitutes a significant threat to the health or safety of individuals receiving emergency care;

(r) negligence on the part of EMS agency personnel in the delivery of emergency medical services, including but not limited to the following:

(i) malpractice or substandard medical care or treatment;

(ii) incompetence;

(iii) abandonment;

(iv) practicing without a valid NM EMT license; or performing outside an applicable standard of care/scope of practice;

(v) failure to retain, transport or use required equipment, or inappropriate use of equipment during treatment or transport of patients; or

(vi) unauthorized disclosure of medical or other confidential information;

(s) unprofessional conduct on the part of EMS agency personnel, including but not limited to the following:

(i) dissemination of a patient's health information to individuals not entitled to such information where such information is protected by law from disclosure;

(ii) falsification or alteration of patient records or EMS agency records;

(iii) misappropriation of money, drugs or property;

(iv) obtaining or attempting to obtain any fee for patient services for one's self or for another through fraud, misrepresentation, or deceit;

(v) aiding, abetting, assisting or hiring an individual to violate the EMS Act or these duly promulgated rules;

(vi) failure to follow established procedure and documentation regarding controlled substances;

(vii) failure to make or keep accurate, intelligible entries in records as required by law, policy and standards for the practice of pre-hospital emergency care;

(viii) failure to report an EMT who is suspected of violating the New Mexico EMS Act (NMSA 1978, Section 24-10B-4) or New Mexico licensing rules for EMS personnel (7.27.2 NMAC);

(ix) intentionally engaging in sexual contact with or toward a patient;

(t) failure of EMS agency personnel to report revocation, suspension, denial, or other adverse action relating to a license, permit, designation or certification taken in any other state or jurisdiction affecting the ability to provide emergency medical services in that state;

(u) the making of any false, fraudulent, or deceptive statement by EMS agency personnel in any document connected with EMS agency operations;

(v) the dispensation, administration, or distribution of any controlled substance (as defined in the New Mexico Controlled Substances Act, NMSA 1978, Section 30-31-1 *et seq.*, other than a controlled substance authorized in an applicable scope of practice, by EMS agency personnel;

(w)willful and deliberate failure of EMS agency personnel to respond to a call;

(x) willful and deliberate failure of EMS agency personnel to transport a patient when required;

(y) except as otherwise provided in this rule, failure of EMS agency personnel to deliver a patient to the most appropriate medical facility as determined by the medical director, dependent upon the patient's medical needs; and

(z) failure to comply with any requirement of this rule;

(4) denial of certification for failure to properly apply or failure to pay a required fee shall not constitute a disciplinary action for purposes of this section, and shall not entitle an applicant to a hearing;

(5) the bureau's refusal to distribute EMS fund monies to an EMS agency shall not constitute a "disciplinary action" for purposes of this section, and an EMS agency that is refused a distribution of EMS fund monies shall not be entitled to a hearing under this section; an EMS agency may appeal the bureau's determination to refuse a distribution of EMS fund monies by following the appeal provisions of the EMS Fund Act rule, 7.27.4 NMAC.

E. Records management. A certification record is maintained for every certified EMS agency in New Mexico; any request for records maintained by the bureau shall be processed in accordance with the Inspection of Public Records Act, NMSA 1978, Section 14-2-1 *et seq.*

(1) Confidentiality of investigations. The bureau shall take every precaution to ensure that preliminary and formal investigations are conducted in a confidential manner. If the bureau initiates an action, all records not exempt from disclosure under the Inspection of Public Records Act, NMSA 1978, Section 14-2-1 *et seq*., shall be placed in the EMS agency's certification record, if one exists.

(2) Records confidentiality. Any files or records in the possession of the bureau, a regional office or a provider containing identifying information about individuals requesting or receiving treatment or other health services and any unsubstantiated complaints received by the bureau regarding any provider shall be confidential and not subject to public inspection; such files, records and complaints may be subject to subpoena for use in any pending cause, in any administrative proceeding, or in any of the courts of this state, unless otherwise provided by state or federal law.

F. Notice of contemplated action. When the bureau contemplates taking disciplinary action against an EMS agency or applicant, it shall serve upon the EMS agency or applicant a written notice containing a statement of the grounds or subject upon which the proposed action is based and identifying any rule(s) violated.

G. Injunctions. The department may apply to a district court of New Mexico to enjoin an EMS agency from engaging in business in the state.

[7.27.10.24 NMAC - N, 3/15/2010]

7.27.10.25 HEARINGS:

A. Right to appeal. An EMS agency or applicant may appeal a decision by the department to take a disciplinary action against the EMS agency or applicant under this rule.

B. Right to hearing. An EMS agency or applicant may request a hearing before a hearing officer appointed by the secretary to contest a proposed action or immediate suspension under this rule, by mailing a certified letter, return receipt requested, to the bureau within twenty days after service of the notice of the contemplated action or immediate suspension.

C. Scheduling the hearing.

(1) Appointment of hearing officer. Upon the bureau's receipt of a timely request for a hearing, the department shall appoint a hearing officer and schedule a hearing.

(2) Hearing date. The hearing shall be held not more than sixty days and not less than fifteen days from the date of service of the notice of hearing. **Exception for immediate suspensions:** in the event that the bureau immediately suspends an EMS agency's certification, the department shall afford the suspended EMS agency an expedited hearing within twenty days of the bureau's timely receipt of the EMS agency's request for a hearing, unless the suspended EMS agency waives this provision.

(3) Notice of hearing. The department shall notify the EMS agency or applicant of the date, time, and place of the hearing and the identity of the hearing officer within twenty days of the bureau's timely receipt of the request for hearing.

Exception for immediate suspensions: in the event that the bureau immediately suspends an EMS agency's certification, the department shall notify the suspended EMS agency of the expedited hearing not less than seven days prior to the scheduled date of the expedited hearing.

(4) Hearing venue. The hearing shall be held in Santa Fe, New Mexico.

D. Method of service. Any notice or decision required to be served under this section may be served either personally or by certified mail, return receipt requested, directed to the EMS agency or applicant at the last known mailing address (or, if service is made personally, by the last known physical address) shown by the records of the bureau. If the notice or decision is served personally, service shall be made in the same manner allowed by the rules of civil procedure for the state district courts of New Mexico. Where the notice or decision is served by certified mail, it shall be deemed to have been served on the date borne by the return receipt showing delivery, or the date of the last attempted delivery of the notice or decision, or the date of the addressee's refusal to accept delivery.

E. Excusal of hearing officer for good cause shown. A party may request that a hearing officer be excused for good cause by submitting to the secretary a motion of excusal for good cause at least twenty days prior to the date of the hearing, or at least five days prior to an expedited hearing concerning the immediate suspension of an EMS agency's certification.

F. Hearing officer duties. The hearing officer shall conduct the hearing, rule on any motions or other matters that arise prior to the hearing, and issue a written report and recommendation(s) to the secretary following the close of the hearing.

G. Official file. Upon appointment, the hearing officer shall establish an official file which shall contain all notices, hearing requests, pleadings, motions, written stipulations, evidence, briefs, and correspondence received in the case. The official file shall also contain proffered items not admitted into evidence, which shall be so identified and shall be separately maintained. Upon conclusion of the proceeding and following issuance of the final decision, the hearing officer shall tender the complete official file to the department for its retention as an official record of the proceedings.

H. Powers of hearing officer. The hearing officer shall have all the powers necessary to conduct a hearing and to take all necessary action to avoid delay, maintain order, and assure development of a clear and complete record, including but not limited to the power to: administer oaths or affirmations; schedule continuances; direct discovery; examine witnesses and direct witnesses to testify; limit repetitious and cumulative testimony; set reasonable limits on the amount of time a witness may testify; decide objections to the admissibility of evidence or receive the evidence subject to later ruling; receive offers of proof for the record; direct parties to appear and confer for the settlement or simplification of issues, and otherwise conduct pre-hearing conferences; take notice of judicially cognizable facts or take notice of general, technical or scientific

facts within the hearing officer's specialized knowledge (provided that the hearing officer notifies the parties beforehand and offers the parties an opportunity to contest the fact so noticed); dispose of procedural requests or similar matters; and enter proposed findings of fact and conclusions of law, orders, reports and recommendations. The hearing officer may utilize his or her experience, technical competence or specialized knowledge in the evaluation of evidence presented.

I. Minimum discovery; inspection and copying of documents. Upon written request to another party, any party shall have access to documents in the possession of the other party that are relevant to the subject matter of the appeal, except confidential or privileged documents.

J. Minimum discovery; witnesses. The parties shall each disclose to each other and to the hearing officer, either orally or in writing, the names of witnesses to be called, together with a brief summary of the testimony of each witness. In situations where written statements will be offered into evidence in lieu of a witness's oral testimony, the names of the persons making the statements and a brief summary of the statements shall be disclosed.

K. Additional discovery. At the hearing officer's discretion, upon a written request by a party that explains why additional discovery is needed, further discovery in the form of production and review of documents and other tangible things, interviews, depositions or written interrogatories may be ordered. In exercising his authority to determine whether further discovery is necessary or desirable, the hearing officer should consider whether the complexity of fact or law reasonably requires further discovery to ensure a fair opportunity to prepare for the hearing, and whether such request will result in unnecessary hardship, cost, or delay in holding the hearing. Depositions shall not be allowed, except by order of the hearing officer upon a showing that the deposition is necessary to preserve the testimony of persons who are sick or elderly, or who will not be able to attend the hearing.

L. Pre-hearing disposition. The subject matter of any hearing may be disposed of by stipulation, settlement or consent order, unless otherwise precluded by law. Any stipulation, settlement or consent order reached between the parties shall be written and shall be signed by the hearing officer and the parties or their attorneys.

M. Postponement or continuance. The hearing officer, at his or her discretion, may postpone or continue a hearing upon his or her own motion, or upon the motion of a party, for good cause shown. Notice of any postponement or continuance shall be given in person, by telephone, or by mail to all parties within a reasonable time in advance of the previously scheduled hearing date.

N. Conduct of hearing. Pursuant to the NM Open Meetings Act, NMSA 1978, Section 10-15-1 *et seq.*, hearings shall be open to the public; provided, however, that hearings may be closed in part to prevent the disclosure of confidential information, including but not limited to health information protected by state and federal laws.

O. Telephonic testimony. Upon timely notice to the opposing party and the hearing officer, and with the approval of the hearing officer, the parties may present witnesses by telephone or live video (if available).

P. Legal representation. The department and EMS agencies or applicants may appear by an officer or employee, or may be represented by an attorney licensed to practice in New Mexico.

Q. Recording. The hearing officer or a designee shall record the hearing by means of a mechanical sound recording device provided by the department for a record of the hearing. Such recording need not be transcribed, unless requested by a party who shall arrange and pay for the transcription.

R. Burden of proof. The department has the burden of proving by a preponderance of the evidence the basis for the proposed action. **Exception:** in cases arising from the proposed denial of initial certification, the applicant for initial certification shall bear the initial burden of proving by a preponderance of the evidence that the application was improperly denied by the department and should be approved.

S. Order of presentation; general rule. Except as provided in an exception in this rule, the order of presentation for hearings in all cases shall be:

(1) appearances: opening of proceeding and taking of appearances by the hearing officer;

(2) pending matters: disposition by the hearing officer of preliminary and pending matters;

(3) opening statements: the opening statement of the department; and then the opening statement of the party challenging the department's action or proposed action;

(4) cases: the department's case-in-chief, and then the case-in-chief of the party challenging the department's action;

(5) rebuttal: the department's case-in-rebuttal;

(6) closing argument: the department's closing statement, which may include legal argument; and then the closing statement of the party opposing the department’s action or proposed action, which may include legal argument; and

(7) close: close of proceedings by the hearing officer.

T. Order of presentation in initial certification cases. The order of presentation in cases arising from the proposed denial of initial certification shall be:

(1) appearances: opening of proceeding and taking of appearances by the hearing officer;

(2) pending matters: disposition by the hearing officer of preliminary and pending matters;

(3) opening statements: applicant's opening statement; and then the opening statement of the department;

(4) cases: the applicant's case-in-chief, and then the department's case-in-chief;

(5) rebuttal: the applicant's case-in-rebuttal.

U. Closing argument. The applicant's closing statement, which may include legal argument; and then the department's closing statement, which may include legal argument.

V. Close. Close of proceedings by the hearing officer.

W. Admissible evidence; rules of evidence not applicable. The hearing officer may admit any evidence and may give probative effect to evidence that is of a kind commonly relied on by reasonably prudent persons in the conduct of serious affairs. Rules of evidence, such as the New Mexico rules of evidence for the district courts, shall not apply but may be considered in determining the weight to be given any item of evidence. The hearing officer may at his or her discretion, upon his or her motion or the motion of a party or a party's representative, exclude incompetent, irrelevant, immaterial or unduly repetitious evidence, including testimony, and may exclude confidential or privileged evidence.

X. Objections. A party may timely object to evidentiary offers by stating the objection together with a succinct statement of the grounds for the objection. The hearing officer may rule on the admissibility of evidence at the time an objection is made or may receive the evidence subject to later ruling.

Y. Official notice. The hearing officer may take notice of any facts of which judicial notice may be taken, and may take notice of general, technical or scientific facts within his or her specialized knowledge. When the hearing officer takes notice of a fact, the parties shall be notified either before or during the hearing of the fact so noticed and its source, and the parties shall be afforded an opportunity to contest the fact so noticed.

Z. Record content. The record of a hearing shall include all documents contained in the official file maintained by the hearing officer, including all evidence received during the course of the hearing, proposed findings of fact and conclusions of law, the recommendations of the hearing officer, and the final decision of the secretary.

AA. Written evidence from witnesses. The hearing officer may admit evidence in the form of a written statement made by a witness, when doing so will serve to expedite the hearing and will not substantially prejudice the interests of the parties.

BB. Failure to appear. If a party who has requested a hearing or a party's representative fails to appear on the date, time or location announced for a hearing, and if no continuance was previously granted, the hearing officer may proceed to hear the evidence of such witnesses as may have appeared or may accept offers of proof regarding anticipated testimony and other evidence, and the hearing officer may further proceed to consider the matter and issue his report and recommendation(s) based on the evidence presented; and the secretary may subsequently render a final decision. Where a person fails to appear at a hearing because of accident, sickness or other cause, the person may within a reasonable time apply to the hearing officer to reopen the proceeding, and the hearing officer may, upon finding sufficient cause, fix a time and place for a hearing and give notice to the parties.

CC. Hearing officer written report and recommendation(s). The hearing officer shall submit a written report and recommendation(s) to the secretary that contains a statement of the issues raised at the hearing, proposed findings of fact and conclusions of law, and a recommended determination. Proposed findings of fact shall be based upon the evidence presented at the hearing or known to all parties, including matters officially noticed by the hearing officer. The hearing officer's recommended decision is a recommendation to the secretary of the New Mexico department of health and is not a final order.

DD. Submission for final decision. The hearing officer's report and recommendation(s) shall be submitted together with the complete official file to the secretary of the New Mexico department of health for a final decision no later than thirty days after the hearing.

EE. Secretary's final decision. The secretary shall render a final decision within forty-five calendar days of the receipt of the hearing officer's written report. A copy of the final decision shall be mailed to the appealing party by certified mail, return receipt requested, within fifteen days after the final decision is rendered and signed. A copy shall be provided to legal counsel for the bureau. **Exception for immediate suspensions:** In the event that the EMS agency's certification has been immediately suspended, the secretary shall render a final decision within ten business days of the receipt of the hearing officer's written report, and a copy of the final decision shall be mailed to the appealing party by certified mail, return receipt requested, within five business days after the final decision is rendered and signed.

FF.Right to judicial review. Pursuant to NMSA 1978, Section 39-3-1.1, an EMS agency or applicant that is entitled to a hearing under this rule and that is aggrieved by an adverse final decision may obtain a judicial review of the decision by filing in state district court a notice of appeal within thirty days of the rendition and signing of the final decision by the secretary.

GG. Court-ordered stay. Filing for judicial review shall not itself stay enforcement of the final decision. Any party may petition the court whose jurisdiction has been properly invoked for an order staying enforcement.

[7.27.10.25 NMAC - N, 3/15/2010]

PART 11: SUPPLEMENTAL LICENSING PROVISIONS

7.27.11.1 ISSUING AGENCY:

New Mexico Department of Health (DOH), Epidemiology and Response Division (ERD), Emergency Medical Systems Bureau (EMSB).

[7.27.11.1 NMAC - Rp, 7.27.11.1 NMAC, 12/12/2017]

7.27.11.2 SCOPE:

These rules apply to New Mexico emergency medical services, including the service directors and medical directors of those services; approved New Mexico emergency medical service (EMS) training programs and graduates of approved New Mexico EMS training programs; New Mexico licensed EMS personnel including those previously licensed; persons trained, certified or licensed in another state or territory, or certified by the national registry of emergency medical technicians, seeking to acquire licensure in New Mexico; EMS licensing commission; and any other entity associated with the licensing of emergency medical services personnel in New Mexico. In the event of a public health emergency that stresses the emergency medical service system and disrupts delivery of medical services, the New Mexico department of health, working with the emergency medical systems bureau, may limit or expand these rules, and may institute certain crisis standards of care, through emergency rulemaking.

[7.27.11.2 NMAC - Rp, 7.27.11.2 NMAC, 12/12/2017]

7.27.11.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: 1) the New Mexico Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to "make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions," and; 2) the Emergency Medical Services Act, NMSA 1978, Section 24-10B-4 ("bureau; duties").

[7.27.11.3 NMAC - Rp, 7.27.11.3 NMAC, 12/12/2017]

7.27.11.4 DURATION:

Permanent.

[7.27.11.4 NMAC - Rp, 7.27.11.4 NMAC, 12/12/2017]

7.27.11.5 EFFECTIVE DATE:

December 12, 2017, unless a later date is cited at the end of a section.

[7.27.11.5 NMAC - Rp, 7.27.11.5 NMAC, 12/12/2017]

7.27.11.6 OBJECTIVE:

These rules are intended to supplement the emergency medical services licensure requirements for emergency medical services personnel, to provide supplemental and additional standards for the licensure of emergency medical dispatchers, emergency medical dispatch-instructors, emergency medical services first responders and emergency medical technicians, and to assist in the provision of a comprehensive system of emergency medical services in the state of New Mexico.

[7.27.11.6 NMAC - Rp, 7.27.11.6 NMAC, 12/12/2017]

7.27.11.7 DEFINITIONS:

[Refer to 7.27.2.7 NMAC]

7.27.11.8 SCOPES OF PRACTICE FOR LICENSED EMERGENCY MEDICAL SERVICES PERSONNEL:

A. Medical director means a physician functioning as the service EMS medical director as defined and described in 7.27.3 NMAC, medical direction for emergency medical services. Medical control means supervision provided by or under the direction of a physician.

B. Prior to approving a new skill, technique, medication, or procedure, it shall be documented by the service director, medical director, or approved EMS training institution that the EMS provider has been appropriately trained to perform those new skills, techniques, medications, or procedures.

C. Service medical director approved: All service medical director approved skills, techniques, medications, or procedures are considered advanced life support. Prior to utilizing any skill, technique, medication or procedure designated as service medical director approved, it shall be documented by the service director, medical director, or approved EMS training institution that the EMS provider has been appropriately trained to administer the medications or perform the skills, techniques, medications or procedures. Additionally, each EMS provider must have a signed authorization from the service’s medical director on file at the EMS service’s headquarters or administrative offices.

D. Any device in an EMS agency's treatment guideline/protocol designed and utilized to facilitate successful completion of a skill or other treatment modality, including but not limited to cardiopulmonary resuscitation (CPR) devices, intraosseous placement devices, and positive pressure ventilation devices, must be approved by the service medical director.

E. Wilderness protocols: The following skills shall only be used by providers who have a current
wilderness certification from a bureau approved wilderness caregiver course, who are functioning in a wilderness environment as a wilderness provider (an environment in which time to a hospital is expected to exceed two hours, except in the case of an anaphylactic reaction, in which no minimum transport time is required), and are authorized by their medical director to provide the treatment:

(1) minor wound cleaning and management;

(2) cessation of CPR;

(3) field clearance of the cervical-spine;

(4) reduction of dislocations resulting from indirect force of the patella, digit, and anterior shoulder.

F. Community emergency medical services programs: Community EMS programs shall be provided by EMS caregivers who, after completing a bureau approved community EMS caregiver course, are functioning as part of a community emergency medical services program that has been reviewed and approved by the EMS bureau. The providers must be authorized by their medical director to perform the skills listed in their application as part of the community EMS program. These programs may include referrals that involve transport to non-hospital locations, and for non-transport decisions. Skills and interventions may include any of the approved skills and interventions for the appropriate level; any skill that exceeds the scope of practice must be approved through the special skill process. Skills may include, but are not limited to:

(1) education of patients in self-medication administration, and assessment of compliance with physician recommendations for health conditions;

(2) assessments for preventing falls and other sources of injury by identifying risks in patient homes;

(3) provide education on disease prevention;

(4) administering immunizations;

(5) in collaboration with a healthcare team, assist in developing a care plan, and educate the patient in following the care plan;

(6) perform in home patient assessments commensurate with level of education and licensure in order to provide information to a care team as to the progress or condition of a patient receiving therapies for medical conditions;

(7) provide assistance in locating and contacting appropriate providers of needed social services;

(8) treat discovered acute healthcare issues, transporting to emergency department if necessary;

(9) for chronic and non-acute issues, confirmed with online medical direction and agreed to by the patient, options other than EMS transport may be considered, including:

(a) arrange for non-emergent and non-EMS transportation to and care at an appropriate facility, such as a physician's office or urgent care center;

(b) provide referral information and arrange for follow up by appropriate care team members or social service personnel.

(10) assist with ongoing prescribed wound care.

G. Critical Care Transport services skills: Paramedic critical care transport skills shall be used only by paramedic providers who have successfully completed a bureau approved critical care transport paramedic or critical care flight paramedic course. Subsequent to completing the approved course, the critical care paramedic must successfully complete a bureau administered or approved third party exam within one year. Additionally, the paramedics shall be functioning as part of a ground or air EMS agency with an approved critical care transport special skill and authorized by the agency medical director to utilize these skills. Critical care transport program skills are only authorized for use during inter-facility critical care transport activities, with the exception of air ambulance agencies providing emergency scene response; or ground critical care agencies requested to a scene by the local authorized and certified 911 response and transport agencies. Critical care transport special skills and medications that may be administered include, but are not limited to any of the below skills and medications; service specific skills and medication requests must be listed on the EMS agency critical care transport special skill application completed per 7.27.11.10 NMAC:

(1) monitoring of infusions including but not limited to anti-arrhythmics, nitrates, vasopressors, blood products, thrombolytics, sedation, pain management and antihypertensive medications that have required titration within the past two hours and may need to have their dosages adjusted during transport;

(2) performance of skills not listed in the paramedic scope of practice, such as but not limited to escharotomy, fasciotomy, insertion of chest tubes, pericardiocentesis, blood administration, and nerve blocks; administration of medications, initiation of

infusions, and utilization of routes, not listed on the paramedic scope but requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau;

(3) utilization of advanced patient monitoring, such as invasive hemodynamic monitoring via monitoring of central venous pressure, pulmonary artery pressure, intracranial pressure monitoring, Swan-Ganz catheters, arterial lines, fetal monitoring, point of care lab values, and other monitoring or tests not listed in the paramedic scope, but requested in the EMS agency's special skill application and approved by the medical direction committee and EMS Bureau;

(4) utilization of intensive care unit (ICU) level ventilator support, to include ventilators delivering positive end expiratory pressure, with multiple adjustable mode and setting parameters that include inspiratory plateau pressures, pressure regulated volume control, pressure support ventilation, pressure control ventilation, airway pressure release ventilation and others; also, any ventilator delivering a mixture of nitric oxide or other beneficial gas mixtures;

(5) transport of patients with intra-aortic balloon pump, temporary internal cardiac pacing, left ventricular assist device or a bi-ventricular assist device and other appropriate devices to address hemodynamic instability as requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau;

(6) administer paralytics and sedatives to maintain airway control previously initiated, and administer and perform rapid sequence airway pharmacology and techniques in order to secure an airway in response to patient condition, as requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau;

(7) pediatric intubation or endotracheal tube management as requested in the EMS agency's special skill application and approved by the medical direction committee and EMS bureau.

H. Utilization of pharmacological agents for the primary purpose of sedation, induction, or muscle relaxation to facilitate placement of an advanced airway requires medical direction committee special skills approval.

I. Over the counter (OTC) medications and products: A physician medical director may approve a list of over the counter (OTC) medications and products (i.e. NSAID's, antihistamines, anti-diarrheal**,** laxatives, antacids, vitamin supplements, hygiene products and other products) for distribution by an EMS caregiver working under medical direction to a requesting individual during scheduled stand-by situations. Examples are long-term wildfire responses, public events (concerts, rodeos, etc), various industry situations such as movie production and ski patrol, long-term

construction & manufacturing projects, long-term search and rescue or tactical operations, and other situations where scheduled stand-by EMS is provided.

(1) The OTC medication/product must be properly labeled in individual dose packaging when distributed to the patient. Distribution from a bulk or multi-dose container is not permitted by this scope of practice, as well as other state and federal laws and regulations; medications will be distributed per manufacturer recommendations and labeling directions.

(2) The agency/EMS caregiver will maintain a written guideline that contains the list of physician approved OTC medications/products and the conditions for which they may be distributed. Specific dosing information and indications for pediatric patients must be included.

(3) The EMS agency/EMS caregiver must develop a method of documentation for the appropriate distribution of the OTC medications/products. This documentation shall include the OTC medication documentation and appropriate patient care report, per 7.27.10.12 NMAC (records and data collection) and 7.27.11.11 NMAC. Public regulation commission (PRC) certified ambulance agencies shall complete patient care documentation per 18.3.14.24 NMAC.

(4) OTC medications/products are distributed for the patient's self-administration and use. EMS caregivers will not administer OTC medications/products, unless approved elsewhere in the scope of practice for specific EMS patient care situations.

J. Licensed emergency medical dispatcher: (EMD).

(1) Medical direction is required for all items in the EMD scope of practice.

(2) The following allowable skills may be performed by EMDs who are licensed by the EMS bureau and functioning with an EMS bureau certified New Mexico emergency medical dispatch agency utilizing protocols and any EMD priority reference system approved by the EMS bureau and service medical director.

(a) Process calls for medical assistance in a standardized manner, eliciting required information for evaluating, advising, and treating sick or injured individuals, and dispatching an appropriate EMS response.

(b) Provide pre-arrival instructions to the patient through the caller when possible and appropriate to do so while functioning in compliance with an emergency medical dispatch priority reference system (EMDPRS).

K. EMS first responders (EMSFR):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

(a) basic airway management;

(b) use of basic adjunctive airway equipment;

(c) suctioning;

(d) cardiopulmonary resuscitation, according to current ECC guidelines;

(e) obstructed airway management;

(f) bleeding control via direct pressure and appropriate tourniquet use;

(g) spine immobilization;

(h) splinting (does not include femoral traction splinting);

(i) scene assessment, triage, scene safety;

(j) use of statewide EMS communications system;

(k) emergency childbirth;

(l) glucometry;

(m) oxygen;

(n) other non-invasive procedures as taught in first responder courses adhering to United States Department of Transportation curricula.

(2) The following require service medical director approval:

(a) allowable skills:

(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO2, and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);

(ii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;

(iii) hemostatic dressings for control of bleeding;

(iv) insertion of laryngeal and supraglottic airway devices (examples: king airway, LMA), excluding multi-lumen airways).

(b) administration of approved medications via the following routes:

(i) nebulized inhalation;

(ii) nasal mucosal atomization (MA);

(iii) intramuscular;

(iv) oral (PO).

(c) allowable drugs:

(i) oral glucose preparations;

(ii) aspirin PO for adults with suspected cardiac chest pain;

(iii) atropine and pralidoxime via IM auto-injection for treatment of chemical or nerve agent exposure;

(iv) albuterol (including isomers) via inhaled administration;

(v) naloxone via nasal mucosal atomizer;

(vi) epinephrine via auto-injection device.

(d) patient's own medication that may be administered:

(i) bronchodilators using pre-measured or metered dose inhalation device;

(ii) naloxone, if provided with a nasal MA or IM delivery system.

L. EMT-BASIC (EMT-B):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

(a) basic airway management;

(b) use of basic adjunctive airway equipment;

(c) suctioning;

(d) cardiopulmonary resuscitation, according to current ECC guidelines;

(e) obstructed airway management;

(f) bleeding control to include appropriate tourniquet usage;

(g) spine immobilization;

(h) splinting;

(i) scene assessment, triage, scene safety;

(j) use of statewide EMS communications system;

(k) childbirth (imminent delivery);

(l) glucometry;

(m) oxygen;

(n) other non-invasive procedures as taught in EMT-B courses adhering to DOT curricula;

(o) wound management.

(2) The following require service medical director approval:

(a) allowable skills:

(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, fraction of inspired oxygen (FiO_2) and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);

(ii) use of multi-lumen, supraglottic, and laryngeal airway devices (examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;

(iii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;

(iv) acupressure;

(v) transport of patients with nasogastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or vascular access devices intended for outpatient use;

(vi) performing point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;

(vii) hemostatic dressings for control of bleeding.

(b) administration of approved medications via the following routes:

(i) nebulized inhalation;

(ii) subcutaneous;

(iii) intramuscular;

(iv) nasal mucosal atomization (MA);

(v) oral (PO);

(vi) intradermal.

(c) allowable drugs:

(i) oral glucose preparations;

(ii) aspirin PO for adults with suspected cardiac chest pain;

(iii) activated charcoal PO;

(iv) acetaminophen PO in pediatric patients with fever;

(v) atropine and pralidoxime via IM autoinjection for treatment of chemical or nerve agent exposure.

(vi) albuterol (including isomers), via inhaled administration;

(vii) ibuprofen PO in pediatric or adults to treat fever or pain;

(viii) ipratropium, via inhaled administration, in combination with or after albuterol administration;

(ix) naloxone by SQ, IM, or IN route;

(x) epinephrine, 1:1000, no single dose greater than 0.3 ml, subcutaneous or intramuscular injection with a pre-measured syringe (including autoinjector) or 0.3 ml TB syringe for anaphylaxis or status asthmaticus refractory to other treatments.

(d) patient's own medication that may be administered:

(i) bronchodilators using pre-measured or metered dose inhalation device;

(ii) sublingual nitroglycerin for unrelieved chest pain, with on line medical control only;

(iii) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, and administer the patient's prescribed medications where appropriate only if the medication is in the EMS provider's scope of practice; EMS services are not expected to provide the prescribed medications for these special needs patients.

(3) Immunizations and biologicals: Administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:

(a) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;

(b) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;

(c) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of pharmaceuticals or tests not listed above.

M. EMT-INTERMEDIATE (EMT-I):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

(a) basic airway management;

(b) use of basic adjunctive airway equipment;

(c) suctioning;

(d) cardiopulmonary resuscitation, according to ECC guidelines;

(e) obstructed airway management;

(f) bleeding control including appropriate use of tourniquet;

(g) spine immobilization;

(h) splinting;

(i) scene assessment, triage, scene safety;

(j) use of statewide EMS communications system;

(k) childbirth (imminent delivery);

(l) glucometry;

(m) oxygen;

(n) wound management.

(2) The following require service medical director approval:

(a) allowable skills:

(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO_2, and pressure relief/alarm and does not have multiple automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation via continuous positive airway pressure (CPAP);

(ii) use of multi-lumen, supraglottic, and laryngeal airway devices (examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;

(iii) application and use of semi-automatic defibrillators, including cardiac rhythm acquisition for ALS caregiver interpretation or transmission to a care facility; this includes multi-lead documentation;

(iv) acupressure;

(v) transport of patients with nasogastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or vascular access devices intended for outpatient use;

(vi) peripheral venous puncture/access;

(vii) blood drawing;

(viii) pediatric intraosseous tibial access;

(ix) adult intraosseous access;

(x) point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;

(xi) hemostatic dressings for control of bleeding.

(b) administration of approved medications via the following routes:

(i) intravenous;

(ii) nasal mucosal atomization (MA);

(iii) nebulized inhalation;

(iv) sublingual;

(v) intradermal;

(vi) intraosseous;

(vii) endotracheal (for administration of epinephrine only, under the direct supervision of an EMT-paramedic, or if the EMS service has an approved special skill for endotracheal intubation);

(viii) oral (PO);

(ix) intramuscular;

(x) subcutaneous.

(c) allowable drugs:

(i) oral glucose preparations;

(ii) aspirin PO for adults with suspected cardiac chest pain;

(iii) activated charcoal PO;

(iv) acetaminophen PO in pediatric patients with fever;

(v) ibuprofen PO to pediatrics and adults for pain or fever; IV or IM with online medical direction only.

(vi) IM autoinjection of the following agents for treatment of chemical or nerve agent exposure: atropine, pralidoxime;

(vii) albuterol (including isomers) via inhaled administration;

(viii) ipratropium, via inhaled administration in combination with or after albuterol administration;

(ix) naloxone;

(x) I.V. fluid therapy (except blood or blood products);

(xi) dextrose;

(xii) epinephrine (1:1000), SQ or IM (including autoinjector) for anaphylaxis and known asthmatics in severe respiratory distress (no single dose greater than 0.3 cc);

(xiii) epinephrine (1:10,000) in pulseless cardiac arrest for both adult and pediatric patients; epinephrine may be administered via the endotracheal tube in accordance with most current ACLS and PALS guidelines;

(xiv) nitroglycerin (sublingual); must have intravenous access established prior to administration or approval of online medical control if IV access is unavailable;

(xv) morphine, fentanyl, or dilaudid for use in pain control with approval of on-line medical control;

(xvi) diphenhydramine for allergic reactions or dystonic reactions;

(xvii) glucagon, to treat hypoglycemia in diabetic patients when intravenous access is not obtainable;

(xviii) anti-emetic agents, for use as an anti-emetic only;

(xix) corticosteroids for respiratory illness or allergic reaction;

(xx) hydroxycobalamine;

(xxi) lidocaine two percent, preservative and epinephrine free for IV use) for administration into the intraosseous space on pain responsive adult patients while receiving intraosseous fluids or medications.

(d) patient's own medication that may be administered:

(i) bronchodilators using pre-measured or metered dose inhalation device;

(ii) sublingual nitroglycerin for unrelieved chest pain; must have intravenous access established prior to administration or approval of online medical control if IV access is unavailable;

(iii) glucagon;

(iv) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, IV access, and the administration of the patient's prescribed medications where appropriate only if the medication is in the EMS provider's scope of practice; online (direct contact) medical control communication must be established with the medical control physician approving the intervention; EMS services are not expected to provide the prescribed medications for these special needs patients.

(e) drugs allowed for monitoring during interfacility transport:

(i) potassium; intermediate EMT's may monitor IV solutions that contain potassium during transport (not to exceed 20 mEq/1000cc or more than 10 mEq/hour);

(ii) antibiotics and other anti-infectives utilizing an infusion pump; intermediate EMT's may monitor antibiotic or other anti-infective agents, provided a hospital initiated infusion has been running for a minimum of 30 minutes prior to the intermediate initiating the transfer, and the intermediate EMT is aware of reactions for which to monitor and the appropriate action to take before assuming responsibility for patient care.

(f) immunizations and biologicals: administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:

(i) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;

(ii) administer vaccines to EMS and public safety personnel;

(iii) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;

(iv) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of pharmaceuticals or tests not listed above.

N. EMT-PARAMEDIC (EMT-P):

(1) The following allowed drugs may be administered and skills and procedures may be performed without medical direction:

(a) basic airway management;

(b) use of basic adjunctive airway equipment;

(c) suctioning;

(d) cardiopulmonary resuscitation, according to current ECC guidelines;

(e) obstructed airway management;

(f) bleeding control including the appropriate use of tourniquet;

(g) spine immobilization;

(h) splinting;

(i) scene assessment, triage, scene safety;

(j) use of statewide EMS communications system;

(k) childbirth (imminent delivery);

(l) glucometry;

(m) oxygen;

(n) wound management.

(2) The following require service medical director approval:

(a) allowable skills:

(i) mechanical positive pressure ventilation utilizing a device that may have controls for rate, tidal volume, FiO_2, and pressure relief/alarm and has multiple

automatic ventilation modes; this skill includes devices that provide non-invasive positive pressure ventilation (including continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP);

(ii) use of multi-lumen, supraglottic, and laryngeal airway devices (examples: PTLA, combi-tube, king airway, LMA) to include gastric suctioning;

(iii) transport of patients with nasogastric tubes, urinary catheters, heparin/saline locks, PEG tubes, or vascular access devices intended for outpatient use;

(iv) application and use of semi-automatic defibrillators;

(v) acupressure;

(vi) peripheral venous puncture/access;

(vii) blood drawing;

(viii) I.V. fluid therapy;

(ix) direct laryngoscopy for endotracheal intubation and removal of foreign body in patients 13 and older; for patients 12 and under, for removal of foreign body only;

(x) endotracheal intubation for patients over the age of 12;

(xi) thoracic decompression (needle thoracostomy);

(xii) surgical cricothyroidotomy;

(xiii) insertion of nasogastric tubes;

(xiv) cardioversion and manual defibrillation;

(xv) external cardiac pacing;

(xvi) cardiac monitoring;

(xvii) use of infusion pumps;

(xviii) initiation of blood and blood products with on-line medical control;

(xix) intraosseous access;

(xx) performing point of care testing; examples include serum lactate values, cardiac enzymes, electrolytes, and other diagnostic values;

(xxi) hemostatic dressings for control of bleeding;

(xxii) vagal maneuvers.

(b) administration of approved medications via the following routes:

(i) intravenous;

(ii) nasal mucosal atomization (MA);

(iii) nebulized inhalation;

(iv) sublingual;

(v) intradermal;

(vi) intraosseous;

(vii) endotracheal;

(viii) oral (PO);

(ix) intramuscular;

(x) topical;

(xi) rectal;

(xii) IV drip;

(xiii) subcutaneous.

(c) allowable drugs:

(i) acetaminophen;

(ii) activated charcoal;

(iii) adenosine;

(iv) albuterol (including isomers);

(v) amiodarone;

(vi) aspirin;

(vii) atropine sulfate;

(viii) benzodiazepines;

(ix) calcium preparations;

(x) corticosteroids;

(xi) dextrose;

(xiii) diphenhydramine;

(xiv) epinephrine;

(xv) furosemide;

(xvi) glucagon;

(xvii) hydroxycobalamine;

(xviii) ipratropium;

(xix) lidocaine;

(xx) magnesium sulfate;

(xxi) naloxone;

(xxii) narcotic analgesics;

(xxiii) nitroglycerin;

(xxiv) nonsteroidal anti-inflammatory drugs (NSAIDS) to pediatric or adult patients with pain or fever;

(xxv) oral glucose preparations;

(xxvi) oxytocin;

(xxvii) phenylephrine nasal spray;

(xxviii) pralidoxime, IM auto-injection for treatment of chemical and nerve agent exposure;

(xxix) anti-emetic agents, for use as an anti-emetic only;

(xxx) sodium bicarbonate;

(xxxi) thiamine;

(xxxii) topical anesthetic ophthalmic solutions;

(xxxiii) vasopressor agents;

(xxxiv) intravenous fluids.

(3) Drugs allowed for monitoring during inter-facility transports (initiated and administered by the sending facility with defined dosing parameters and requiring an infusion pump when given by continuous infusion unless otherwise specified); the infusion may be terminated by the paramedic if appropriate, but if further adjustments are anticipated, appropriate hospital personnel should accompany the patient, or a critical care transport unit should be utilized:

(a) potassium (no infusion pump needed if concentration not greater than 20mEq/1000cc;

(b) anticoagulation type blood modifying agents (such as fibrolytic drugs, heparin, glycoprotein IIb-IIIa inhibitors/antagonists);

(c) tranexamic acid (txa);

(d) procainamide;

(e) mannitol;

(f) blood and blood products (no pump required);

(g) aminophylline;

(h) antibiotics and other anti-infective agents;

(i) sodium nitroprusside;

(j) insulin;

(k) terbutaline;

(l) octreotide;

(m) nutritional supplements;

(n) beta blockers;

(o) calcium channel blockers;

(p) nesiritide;

(q) propofol in patients that are intubated prior to transport;

(r) proton pump inhibitors and H2 antagonists;

(s) crotalidae polyvalent immune fab (ovine) ("crofab") crofab may be monitored during inter-facility transport provided the physician initiated crofab infusion has been running for a minimum of 30 minutes prior to the paramedic initiating the transfer and assuming responsibility for patient care.

(4) Immunizations and biologicals: administration of immunizations, vaccines, biologicals, and TB skin testing is authorized under the following circumstances:

(a) to the general public as part of a department of health initiative or emergency response, utilizing department of health protocols; the administration of immunizations is to be under the supervision of a physician, nurse, or other authorized health provider;

(b) administer vaccines to EMS and public safety personnel;

(c) TB skin tests may be applied and interpreted if the licensed provider has successfully completed required department of health training;

(d) in the event of a disaster or emergency, the state EMS medical director or chief medical officer of the department of health may temporarily authorize the administration of other pharmaceuticals or tests not listed above.

(5) Skills approved for monitoring in transport:

(a) internal cardiac pacing;

(b) chest tubes.

(6) Medications for administration during patient transfer:

(a) retavase (second dose only);

(b) protamine sulfate;

(c) non-depolarizing neuromuscular blocking agents in patients that are intubated prior to transport;

(d) acetylcysteine.

(7) Patient's own medication that may be administered:

(a) epoprostenol sodium, treprostinil sodium, or other medications utilized for certain types of pulmonary hypertension;

(b) bronchodilators using pre-measured or metered dose inhalation device;

(c) sublingual nitroglycerin for unrelieved chest pain; must have intravenous access established prior to administration;

(d) glucagon;

(e) situations may arise involving patients with uncommon conditions requiring specific out of hospital administered medications or procedures; family members or the designated caregiver trained and knowledgeable of the special needs of the patient should be recognized as the expert regarding the care of the patient; EMS can offer assistance in airway management appropriate to their level of licensure, IV access, and the administration of the patient's prescribed medications where appropriate only if the medication is in the EMS provider's scope of practice; online (direct contact) medical control communication must be established with the medical control physician approving the intervention; EMS services are not expected to provide the prescribed medications for these special needs patients.

[7.27.11.8 NMAC - Rp, 7.27.11.8 NMAC, 12/12/2017]

7.27.11.9 APPROVED TRAINING PROGRAMS:

"Approved emergency medical services training

program" means a New Mexico emergency medical services training program that is sponsored by a post-secondary educational institution, is accredited by the national accrediting organization for emergency medical services or active in the accreditation process, and is approved by the joint organization on education (JOE) and participates in the joint organization on education. Currently, there are five approved EMS training programs.

A. Emergency medical services academy. University of New Mexico, (700 Camino De Salud NE., Albuquerque, New Mexico 87106, Tel: 505-272-5757). The EMS academy is designated as the lead training agency for providers in New Mexico as stated in Section 24-10B-12 NMSA 1978. The EMS academy teaches formal EMS

education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

B. Dona Ana community college. New Mexico state university, (Box 30001, Las Cruces, NM 88003-000 1 ,Tel: 505-527-7530). Dona Ana community college teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

C. Eastern New Mexico university. EMS program, (Box 6000, Roswell, NM 88202-6000, Tel: 505- 624-7000). The eastern New Mexico university teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

D. Central New Mexico community college. EMS program, (525 Buena Vista Rd. SE, Albuquerque, NM 87106, Tel: 505-224-4000). Central New Mexico community college teaches formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

E. San Juan college EMS program. (4601 College Blvd; Farmington, NM 87402; 505-566-3857). San Juan College conducts formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

F. Santa Fe community college. EMS Program, (6401 Richards Ave, Santa Fe, NM 87508, 505-428-1820) SFCC conducts formal EMS education courses including EMS first responder, EMT-basic, EMT-intermediate, and EMT-paramedic.

[7.27.11.9 NMAC - Rp, 7.27.11.9 NMAC, 12/12/2017]

7.27.11.10 SPECIAL SKILLS APPLICATION AND REPORTING PROCEDURES:

A. Purpose: Special skills are those skills, procedures, and medications that are requested by an EMS service to enhance emergency treatment capabilities beyond the normal scope of practice, as defined in the Emergency Medical Services Act. Use the enclosed procedures for application, reporting and renewal for special skills. Applications are reviewed and approved or disapproved by the medical direction committee, and once approved, become a legally recognized addition to the service capabilities.

B. General: All levels of EMS personnel, including licensed EMS first responders and all levels of licensed EMTs are eligible for special skills consideration for any procedure, skill or medication.

C. Application procedure: The EMS service medical director, or his designee, shall coordinate with the EMS service director, and shall apply for special skills to the EMS medical direction committee.

D. Application document: The application document for a special skill must be tailored to the level of the request. While the degree of detail in each section may vary to match the nature of the skill requested, all applications should include the following elements, in order:

(1) application cover page: titled to state the requested special skill, date of application, name of service, service director name and medical director name;

(2) contact information page: must include address and contact information for the service, service director and medical director;

(3) letters of support: must include individual letters of support from the service director and medical director; additional letters of support from the local medical community or evidence of notification of the local medical community may be required; the need for letters of notification and support from the local medical community and who provides the letters must be adjusted to match the nature of the special skill requested;

(4) service description: provide a concise description of the EMS service; this includes such items as basic call demographics relevant to the applicant, level of licensure of providers and names and locations of the primary receiving medical facilities;

(5) description of the special skill: provide a description of the procedure, medication or requested skill; include information on risks, benefits, indications and contraindications;

(6) justification and statement of need: provide a statement explaining why the special skill is needed; this should include a description of the current medical intervention or alternative practice to the special skill and a risk or benefit analysis that supports the special skill requested; the estimated number of potential interventions per year, other relevant statistical data and a statement indicating the level of current scientific information/studies to support the requested special skill; the level of scientific justification can be adjusted to match the level of the special skill requested;

(7) protocol: provide a copy of the treatment protocol; include other operational protocols relevant to the special skill, if applicable;

(8) training: provide a training syllabus; this must include learning objectives and the training hours for initial and continuing education; this section should also include a description of the instructors, how training will be completed, and a description of the method used to initially evaluate the skill; once initial training is completed, a list of trained and approved personnel shall be provided to the medical direction committee; these special skill authorized licensed EMS personnel must appear on the service's personnel list on the *New Mexico EMS tracking and reporting system database*.

(9) QA/QI program: provide a description of the QA/QI process for the special skill, including frequency of evaluation, names and qualifications of the personnel involved in the process; include a copy of the evaluation tool or forms that will be used, if applicable; and

(10) the application and all supporting documentation shall be submitted to the EMS bureau, attn: state EMS training coordinator.

E. Applicants may involve the EMS regional offices when preparing a special skill request and include a letter evidencing regional review. Applicants shall forward a copy of their application to their EMS regional office when completed.

F. Upon receipt, the state EMS medical director and state EMS training coordinator will review the application. The service will be notified if the application is found to be incomplete or to contain significant errors.

G. Applications must be received at the bureau at least 45 days prior to the next regularly scheduled medical direction committee meeting to be placed on the agenda of that meeting for consideration by the medical direction committee.

H. The medical direction committee shall take action on all special skills applications on the agenda at their regularly scheduled meeting. The medical direction committee may take the following actions on the application: approved with limitations or restrictions, denied or tabled with a request for a formal presentation or additional information by the requesting service medical director or their designee.

I. The medical direction committee may give an approval subject to specific conditions, limitations or restrictions. This may include a written and practical examination.

J. Within 10 working days following the decision of the medical direction committee, the state EMS training coordinator shall provide a written response to the applicant regarding the action of the medical direction committee.

K. Special skills may not be utilized until receipt of the special skill approval letter from the bureau any specific conditions or limitations will be evidenced in the approval letter from the bureau.

L. Monitoring: It is expected that EMS services with approved special skills will continuously comply with the requirements of their application and approval letter. This includes, but is not limited to, such items as training curricula, approved instructors, quality assurance, protocols and data collection. Any changes to the approved application shall be sent to the state EMS training coordinator for concurrence/coordination with the medical direction committee.

M. The medical direction committee may immediately suspend or revoke special skill privileges for an individual or service that loses medical direction, or fails to comply with the stated requirements, or for any other reason to protect the health and welfare of the people of New Mexico.

N. If a new medical director assumes control of a service with an active special skill program, the bureau shall receive a letter of support from the new medical director within 30 days or the special skill approval may be withdrawn.

O. The service shall maintain a current list of all providers trained and approved to utilize the special skill. This list must be provided to the bureau upon request.

P. Reporting: The service shall provide to the state EMS training coordinator periodic written special skill reports. During the first year, the report shall be due semi-annually, occurring on June 1 and December 1. Subsequent reports shall be due annually on June 1.

Q. Report document: The written special skill report shall include the following minimum elements:

(1) report cover page: titled to state the special skill reported, date, name of service, service director and medical director;

(2) contact information page: shall include address and contact information for the service, service director and medical director;

(3) letters of support: must include individual letters of continued support from the service director and service medical director;

(4) statistics and outcome data: provide data on the utilization and patient outcomes involving the special skill; do not include patient identifiers; all adverse outcomes related to the special skill must be reported;

(5) continuing education: provide evidence of the continuing education program and refresher program;

(6) personnel list: provide a list of all personnel authorized to perform the special skill; these special skill authorized licensed EMS personnel must appear on the service's personnel list required for the *New Mexico EMS tracking and reporting system database*.

(7) QA/QI program: provide evidence of the ongoing QA/QI program;

(8) renewal: during a regularly scheduled meeting, the medical direction committee shall review all ongoing individual special skills programs on their three year anniversary and make a determination on renewal;

(9) if the medical direction committee determines not to provide automatic renewal on an ongoing special skill program, the state EMS training coordinator shall provide a written notification to the service director and the service medical director within 10 working days; and

(10) the special skills program will be placed on the agenda of the next, or subsequent, regularly scheduled meeting of the medical direction committee and final determination regarding renewal will be made.

R. Special skills programs will remain active until a final determination regarding renewal has been made.

S. Special skills application:

(1) general section;

(2) EMS service name;

(3) address;

(4) service chief/director;

(5) contact phone number;

(6) physician medical director;

(7) physician/medical director contact phone number;

(8) special skill proposed;

(9) level of licensure necessary for special skill;

(10) estimated number of personnel to be trained;

(11) estimated date of initial training;

(12) training/quality assurance;

(13) describe or identify the curriculum, including learning objectives, training hours, etc.;

(14) please identify the lead instructor and provide a brief summary of their qualifications or attach a resume;

(15) resumes required for new instructors;

(16) if training/experience is required, provide a letter of commitment from the supporting institution;

(17) describe or attach a proposed continuing education plan;

(18) attach a description of quality assurance plan, including periodic case reviews and ongoing problems;

(19) identification and steps for remedial action if necessary;

(20) signatures; person completing the application, service chief/service director and medical director;

(21) submit 10 copies of the application in its entirety to: EMS bureau, state EMS training coordinator, (1301 Siler Rd., Building F, Santa Fe, NM 87507);

(22) submit one copy to the regional office.

[7.27.11.10 NMAC - Rp, 7.27.11.10 NMAC, 12/12/2017]

7.27.11.11 EMS PERSONNEL JOB DESCRIPTIONS:

A. Introduction: The bureau is providing the following general position description for the New Mexico EMS provider positions for first responder, EMT-basic, EMT-intermediate, and EMT-paramedic. It is the ultimate responsibility of an employer to define specific job descriptions within each EMS service.

B. Qualifications:

(1) successfully complete a recognized training course from an approved EMS training institution;

(2) possess a valid course completion certificate, and accomplish all state licensure examination application requirements;

(3) additionally, applicants shall meet all established requirements for initial licensing as identified by the current EMS licensure regulations;

(4) a copy of these regulations is available through the EMS bureau;

(5) generally, the knowledge and skills required demonstrate the need for a high school education or equivalent;

(6) ability to communicate verbally; via telephone and radio equipment;

(7) ability to lift, carry, and balance up to 125 pounds (250 pounds with assistance);

(8) ability to interpret written, oral, and diagnostic form instructions;

(9) ability to use good judgment and to remain calm in high-stress situations;

(10) ability to work effectively in an environment with loud noises and flashing lights;

(11) ability to function efficiently throughout an entire work shift;

(12) ability to calculate weight and volume ratios and read small English print, both under life threatening time constraints;

(13) ability to read and understand English language manuals and road maps;

(14) accurately discern street signs and address numbers;

(15) ability to interview patient, family members, and bystanders;

(16) ability to document, in writing, all relevant information in a prescribed format;

(17) ability to converse orally and in written form in English with coworkers and hospital staff as to status of patient;

(18) good manual dexterity, with ability to perform all tasks related to the highest quality of patient care;

(19) ability to assume a variety of postural positions to carry out emergency and non-emergency patient care, including light extrication; from crawling, kneeling, squatting, twisting, turning, bending, to climbing stairs and ladders, and the ability to withstand varied environmental conditions such as extreme heat, cold, and moisture; and

(20) ability to work in low light, confined spaces and other dangerous environments.

C. Competency areas:

(1) Licensed EMS first responder: Must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of first responder, to include the ability to demonstrate competency for all skills and procedures currently

approved for the first responder, as identified by the current scope of practice document.

(2) Emergency medical technician-basic: Must demonstrate competency handling emergencies utilizing all basic life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-basic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-basic, as identified by the current scope of practice document.

(3) Emergency medical technician-intermediate: Must demonstrate competency handling emergencies utilizing all basic life support and intermediate life support equipment and skills in accordance with all behavioral objectives of the approved New Mexico curriculum of EMT-intermediate, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-intermediate, as identified by the current scope of practice document.

(4) Emergency medical technician-paramedic: Must demonstrate competency handling emergencies utilizing all basic life support and advanced life support equipment and skills in accordance with all behavioral objectives of an approved New Mexico curriculum of EMT-paramedic, and to include the ability to demonstrate competency for all skills and procedures currently approved for the EMT-paramedic, as identified by the current scope of practice document.

D. Description of tasks for all EMS levels:

(1) Receives call from dispatcher, responds verbally to emergency calls, reads maps, may drive emergency vehicle to emergency site, uses most expeditious route, and observes traffic ordinances and regulations.

(2) May use equipment and other devices and procedures as authorized by level of licensure and scope of practice.

(3) Assists in lifting, carrying, and transporting patient to an ambulance and to a medical facility.

(4) Reassures patients and bystanders and searches for medical identification emblem to aid in care.

(5) Extricates patient from entrapment, assesses extent of injury, uses prescribed techniques and appliances, radio dispatcher for additional assistance or services, provides light rescue service if required and trained, provides additional emergency care following service established protocols.

(6) Complies with regulations in handling deceased, notifies authorities, arranges for protection of property and evidence at scene.

(7) Determines appropriate facility to which patient will be transported, report nature and extent of injuries or illness to the facility, asks for direction from hospital physician or emergency department staff.

(8) Observes patient in route and administers care as directed by physician or service- established protocols.

(9) Identifies diagnostic signs that require communication with facility.

(10) Assists in removing patient(s) from ambulance and into emergency facility.

(11) Reports verbally, and in writing, observations about and care of patient at the scene, en-route to facility, and to the receiving facility. Written reports shall be completed for all patient interactions, which include any visual, verbal, or physical patient contact, by the most appropriate EMS caregiver, whether or not the patient was transported to a facility, including patient refusals.

(12) Provides assistance to emergency department staff as required.

(13) Replaces supplies, sends used supplies for sterilization, checks all equipment for future readiness, maintains ambulance in operable condition, ensures ambulance cleanliness and orderliness of equipment and supplies, decontaminates vehicle interior, determines vehicle readiness by checking oil, gas, water in battery and radiator, and tire pressure, maintains familiarity with all specialized equipment.

[7.27.11.11 NMAC - Rp, 7.27.11.11 NMAC, 12/12/2017]

7.27.11.12 COVID-19 PUBLIC HEALTH EMERGENCY; APPROVED DEVIATIONS FROM EMS RULES:

On March 11, 2020, New Mexico Governor Michelle Lujan Grisham issued executive order 2020-004 pursuant to the Public Health Emergency Response Act, Subsection A of Section 12-10A-5, NMSA 1978, declaring a state of public health emergency concerning the spread of the novel coronavirus disease named COVID-19. In accord with 7.27.11.2 NMAC, the department of health finds that this public health emergency stresses the emergency medical services system and disrupts delivery of medical services. Consistent with the authority of the emergency medical systems bureau pursuant to the Emergency Medical Services System Act at Section 24-10B-1 through -13, NMSA 1978, the department hereby authorizes deviations from the department's emergency medical services rules, found in New Mexico Administrative Code, Title 7, Chapter 27 ("EMS rule"), during the pendency of the COVID-19 public health emergency, including but not limited to deviations from the emergency medical technician scopes of practice, as permitted herein.

A. Procedure: A person who wishes to request a deviation from an EMS rule of the department of health shall contact the EMS bureau and shall provide:

(1) the department EMS rule at issue;

(2) factual information relevant to the requested deviation; and

(3) such additional information as the bureau may request.

B. Approval and denial: The bureau may approve or deny a requested deviation from an EMS rule of the department within its discretion. Any such determination may be rendered by the emergency medical systems bureau chief or his or her designee, or by the state emergency medical systems medical director or his or her designee.

C. Expiration of approved deviation: An approved deviation from EMS rule shall expire upon either termination of the declared public health emergency or rescission by the bureau, whichever occurs first.

[7.27.11.12 NMAC – N/E, 3/26/2020]

PART 12: CERTIFICATION OF S-T SEGMENT ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING AND REFERRING CENTERS

7.27.12.1 ISSUING AGENCY:

New Mexico Department of Health, Epidemiology and Response Division, Emergency Medical Systems Bureau.

[7.27.12.1 NMAC - N, 8/15/14]

7.27.12.2 SCOPE:

These rules apply to New Mexico acute care hospitals that seek to be accredited or become accredited as a STEMI receiving or referring center by the society of cardiovascular patient care or another nationally recognized and Department of Health approved organization that provides such accreditation.

[7.27.12.2 NMAC - N, 8/15/14]

7.27.12.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: 1) the New Mexico Department of Health Act, Subsection E of NMSA 1978, Section 9-7-6, which authorizes the secretary of the department of health to "make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions," and 2) the Emergency Medical Services Act, NMSA 1978, Section 24-10B-4 ("Certification of STEMI receiving and referring centers").

[7.27.12.3 NMAC - N, 8/15/14]

7.27.12.4 DURATION:

Permanent.

[7.27.12.4 NMAC - N, 8/15/14]

7.27.12.5 EFFECTIVE DATE:

August 15, 2014, unless a later date is cited at the end of a section.

[7.27.12.5 NMAC - N, 8/15/14]

7.27.12.6 OBJECTIVE:

These rules are intended to establish the requirements necessary for acute care hospitals to be certified as STEMI receiving or referring centers. Additionally, the rule intends to identify incentives for participation in a STEMI registry, as well as assist and encourage STEMI receiving centers to enter into coordinated care agreements with STEMI referring centers and other health care facilities throughout the state to provide appropriate access to care for acute heart attack patients.

[7.27.12.6 NMAC - N, 8/15/14]

7.27.12.7 DEFINITIONS:

Unless a different meaning is plainly required by the context, the following words and phrases used in these regulations shall have the meanings indicated.

A. "Accredited" means a process of validation by an organization recognized by the department.

B. "Acute care hospital" means a facility with an emergency department and physicians(s) available, licensed under state statute, or a comparable facility operated by the federal government or located and licensed by another state.

C. "Bureau" means the EMS bureau of the epidemiology and response division of the department of health.

D. "Certified" means a formal determination by the department that an acute care facility has met the standards necessary for national accreditation, including functioning in a STEMI and other heart attack care system, and capable of providing special resources and care as a STEMI receiving or STEMI referring center.

E. "Department" means the New Mexico department of health.

F. "Recognized" means written acknowledgement by the bureau.

G. "Registry" means a bureau approved database which documents and integrates medical and system information related to the provision of STEMI and other heart attack care by acute care hospital facilities.

H. "STEMI" means ST segment elevation myocardial infarction, a common type of heart attack caused by a blocked artery that supplies blood to the heart muscle.

[7.27.12.7 NMAC - N, 8/15/14]

7.27.12.8 STEMI AND OTHER HEART ATTACK REGISTRY:

A. Funding for data submission: The department will, depending on availability of funds and based on guidelines approved by the department and administered by the bureau, provide limited financial assistance to acute care hospitals providing STEMI and other heart attack care data to the approved registry data platform, and allowing department access to that data. This funding is provided to defray licensing costs associated with the submission of data to the approved data platform. Participation in data submission to the registry is required to be eligible for funds. Acute care hospitals designated or seeking designation as STEMI receiving or referring centers must report data to the department approved data platform that is consistent with nationally recognized guidelines on the treatment of individuals with confirmed STEMI or other heart attack.

B. Data platform: The department of health shall approve a single data platform, to which data is submitted by each hospital, and maintain a statewide STEMI heart attack database that compiles information and statistics on heart attack care through this data platform.

[7.27.12.8 NMAC - N, 8/15/14]

7.27.12.9 STEMI RECEIVING OR REFERRING CENTER CERTIFICATION:

The department shall certify an acute care hospital as a STEMI receiving center or STEMI referring center if that hospital has been accredited as a STEMI receiving center or STEMI referring center by the society of cardiovascular patient care or another nationally recognized organization approved by the department of health that provides STEMI receiving or referring accreditation. The department shall post information regarding certification on the department's web site. If a hospital loses its national accreditation as a STEMI receiving center or STEMI referring center, the secretary shall revoke the hospital's certification.

[7.27.12.9 NMAC - N, 8/15/14]

7.27.12.10 STEMI HEART ATTACK SYSTEM DEVELOPMENT AND IMPROVEMENT:

To every extent possible, the department of health will:

A. Facilitate the communication and analysis of information and data between the department, acute care hospitals, emergency medical services, and other care providers regarding ways to improve the quality of care for heart attack patients.

B. Establish a STEMI and heart attack data oversight process, and implement a plan for continuous quality improvement in the quality of care provided to heart attack patients statewide based on STEMI and other data sources, which will include:

(1) analyzing data generated by the registry on STEMI heart attack response and treatment;

(2) identifying potential interventions to improve STEMI heart attack care in the prehospital and acute care hospital settings throughout the state, and based on guidelines approved by the department and administered by the bureau, provide limited financial assistance depending on availability of funds; and

(3) assuring that data reported under section 7.27.12.8 NMAC shall be made available to requesting entities that have responsibility for the management and administration of services that provide prehospital and acute hospital care of heart attack patients.

[7.27.12.10 NMAC - N, 8/15/14]

PART 13: CERTIFICATION OF STROKE CENTERS

7.27.13.1 ISSUING AGENCY:

New Mexico Department of Health (DOH), Epidemiology and Response Division (ERD), Emergency Medical Systems Bureau (EMSB).

[7.27.13.1 NMAC - Rp, 7.27.13.1 NMAC, 12/12/2017]

7.27.13.2 SCOPE:

These rules apply to New Mexico acute care hospitals that seek to be accredited or become accredited as an acute stroke capable center, primary stroke center, or comprehensive stroke center by the joint commission or another nationally recognized accrediting body.

[7.27.13.2 NMAC - Rp, 7.27.13.2 NMAC, 12/12/2017]

7.27.13.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: 1) the New Mexico Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to "make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions," and; 2) the Public Health Act, Section 24-1-34 NMSA 1978 ("primary stroke centers; comprehensive stroke centers; acute stroke capable centers; department certification; rulemaking").

[7.27.13.3 NMAC - Rp, 7.27.13.3 NMAC, 12/12/2017]

7.27.13.4 DURATION:

Permanent.

[7.27.13.4 NMAC - Rp, 7.27.13.4 NMAC, 12/12/2017]

7.27.13.5 EFFECTIVE DATE:

December 12, 2017, unless a later date is cited at the end of a section.

[7.27.13.5 NMAC - Rp, 7.27.13.5 NMAC, 12/12/2017]

7.27.13.6 OBJECTIVE:

These rules are intended to establish the requirements necessary for acute care hospitals to be certified by the department as an acute stroke capable center, primary stroke center, or comprehensive stroke center. Additionally, the rule intends to identify incentives for participation in a stroke registry, as well as assist and encourage stroke centers to enter into coordinated care agreements with other health care facilities throughout the state to provide appropriate access to care for stroke patients.

[7.27.13.6 NMAC - Rp, 7.27.13.6 NMAC, 12/12/2017]

7.27.13.7 DEFINITIONS:

Unless a different meaning is plainly required by the context, the following words and phrases used in these regulations shall have the meanings indicated.

A. "Accredited" means a process of validation by the joint commission or any other nationally recognized accrediting body recognized by the department.

B. "Accrediting body" means an independent, not-for-profit entity, recognized nationally and by the DOH, that evaluates hospitals for, and addresses crucial elements in, operations regarding patient care and related aspects.

C. "Acute care hospital" means a facility with an emergency department and physicians(s) available, licensed under state statute, or a comparable facility operated by the federal government or located and licensed by another state.

D. "Bureau" means the emergency medical systems bureau of the epidemiology and response division of the New Mexico department of health.

E. "Certified" means a formal determination by the department that an acute care facility has met the standards necessary for joint commission or any other nationally recognized accrediting body accreditation, including functioning in a stroke care system, and capable of providing special resources and care as an acute stroke capable, primary, or comprehensive center.

F. "Department (DOH)" means the New Mexico department of health.

G. "Emergency Medical Service (EMS)" means the services rendered by licensed emergency medical technicians, emergency medical services first responders or emergency medical dispatchers in response to a person's need for immediate medical care to prevent loss of life or aggravation of physical or psychological illness or injury.

H. "Recognized" means written acknowledgement by the bureau.

I. "Registry" means a bureau approved database which documents and integrates medical and system information related to the provision of stroke care by acute care hospital facilities.

J. "Stroke" is a term that broadly describes the death of central nervous system cells and tissues attributed to an insufficient supply of blood to the central nervous system. It includes conditions caused by ischemic stroke, intracerebral hemorrhage and subarachnoid hemorrhage.

K. "Stroke center" means an acute care hospital with a group of medical caregivers that have specific education and resources to diagnose and treat stroke; three levels of stroke centers - acute stroke capable, primary, and comprehensive - are accredited by the joint commission or any other nationally recognized accrediting body based on the capability of stroke care by the acute care hospital.

[7.27.13.7 NMAC - Rp, 7.27.13.7 NMAC, 12/12/2017]

7.27.13.8 STROKE REGISTRY:

A. Funding for data submission:

(1) The department shall, depending on availability of funds and based on guidelines approved by the department and administered by the bureau, provide limited financial assistance to acute care hospitals providing stroke data to the approved

registry data platform, and allowing department access to that data. This funding is provided to defray licensing costs associated with the submission of data to the approved data platform. Participation in data submission to the registry is required to be eligible for funds.

(2) Acute care hospitals designated or seeking designation as acute stroke capable, primary, or comprehensive centers must report data to the department approved data platform that is consistent with nationally recognized guidelines on the treatment of individuals with confirmed stroke.

B. Data platform: The department of health shall approve a single data platform, to which data is submitted by each hospital, and maintain a statewide stroke database that compiles information and statistics on stroke care through this data platform.

[7.27.13.8 NMAC - Rp, 7.27.13.8 NMAC, 12/12/2017]

7.27.13.9 ACUTE STROKE CAPABLE, PRIMARY, OR COMPREHENSIVE STROKE CENTER CERTIFICATION:

The department shall certify an acute care hospital as a primary stroke center, comprehensive stroke center, or acute stroke capable center if that hospital has been accredited as an acute stroke capable center, primary stroke center, or comprehensive stroke center. The department shall post information regarding certification on the department's web site. If a hospital loses its national accreditation as a stroke center, the secretary shall revoke the hospital's certification.

[7.27.13.9 NMAC - Rp, 7.27.13.9 NMAC, 12/12/2017]

7.27.13.10 STROKE SYSTEM DEVELOPMENT AND IMPROVEMENT:

To every extent possible, the department of health emergency medical systems bureau will:

A. Facilitate the communication and analysis of information and data between the department, acute care hospitals, emergency medical services, and other care providers regarding ways to improve the quality of care for stroke patients.

B. Establish a stroke data oversight process, and implement a plan for continuous quality improvement in the quality of care provided to stroke patients statewide based on stroke and other data sources. This will include:

(1) analyzing data generated by the registry on stroke response and treatment;

(2) identifying potential interventions to improve stroke care in the prehospital and acute care hospital settings throughout the state, and based on guidelines

approved by the department and administered by the bureau, provide limited financial assistance depending on availability of funds;

(3) assuring that data reported under Section 7.27.13.8 NMAC shall be made available to requesting entities that have responsibility for the management and administration of services that provide prehospital and acute hospital care of stroke patients.

C. Work in coordination with all local and regional emergency medical services authorities statewide on the development of pre-hospitalization protocols related to the assessment, treatment and transport of stroke patients by licensed emergency medical services providers. These protocols shall include, at a minimum, plans for the triage and transport of stroke patients to the closest comprehensive or primary stroke center or, when appropriate, to an acute stroke capable center.

[7.27.13.10 NMAC - Rp, 7.27.13.10 NMAC, 12/12/2017]

CHAPTER 28: HOME HEALTH SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR HOME HEALTH AGENCIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.22 NMAC.]

CHAPTER 29: PRIMARY AND RURAL HEALTH CARE SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: NEW MEXICO HEALTH SERVICE CORPS

7.29.2.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.29.2.1 NMAC - Rp, 7 NMAC 29.2.1, 02/13/04]

7.29.2.2 SCOPE:

Applies to licensed health professionals, students, and eligible communities or practice sites.

[7.29.2.2 NMAC - Rp, 7 NMAC 29.2.2, 02/13/04]

7.29.2.3 STATUTORY AUTHORITY:

These regulations are promulgated pursuant to the following statutory authority:

A. the Department of Health Act, Section 9-7-6E NMSA 1978, which authorizes the secretary of the department of health to "...make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions" and

B. the Health Service Corps Act, Section 24-1D-3B(2) NMSA 1978, which authorizes the department to adopt regulations to carry out the provisions of the act.

[7.29.2.3 NMAC - Rp, 7 NMAC 29.2.3, 02/13/04]

7.29.2.4 DURATION:

Permanent.

[7.29.2.4 NMAC - Rp, 7 NMAC 29.2.4, 02/13/04]

7.29.2.5 EFFECTIVE DATE:

February 13, 2004, unless a later date is cited at the end of a section.

[7.29.2.5 NMAC - Rp, 7 NMAC 29.2.5, 02/13/04]

7.29.2.6 OBJECTIVE:

The objective of these regulations is to set forth the duties and functions of the corps.

[7.29.2.6 NMAC - Rp, 7 NMAC 29.2.6, 02/13/04]

7.29.2.7 DEFINITIONS:

A. "Advisory committee" means a committee appointed by the secretary of the department composed of representatives of the department, university of New Mexico health sciences center training departments, health professional organizations, primary care clinics and consumers for purposes of recommending student selection of commitment stipends, prioritizing a list of eligible communities and practice sites, and advising the corps on program policy.

B. "Corps" means the New Mexico health service corps, an entity of the department.

C. "Commitment stipend" means the monies provided to health professional students and licensed health professionals in return for a promise stated in a contract to serve at an eligible community or practice site in New Mexico for at least two years.

D. "Commitment stipend contract" means a contract executed between the corps and licensed health professionals or students outlining provisions of service, potential eligible communities/practice site placements, penalties and forgiveness provisions.

E. "Dental hygienist" means an individual licensed as a registered dental hygienist (R.D.H.) in New Mexico.

F. "Dentist" means an individual licensed as a doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) in New Mexico.

G. "Department" means the New Mexico department of health.

H. "Eligible community" means a location in New Mexico that has satisfied criteria established by the department as a medically underserved area for specific health professionals.

I. "Emergency medical technician-paramedic" means a paramedic licensed to practice in New Mexico by the department.

J. "Health professional" means a licensed physician, physician assistant, nurse practitioner, nurse midwife, emergency medical technician-paramedic, dentist, or dental hygienist.

K. "Medically underserved area" means a community or area in New Mexico designated by the department as having a shortage of specific health professionals.

L. "Nurse-midwife" means an individual licensed by the New Mexico board of nursing and certified by the American college of nurse-midwives accreditation council.

M. "Nurse practitioner" means an individual licensed as a nurse practitioner in New Mexico.

N. "Physician" means an allopathic doctor or doctor of osteopathic medicine licensed to practice in New Mexico.

O. "Physician assistant" means a physician assistant or osteopathic physician assistant certified to practice in New Mexico.

P. "Practice site" means a public health clinic, a public or private nonprofit primary care clinic that is located in a state-designated medically underserved area or that serves a high-needs population, and that uses a sliding fee scale approved by the department.

Q. "Resident" means a licensed allopathic or osteopathic physician who is engaged in a postgraduate residency program in the following specialties: family practice, internal medicine, emergency medicine, pediatrics, dentistry, or OB-GYN.

R. "Service" means at least 1,600 hours of on-site health care during each one-year period or as negotiated with the corps, and as agreed upon in a written contract.

S. "Service contract" means a contract executed between the corps and the health professional outlining the provisions of service, eligible community/practice site placement, forgiveness and penalty provisions.

T. "Student" means a potential health professional who is domiciled in New Mexico, and is enrolled in or accepted by an accredited or otherwise approved educational program or performing their preceptorship in the fields of nurse practitioner, nurse midwifery, physician assistant, or emergency medical technician-paramedic; or participating in an allopathic or osteopathic medical residency program, clinical dental school program, dental hygiene program, or dental residency program. Persons enrolled in a clinical dental school program, dental hygiene program, or dental residency program are exempted from the requirement that they be domiciled in New Mexico.

[7.29.2.7 NMAC - Rp, 7 NMAC 29.2.7, 02/13/04]

7.29.2.8 POWERS AND DUTIES OF THE CORPS:

The corps shall:

A. enter into contracts to carry out provisions of the Health Service Corps Act, and may sue for enforcement of those contracts;

B. recruit and assign health professionals to eligible communities/practice sites;

C. determine a mix of health professional specialties to be recruited, with an emphasis on family practice physicians;

D. establish criteria and procedures for acceptance of applications and selection of students and licensed health professionals;

E. establish criteria and procedures for evaluating and selecting students and licensed health professionals;

F. determine and maintain a list of eligible communities/practice sites and establish a priority of those locations based on relative need; and

G. convene an advisory committee to recommend students and licensed health professionals to receive commitment stipends, recommend priorities for eligible communities/practice sites, and advise the corps on program policy.

[7.29.2.8 NMAC - Rp, 7 NMAC 29.2.8, 02/13/04]

7.29.2.9 ELIGIBILITY TO RECEIVE A COMMITMENT STIPEND:

A. To be eligible to receive a commitment stipend, students and licensed health professionals shall:

(1) provide references and undergo interviews;

(2) be enrolled in or accepted by an accredited or otherwise approved medical school residency program, school of nursing, physician assistant training program, school of dentistry, dental hygiene program,or emergency medical technician-paramedic training program, or be engaged in a residency training program or preceptorship;

(3) be a citizen of the United States or a permanent resident alien and domiciled in New Mexico, except that students enrolled in a school of dentistry, dental hygiene program, or dental residency are exempt from the requirement that they be domiciled in New Mexico;

(4) declare his or her intent to practice as a health professional at an eligible community/practice site in New Mexico for at least two years; and

(5) prior to service, be evaluated by the corps utilizing evaluation of clinical performance and community service during training; licensing test scores; recommendations of professors, professional mentors and co-workers; and other factors as determined by the corps to ensure provision of quality health services through the corps.

B. Commitment stipends may be awarded based on the following considerations:

(1) recommendation of the advisory committee;

(2) ability, character and qualifications of the applicant;

(3) demonstrated commitment to completion of training and service in an eligible community/practice site in the state;

(4) financial need; and

(5) recommendation, support, or evidence of acceptance at an eligible community/practice site, if appropriate.

[7.29.2.9 NMAC - Rp, 7 NMAC 29.2.9, 02/13/04]

7.29.2.10 PAYMENT OF COMMITMENT STIPENDS:

A. The amount of any stipend awarded shall be dependent upon available resources and shall be paid for a maximum of two years; for paramedic students, the

stipend will be paid for one year, unless the student is enrolled in a two-year associate of arts or baccalaureate degree program.

B. Upon approval by the corps of a commitment stipend, the student or licensed health professional shall enter into a commitment stipend contract.

[7.29.2.10 NMAC - Rp, 7 NMAC 29.2.9, 02/13/04]

7.29.2.11 REPAYMENT OF COMMITMENT STIPENDS:

A student or licensed health professional who receives a commitment stipend shall:

A. provide a current address to the corps within sixty (60) days of completion of training and maintain a current address with the corps throughout the period of repayment;

B. apply for necessary licensure or certification to practice at the first opportunity after completion of training;

C. pay back the stipend amount by serving a period of time equal to the number of yearly stipends received, for a minimum of a two-year repayment period; and

D. be subject to repayment penalties as outlined in Subsection F of 7.29.2.12 NMAC if he or she fails to complete training, obtain licensure or certification, or complete obligation service at an eligible site.

[7.29.2.11 NMAC - Rp, 7 NMAC 29.2.9, 02/13/04]

7.29.2.12 PENALTY:

A. If the student or licensed health professional breaches his or her commitment stipend contract, he or she shall be subject to a penalty of three times the amount of the stipend received, plus 18 percent interest of the original stipend per year.

B. The penalty repayment period shall be a maximum of ten (10) years.

C. The student or licensed health professional may present to the corps a written explanation of any mitigating circumstances that prevented the full completion of training, the obtaining of licensure or certification, or the completion of a service obligation at an eligible site.

D. The corps shall evaluate the reasons for failure to complete training, obtain licensure or certification, or complete a service obligation at an eligible site and determine their validity.

E. Decisions of the corps regarding breach of commitment stipend contracts are final and binding for all purposes.

[7.29.2.12 NMAC - Rp, 7 NMAC 29.2.9, 02/13/04]

7.29.2.13 HEALTH PROFESSIONALS SERVING WITH STIPEND OBLIGATIONS:

A. Health professionals who received a commitment stipend and are serving at an eligible community/practice site shall:

(1) be covered by malpractice insurance; and

(2) be subject to evaluation by the eligible community/practice site.

B. Service contract: The health professional shall enter into a service contract with the corps that shall outline service requirements, the agreed upon eligible communities/practice sites, penalty and forgiveness provisions, and other legal provisions.

C. Compensation: If an employee or contractor of the local eligible community/practice site, compensation shall be paid by the local program, with notice given to the corps as reflected in the service contract.

[7.29.2.13 NMAC - Rp, 7 NMAC 29.2.10, 02/13/04]

7.29.2.14 DELEGATION OF ADMINISTRATION:

The corps may contract with any appropriate entity to co-administer the Health Service Corps Act.

[7.29.2.14 NMAC - Rp, 7 NMAC 29.2.12, 02/13/04]

7.29.2.15 ELIGIBLE COMMUNITY/PRACTICE SITE SELECTION:

The corps, upon recommendation of the advisory committee, shall determine priority of eligible communites/practice for placement of health professionals.

[7.29.2.15 NMAC - Rp, 7 NMAC 29.2.13, 02/13/04]

7.29.2.16 ELIGIBLE COMMUNITY/PRACTICE SITE CONTRACTS:

The corps may contract with eligible community/practice sites to support the recruitment, placement, or retention of eligible health professionals.

[7.29.2.16 NMAC - Rp, 7 NMAC 29.2.14, 02/13/04]

7.29.2.17 ELIGIBLE COMMUNITY/PRACTICE SITE REIMBURSEMENT:

The corps may require a community or practice site to pay the costs associated with the provision of corps health professionals in the community.

[7.29.2.17 NMAC - Rp, 7 NMAC 29.2.15, 02/13/04]

PART 3: RURAL PRIMARY HEALTH CARE ACT

7.29.3.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.29.3.1 NMAC - Rp, 7 NMAC 29.3.1, 10/16/06]

7.29.3.2 SCOPE:

Rural Primary Health Care Act rules shall apply to the use of the funds by eligible programs available pursuant to the Rural Primary Health Care Act, Sections 24-1A-1 to 24-1A-4 NMSA 1978.

[7.29.3.2 NMAC - Rp, 7 NMAC 29.3.2, 10/16/06]

7.29.3.3 STATUTORY AUTHORITY:

The Rural Primary Health Care Act, Sections 9-7-6(F) and 24-1A-4 NMSA 1978, as amended.

[7.29.3.3 NMAC - Rp, 7 NMAC 29.3.3, 10/16/06]

7.29.3.4 DURATION:

Permanent.

[7.29.3.2 NMAC - Rp, 10/16/06]

7.29.3.5 EFFECTIVE DATE:

October 16, 2006, unless a later date is cited at the end of a section.

[7.29.3.5 NMAC - Rp, 7 NMAC 29.3.5, 10/16/06]

7.29.3.6 OBJECTIVE:

The objective of 7.29.3 NMAC is to establish standards and procedures for regulating programs under the Rural Primary Health Care Act. The purpose of the Rural Primary

Health Care Act is to assist in the provision of primary health care services in underserved areas of the state in order to better serve the health care needs of the public. This purpose will be accomplished through, but not limited to, the following activities:

A. assist communities in the recruitment, placement, and retention of health care personnel in underserved areas of the state which includes the coordination of such effort with health professional education programs at post-secondary schools and other institutions involved in the training of health professional personnel;

B. develop plans and encourage coordination between publicly supported programs, and between public and private sector providers;

C. provide technical assistance;

D. distribute financial assistance to eligible programs in order to sustain or provide a minimum level of primary health care services; and which assist in the provision of primary health care services in underserved areas in order to better serve the health needs of the public; and

E. provide a program for enabling the development of new primary health care services and facilities.

[7.29.3.6 NMAC - Rp, 7 NMAC 29.3.6, 10/16/06]

7.29.3.7 DEFINITIONS:

A. "Act" means the Rural Primary Health Care Act, Sections 24-1A-1 to 24-1A-4 NMSA 1978.

B. "Department" means the department of health.

C. "Eligible programs" means nonprofit community based entities that provide or commit to provide primary health care services for residents of health care underserved areas and include rural health facilities and those serving primarily low income populations.

D. "Health care personnel" means health care professionals who contribute to ensuring adequate availability of primary health care services including but not limited to: licensed practical nurses, registered nurses, pharmacists, physician assistants, nurse practitioners, certified nurse midwives, primary care physicians (family practice, general practice, pediatrics, obstetrics and gynecology, and internal medicine), dentists and dental hygienists.

E. "Health care underserved areas" (HCUA) means geographic areas where it has been determined by the department of health, through the use of indices and other

standards set by the department, that sufficient primary health care is not being provided to the citizens of that area. These designations may recognize need for either general or special health care services. HCUA designations may give consideration to federally designated health professional shortage areas (HPSA) and medically underserved areas (MUA).

F. "Medically indigent" means individuals who are unable to afford all medical care that they require. This includes both those individuals below the federal poverty level not covered by medicaid, medicare or other third party health care insurance and those individuals between 100 percent and 200 percent of federal poverty levels who are not covered by any third party health insurance. Medically indigent individuals are usually expected to pay for some portion of the cost of their health care based upon the level of their income.

G. "Minimum level of primary health care services" means basic primary health care services provided to the general population by health care personnel.

H. "Nonprofit community based entities" means nonprofit organizations with an internal revenue service 501c(3) tax exempt status which have a governing board whose membership is broadly representative of the area served including consumer representatives. Nonprofit community based entities also include local governments and tribal governments. Nonprofit community based entities which are local governments, tribal governments and/or are multi-purpose or provide services in more than one HCUA, shall have local or regional primary health care advisory boards whose membership is generally representative of the area served.

I. "Patient collections" means receipts generated from patient encounters for primary health care services. Patient collections include revenues from medicaid, medicare, private insurance, Title XX, other third party sources or self pay.

J. "Primary health care advisory board" means a board, advisory to an organization's governing board, which has responsibility for consideration of and input into matters related to the provision of primary health care services in a local HCUA or regional combination of HCUA(s) being served. A majority of the advisory board shall be consumers of primary health care services.

K. "Primary health care services" are those provided at the first level of basic or general health care for an individual's health needs, including medical, dental and behavioral health diagnostic and treatment services and supportive services. Any dental or behavioral health services shall be provided in conjunction with primary medical services. Primary health care services are those provided as part of either general practice, family practice, obstetrics, gynecology, pediatrics or general internal medicine.

L. "Total revenues" means all receipts collected in support of primary health care services. Includes but not limited to: patient collections; Section 329, 330 and 340 Federal Funds, P.L. 93-638 or IHS support; Title V, X and WIC programs; other federal

grants; other state grants/contracts; and local income, including city, county or other unit of government, direct grant or value of donated property or facilities. In addition, other revenues including but not limited to: gifts, cash donations or grants from private foundations, church organizations, or other sources, general operating revenues from clinic services and interest, dividends, and other income derived from certificates of deposit, saving accounts and other investments.

[7.29.3.7 NMAC - Rp, 7 NMAC 29.3.7, 10/16/06]

7.29.3.8 FUND DISTRIBUTION:

A. Duty of the department: To the extent funds are made available for the purposes of the act Section 24-1A-3.1D NMSA 1978, the department, in accordance with applicable procurement procedures, 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.

B. Eligibility: To receive financial assistance through Section 24-1A-3.1D NMSA 1978, of the act, an eligible program shall:

(1) be a New Mexico nonprofit community based entity with federal internal revenue service 501c(3) tax exempt status, a local government or a tribal government which provide or commits to provide primary health care services to residents of an health care underserved area (HCUA) designated for primary health care needs;

(2) have a governing board whose membership is generally representative of the HCUA(s) it serves, including consumers of the primary health care services it provides; an eligible program which is a local government or tribal government and/or is multi-purpose or provides services in more than one HCUA shall have a local or regional primary health care advisory board whose membership is generally representative of the HCUA(s) being served; a majority of the advisory board shall be consumers of the primary health care services; the local or regional primary health care advisory board shall have opportunity for consideration of and input into the decisions regarding budgets, scope of services, payment policies and procedures, hours of operation and staffing; the eligible program shall be able to demonstrate the ability to meet the governing board and/or the advisory board requirements or have a practical plan for its establishment and implementation;

(3) have as its purpose to sustain or provide a minimum level of primary health care services as defined in Subsection D of 7.29.3.6 NMAC; services may additionally include medical support, diagnostic and treatment services, pharmacy, laboratory, radiology, preventive health services, behavioral health services, patient follow-up and/or dental and dental support services; any dental and/or behavioral health services shall be provided in conjunction with primary medical care services;

(4) have policies and procedures which assure that no person will be denied primary health care services they require because of inability to pay; these policies and procedures should address medically indigent persons below poverty not covered by third party payors and those between 100 percent and 200 percent of poverty without third party coverage; the eligible program should be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

(5) have billing policies and procedures which maximize patient collections, except where federal rules or contractual obligations prohibit the use of such measures; the program should be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation;

(6) have viable systems and infrastructure to deliver primary health care services including facility, staff and financial management systems;

(7) have comprehensive policies and procedures governing the primary health care operations which assure the delivery of effective, efficient and quality care; and

(8) meet other requirements as determined by the department.

C. Eligible items/uses of expenditures: Funds made available under Section 24-1A-3.1D NMSA of the act may be used for the following types of expenditures:

(1) salaries and benefits for the employees of contractor in support of the provision of primary health care services;

(2) purchase, repair and/or maintenance of necessary medical and dental equipment;

(3) purchase of office, medical, and/or dental supplies;

(4) in-state travel to obtain training or improve coordination in order to better support or provide primary health care services;

(5) general operating expenses;

(6) programs or plans to improve the coordination, effectiveness or efficiency of the delivery of primary health care services; and

(7) contracts for medical and dental personnel services.

D. Ineligible item/uses of expenditures: Costs which are not eligible for funding under Section 24.1A-3.1.D., NMSA 1978, of the act include:

(1) land acquisition;

(2) building, construction, renovation;

(3) debt amortization;

(4) emergency medical services (EMS) including stand-by, dispatch, transport, ambulance runs, equipment and salary, fringe benefits and other costs associated with personnel to provide emergency medical services;

(5) home health care or visiting nurses services;

(6) school nurse programs;

(7) in-patient care;

(8) non-primary health care specialty care including but not limited to surgery, outpatient specialty care and long term care;

(9) freestanding services not otherwise meeting the definition of primary health care;

(10) political activity; and

(11) lobbying.

E. Distribution of financial assistance: In any state fiscal year, the distribution of financial assistance to eligible programs selected pursuant to these rules shall be determined according to the following guidelines.

(1) The award amount will be set by the department reflecting the demonstrated need of the eligible program in its proposal. The demonstrated need of an applicant will be established by the department based upon information contained in the proposal. The department reserves the right to award an amount less than the full amount of demonstrated need.

(2) In any state fiscal year, a maximum award to an eligible program for use in a single HCUA designated for primary health care needs shall not exceed an amount greater than 10 percent of the funds made available by the department for the purposes of distribution of financial assistance under Subsection D of 7.29.3.6 NMAC of these rules, except that eligible programs which are found to have exceptional need may be funded in an amount not to exceed 15 percent of the funds available.

(3) The relative need of an eligible program for financial assistance as demonstrated in the proposal.

(4) The relative need for primary health care services of the HCUA served by the eligible program as reflected in the proposal or other department documents which demonstrate the relative need for primary health care services. Consideration will be given by the department to avoiding the funding of duplicative services and to sustain the provision of a minimum level of primary health care services by eligible organizations which demonstrate the ability to deliver and maintain quality, effective, efficient and appropriate primary health care services.

(5) The degree to which the eligible program has adequate structures and procedures to administer and deliver primary health care services, including but not limited to staffing, the ability to administer effective and appropriate primary health care services, effective and appropriate financial management systems and adequate systems to maximize patient revenues.

(6) The priority given by the department for the proposed use of the funds.

(7) Other guidelines as determined by the department.

F. Evaluation of proposals: Each proposal will be evaluated and ranked with consideration given to the following factors:

(1) the relative need of an eligible program for financial assistance to sustain or provide primary health care services in a HCUA designated for primary health care needs as demonstrated in the proposal process. Financial need will be evaluated based on several factors, including but not limited to:

(a) the applicant's dependence upon patient collections as a percentage of total revenues available to the applicant for primary health care services;

(b) the extent to which write-offs and adjustments to charges, based on appropriate sliding fee scale implementation, affect the ability of the eligible program to sustain the delivery of primary health care services to an HCUA designated for primary health care needs, as demonstrated in the proposal;

(c) the existence of fund balances which may be used by the applicant to sustain or provide a minimum level of primary health care services in an HCUA designated for primary health care needs;

(d) the projected deficit as demonstrated in the proposal which will impact the ability to sustain or provide a minimum level of primary health care services in an HCUA designated for primary health care needs;

(e) the probable impact which any projected deficit as demonstrated in the proposal will have on the provision of primary health care in an HCUA; and

(f) other need criteria developed by the department.

(2) the relative need of the HCUA served by the applicant for primary health care services, as reflected in the proposal and measured by, including but not limited to:

(a) the severity of need within the HCUA as indicated in department documents or demonstrated in the proposal;

(b) the number and/or percentage of medically indigent population residing in the HCUA; and

(c) other need criteria developed by the department;

(3) the degree to which the applicant has adequate structure and procedures to administer and deliver primary health care services including, but not limited to, staffing, ability to administer effective and appropriate primary health care services, effective and appropriate financial management systems and adequate systems to maximize patient revenues;

(4) the priority given by the department will be for application proposals which have shown need under Subsection E of 7.29.3.9 NMAC of these rules and will be evaluated based on the following criteria, including but not limited to:

(a) proposals where state funds are critical in assuring that any basic primary health care services can be provided in an HCUA designated for primary health care needs. This could include, but not be limited to, support for compensation of providers which is needed for their recruitment and/or retention;

(b) proposals where state funds will be used to supplement the quality/quantity of basic primary health care services in an HCUA designated for primary health care needs. This could include, but not be limited to, support for compensation of providers which is needed for their recruitment and/or retention;

(c) proposals which demonstrate coordination and/or innovative relationships with those funded by the department including, but not limited to, local public health division offices, mental health programs, and substance abuse program and/or other health care services;

(d) proposals where state funds will be used to maintain or expand the comprehensiveness of services beyond basic primary medical services in an HCUA designated for primary health care needs. This could include, but not be limited to, support for compensation of providers which is needed for their recruitment and/or retention; and

(e) other priorities as established by the department.

(5) other factors established by the department.

G. Reports: The department will monitor the performance of the contractor(s) to ensure compliance with the intent of the act.

H. Award of contracts: The department will award contracts in accordance with the New Mexico Procurement Code and applicable department rules.

I. Protest procedure: Any offeror or contractor who is aggrieved in connection with the award process may use the protest procedure established by the New Mexico Procurement Code and applicable department rules.

[7.29.3.8 NMAC - Rp, 7 NMAC 29.3.9, 10/16/06]

7.29.3.9 NEW PRIMARY HEALTH CARE SERVICES/FACILITIES:

A. Duty of the department: To the extent funds are made available for the purposes of the act, Section 24-1A.3.1E NMSA 1978, the department shall provide a program for enabling the development of new primary health care services or facilities. The department in establishing the program for new primary health care services or facilities will give consideration to proposals for planning as well as for implementation.

B. Eligibility: To be eligible to receive funds to assist in planning for the development of primary health care services or facilities in HCUA(s) designated for primary health care needs, eligible program(s) shall:

(1) be a New Mexico nonprofit community based entity with Federal Internal Revenue Service 501c(3) tax exempt status, local government or tribal government;

(2) have a local or regional primary health care advisory board whose membership is generally representative of the HCUA(s) for which it is developing the primary health care plan; and

(3) meet other requirements as determined by the department.

[7.29.3.9 NMAC - Rp, 7 NMAC 29.3.10, 10/16/06]

7.29.3.10 PERSONNEL RECRUITMENT:

A. Duty of the department: To the extent funds are made available for the purposes of the act, Section 24-1A-3.1A NMSA 1978, the department may contract, in accordance with applicable procurement procedures, with New Mexico nonprofit entities to assist communities in the recruitment, placement, and retention of health care personnel in health care underserved areas of the state and to coordinate such effort with health professional education programs. Such efforts shall be consistent with priorities set out by the department. The department will monitor the performance of the contractor to ensure compliance with the intent of the act.

B. Eligibility: In order to contract pursuant to this part of the rules, the entity shall meet the following requirements:

(1) be a New Mexico nonprofit entity which has obtained and maintains a federal internal revenue service 501c(3) tax exempt status;

(2) have a governing board of directors which is representative of the geographic areas and ethnic populations in New Mexico and is comprised of both health care providers and consumers;

(3) have the capability to carry out the purposes of Subsection A of 7.29.3.8 NMAC of these rules, including qualified professional staff;

(4) not be a health care provider or association of health care providers; and

(5) meet other requirements as determined by the department.

C. Reports: The department will monitor the performance of the contractor(s) to ensure compliance with the intent of the act. The contractor shall submit to the department all financial and program reports required by the contract.

D. Selection of candidates: The contractor shall conduct all recruitment activities based upon the following considerations:

(1) all candidates shall be considered on an equal opportunity basis without regards to race, age, color, national origin, gender, sexual orientation, handicap or disability or religion or ethnicity; and

(2) whenever possible, emphasis will be placed upon assisting native New Mexicans, New Mexico residents and graduates from New Mexico health professional education programs in relocating to health care underserved areas.

[7.29.3.10 NMAC - Rp, 7 NMAC 29.3.8, 10/16/06]

PART 4: PRIMARY CARE CAPITAL FUND PROGRAM

7.29.4.1 ISSUING AGENCY:

New Mexico Department of Health - Public Health Division.

[7.29.4.1 NMAC - Rp 7 NMAC 29.4.1, 12/28/01]

7.29.4.2 SCOPE:

The Primary Care Capital Fund Program Regulations shall apply to the use of funds by eligible entities available pursuant to the Primary Care Capital Funding Act, Sections 24-1C-6., et seq., NMSA 1978.

[7.29.4.2 NMAC - Rp 7 NMAC 29.4.2, 12/28/01]

7.29.4.3 STATUTORY AUTHORITY:

These regulations are promulgated pursuant to: 1) the Department of Health Act, Section 9-7-6.E., NMSA 1978; 2) the Primary Care Capital Funding Act, Sections 24-1C-1., et seq., NMSA 1978.

[7.29.4.3 NMAC - Rp 7 NMAC 29.4.3, 12/28/01]

7.29.4.4 DURATION:

Permanent

[7.29.4.4 NMAC - Rp 7 NMAC 29.4.4, 12/28/01]

7.29.4.5 EFFECTIVE DATE:

December 15, 2001, unless a later date is cited in a section.

[7.29.4.5 NMAC - Rp 7 NMAC 29.4.5, 12/28/01]

7.29.4.6 OBJECTIVE:

The objective is to establish standards and procedures for regulating Programs under the Primary Care Capital Funding Act. Section 24-1C-6. NMSA 1978 of the Primary Care Capital Funding Act directs the Department of Health and the New Mexico Finance Authority to jointly develop and administer loan and Contract for Services Programs established pursuant to the provisions of the Act.

[7.29.4.6 NMAC - Rp 7 NMAC 29.4.6, 12/28/01]

7.29.4.7 DEFINITIONS:

A. "Act" means the Primary Care Capital Funding Act (Sections 24-1C-1 to 24-1C-10 NMSA 1978).

B. "Agreement" means the document or documents signed by the Board and the Eligible Entity which specify the terms and conditions of obtaining Financial Assistance under the Program;

C. "Applicant" means an Eligible Entity which has filed a request for Financial Assistance with the Department and the Authority;

D. "Application" means a written document filed with the Department and the Authority by an Applicant for the purpose of obtaining Financial Assistance; an application may include a form prescribed by the Department and the Authority, written responses to requests for information by the Department and the Authority, or other format as determined by the Department and the Authority;

E. "Authority" means the New Mexico Finance Authority;

F. "Authorized Representative" means one or more individuals authorized by the governing body of an Eligible Entity to act on behalf of the Eligible Entity in connection with its application. An Authorized Representative may act on behalf of the Eligible Entity to the extent provided by law;

G. "Board" means the New Mexico Finance Authority Board;

H. "Capital Project" means repair, renovation or construction of a facility, purchase of land, or purchase of capital equipment;

I. "Contract for Services" means an agreement with an Eligible Entity to provide free or reduced fee Primary Care services for Sick and Medically Indigent persons as reasonably adequate legal consideration for money from the Fund to the Eligible Entity so it may acquire or construct a Capital Project to provide the services;

J. "Department" means the New Mexico Department of Health;

K. "Eligible Entity" means a community-based nonprofit Primary Care clinic or Hospice that operates in a rural or other Health Care Underserved Area of the State and that has assets totaling less than ten million dollars ($10,000,000.00) and is a 501 (c)(3) nonprofit corporation for federal income tax purposes;

L. "Finance Committee" means a six-member body, three members appointed by the chairman of the Board from the members of the Board and/or the Authority staff and three members appointed by the Department;

M. "Financial Assistance" means loans, contracts for services, and any other type of assistance authorized by the Act, or a combination thereof, provided by the Authority to an Eligible Entity under the Program for the funding of a Capital Project;

N. "Fund" means the Primary Care Capital Fund;

O. "Health Care Underserved Area" (HCUA) means geographic areas, special populations or institutions designated by the Department as having identifiable need for health services. These designations may recognize need for either general or special

health care services. State HCUA designations may give consideration to federally designated Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA).

P. "Hospice" means an organization, company, or any other entity which provides a Program of palliative and supportive services which provides physical, psychological, social and spiritual care for terminally ill patients and their family members in a Licensed Facility equipped and staffed to provide services on a twenty-four (24) hour basis.

Q. "Licensing Authority" means the Department.

R. "Licensed Facility" means facility licensed by the Department and complies with all applicable state and federal licensing requirements.

S. "Mid-level Provider" means licensed or certified non-physician Primary Care provider including physician assistant, nurse practitioner or nurse midwife.

T. "Primary Care" means the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services; "Primary Care" includes the provision of mental health services if those services are integrated into the Eligible Entity's service array;

U. "Program" means the Primary Care Capital Project Finance Program authorized by the Act;

V. "Sick and Medically Indigent" means both those individuals below the federal poverty level not covered by private third party health care insurance and those individuals between 100% and 200% of federal poverty levels who are not covered by any private third party health insurance. Medically indigent individuals are usually expected to pay for some portion of the cost of their health care based upon the level of their income.

[7.29.4.7 NMAC - Rp 7 NMAC 29.4.7, 12/28/01]

7.29.4.8 APPLICATION PROCEDURES FOR FINANCIAL ASSISTANCE:

A. Contingent upon a sufficient balance in the Fund, the Department and the Authority may establish one or more application cycles in any state fiscal year. At the beginning of any application cycle, the Department and the Authority will notify eligible entities that applications are being accepted for financing of Capital Projects.

B. The Department and the Authority will provide forms and/or guidelines for application to apply for Program funds. The application shall be signed by the Authorized Representative and submitted to the Department. The application shall include the following:

(1) type of Financial Assistance being sought and itemization of the proposed use or uses of the Financial Assistance;

(2) detailed description of the circumstances which justify the need for the Capital Project, including:

(a) eligibility of application entity

(b) programmatic appropriateness

(c) facility need as covered in Section 9.2.a.

(d) needs of community as covered in Section 9.2 b.

(3) detailed description of the Capital Project to be financed. Information on each Capital Project must include:

(a) description of the scope of work of the Capital Project;

(b) the estimated cost of the Capital Project;

(c) the target date for the initiation of the Capital Project and the estimated time to completion;

(d) the estimated useful life of the Capital Project and selected components (furnishings, equipment, etc.), as detailed on the application form;

(e) proof of applicable licenses and certifications; and

(f) other data as requested by the Department or the Authority.

(4) a copy of the Applicant's articles of incorporation and by-laws;

(5) a copy of the Applicant's Internal Revenue Service tax exempt determination letter;

(6) a letter certifying that the Capital Project was duly authorized and approved by the Applicant's governing body;

(7) identification of the source of funds for repayment of the Financial Assistance and the source of funds to operate and maintain the Capital Project over its useful life;

(8) the Applicant's audited financial reports for the most recent three years;

(9) the requested loan payback period;

(10) any existing title insurance policies, title abstracts or searches of the real property owned by the Applicant;

(11) information on the current and proposed services of the Applicant to the sick and medically indigent;

(12) additional information as requested by the Department, Board or Finance Committee.

C. The Department shall conduct a review of the application for eligibility, completeness and programmatic priority.

D. The Department will refer the applications to the Finance Committee. The Finance Committee will consider the Capital Project and may confer with outside parties as necessary to obtain more information on the financial feasibility, Capital Project feasibility, and readiness to proceed. The Finance Committee will make a written recommendation to the Board. Such recommendation will include approval or disapproval of specific Capital Projects and the estimated costs thereof. The Finance Committee may also, at its discretion, recommend interest rates, loan periods, loan amounts and amounts of contracts for services.

E. Once a recommendation has been made on the application by the Finance Committee, the Board will act on the application no later than the next regular Board meeting at which such item may be properly considered, or 45 days after Finance Committee action, whichever comes first. The Board may approve all or part of the application as recommended by the Finance Committee. Board approval may specify, at the Board's discretion, terms and conditions of the Financial Assistance as necessary to ensure repayment, including but not limited to, maximum loan term and maximum annual payments.

F. The Board will notify the Applicant of the approval or disapproval of its application by telephone and will mail written notification by certified mail within seven working days of Board action. Written notification of the approval will be accompanied by an Agreement to be signed by an Authorized Representative of the Applicant and returned to the Board by certified mail.

G. All communications regarding an Eligible Entity's original application shall be directed to the Department.

[7.29.4.8 NMAC - Rp 7 NMAC 29.4.8, 12/28/01]

7.29.4.9 EVALUATION OF APPLICANT AND CAPITAL PROJECT:

The Department and Authority will complete an evaluation of the Applicant and proposed Capital Project. Such evaluation will include, to the extent applicable, an evaluation of Capital Project feasibility, administrative capacity, and financial position.

A. An Eligible Entity:

(1) Must be a community-based nonprofit Primary Care clinic or Hospice that operates in a rural or other Health Care Underserved Area of the State and that has assets totaling less than ten million dollars ($10,000,000.00) and is a 501 (c)(3) nonprofit corporation for federal income tax purposes.

(2) Have a governing board whose membership is generally representative of the health care underserved area served. An eligible organization which is multipurpose or provides services in more than one Health Care Underserved Area must have a local or regional Primary Care or Hospice advisory board whose membership is generally representative of the Health Care Underserved Area being served.

(3) If a Primary Care clinic, must sustain or provide a minimum level of primary health care services through the services of a physician or midlevel provider. Services may additionally include, but not be limited to, medical support, diagnostic and treatment services, pharmacy, laboratory, radiology, preventive health services, emergency medical services, mental health, patient follow-up, and/or dental and dental support services. Such services shall be provided in coordination with primary medical care services.

(4) If a Hospice, comply with all New Mexico Requirements for Inhome and Inpatient Hospice Care as specified in 7 NMAC 12.2 or such other regulations as may be adopted by the Department.

(5) Have policies and procedures which assure that no person will be denied services because of inability to pay. These policies and procedures must address the medically indigent persons below poverty not covered by third party payors and those between 100% and 200% of poverty without third party coverage. The Eligible Entity must be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation.

(6) Have billing policies and procedures which maximize patient collections except where Federal regulations or contractual obligations prohibit the use of such measures. The Eligible Entity must be able to demonstrate either the successful impact of these policies and procedures, or have a practical plan for their implementation.

(7) Provide a written assurance, signed by an attorney, that it has proper title, easements, leases, and right of ways to the property upon which any facility proposed for funding is constructed or improved.

(8) Comply with all applicable federal, state, and local laws and regulations.

(9) Meet other requirements as determined by the Department.

B. Need. The Department will determine priorities for community need and facility/equipment need.

C. Capital Project Feasibility. The Finance Committee will analyze each Capital Project to determine whether the Capital Project is feasible. Extension of Financial Assistance by the Authority does not constitute a warranty or other guarantee as to the feasibility of the Capital Project.

D. Administrative Capacity. The Finance Committee will evaluate the extent to which the Applicant has sufficient administrative capacity.

E. Financial Position. Financial performance is a key factor in the evaluation of an Applicant. The Applicant must demonstrate that the excess of public support and revenues over expenses for the most recent fiscal year or the projected amount for the fiscal year after the Capital Project's completion (after adding back annual depreciation and interest) provides sufficient coverage of the previous year's annual debt service and sufficient coverage of projected maximum annual debt service after accounting for the Authority's loan.

F. Service Capacity. The Department will establish priorities for Financial Assistance, determine the appropriateness of the Capital Project, evaluate the capability of an Applicant to maintain Primary Care or Hospice services, and determine that Capital Projects comply with all state and federal licensing requirements. The Department will determine, for applications for contracts for service, the adequacy of proposed plans to provide Primary Care services in lieu of loan repayment.

G. Geographic Location. The Department will determine whether there is fair geographic distribution of Financial Assistance.

[7.29.4.9 NMAC - Rp 7 NMAC 29.4.9, 12/28/01]

7.29.4.10 ELIGIBLE PUBLIC CAPITAL PROJECTS AND COSTS:

The Authority provides Financial Assistance to eligible entities only for Capital Projects, as defined above. Costs which may be financed under the Program include all or any portion of the cost of eligible Capital Projects. An Applicant which has had Financial Assistance approved by the Board may apply to the Board to redirect the Financial Assistance to modify a Capital Project made necessary by unanticipated events.

[7.29.4.10 NMAC - Rp 7 NMAC 29.4.10, 12/28/01]

7.29.4.11 CAPITAL PROJECT FINANCING:

A. The Authority reserves the right to structure Financial Assistance packages that include loans, contracts for services, and any other type of assistance authorized by the Act. The structure, terms and conditions of the Financial Assistance will be determined

by Board resolution. Financial Assistance for Capital Projects may be pooled, at the discretion of the Authority.

B. Priority will be given to applications for Capital Projects which show substantial community support, including, but not limited to, the identification of other financing.

C. Eligible Items/Ineligible Items. The following items shall be eligible or ineligible for purposes of funding through a loan or Contract for Services.

(1) Eligible Item/Uses of Funds

a. Building, construction, renovation

b. Land (can only be funded by a loan)

c. Capital Project planning and design

d. Purchase of capital equipment

(2) Ineligible Item/Uses of Funds

a. Repair and/or maintenance of necessary medical and dental equipment

b. Mobile clinics

c. Purchase of office, medical, and/or dental supplies

d. General operating expenses.

D. Loans. Capital Projects or Applicants may be eligible for loans made directly from available resources.

E. Contracts for Services. The Authority may enter into a Contract for Services to offset a portion or all of an Applicant's loan repayments. No more than 20% of the Funds awarded in any application cycle shall be made available as contracts for services in that cycle. The amount of any Contract for Services offered as part of any Financial Assistance package will be recommended by the Finance Committee based upon consideration of the need for the Capital Project, the inability of the Applicant to afford debt financing in the near term and the proposed plan to provide services for Sick and Medically Indigent free or at a reduced fee.

[7.29.4.11 NMAC - Rp 7 NMAC 29.4.11, 12/28/01]

7.29.4.12 FINANCING APPROVAL REQUIREMENTS:

Based on the evaluation factors set forth in 7.29.4.9, the Board may award Financial Assistance to the Applicant provided the following requirements are satisfied:

A. In determining the qualification for Financial Assistance, the Board may consider the ability of the Eligible Entity to secure financing from other sources and the costs of the Financial Assistance.

B. In approving a Contract for Services, the Board will consider the recommendations of the Finance Committee.

C. In approving a loan application, the Board will review the Applicant's ability to repay the loan extended. The Board will establish a base interest rate for loans. A portion or all of the loan repayment may be offset by a contract for service.

D. In approving an application for debt financing, the Board will find that the useful life of the Capital Project will meet or exceed the final maturity of loans made or bonds purchased or issued by the Board and must meet standards for reasonable costs set by the Board.

E. To be eligible for a loan, the Applicant shall agree to properly maintain separate Capital Project accounts in accordance with generally accepted accounting principles and to conduct an annual audit of the Capital Project's financial records during the term of the loan.

F. In order to receive Financial Assistance, the Applicant shall provide a written opinion, signed by an attorney, that the Eligible Entity has or will acquire proper title, easements and rights-of-way to the property upon or through which the Capital Project is to be constructed or extended.

G. Any contract or subcontract executed for the completion of any Capital Project shall contain a provision that there shall be no discrimination against any employee or Applicant for employment because of race, color, creed, sex, religion, sexual preference, ancestry or national origin.

H. In order to receive Financial Assistance, the Applicant shall require any contractor of a Capital Project to post a performance and payment bond in accordance with the requirements of Section 13-4-18 NMSA 1978 and its subsequent amendments and successor provisions.

I. In addition to the foregoing, the Eligible Entity shall satisfy any other requirements as may be determined by the Authority.

J. Reserved

[7.29.4.12 NMAC - Rp 7 NMAC 29.4.12, 12/28/01]

7.29.4.13 RECONSIDERATION:

A. An Applicant may request reconsideration of a contrary decision by the Department as to whether it is an Eligible Entity as defined by the Act. Notice must be given to the Department in writing within ten (10) working days of receipt of the Department's decision as to eligibility.

B. An Applicant may request reconsideration of a decision by the Board denying funding to an Eligible Entity by notifying the Authority in writing within forty-five days of the date on which notice of an adverse decision is given by the Authority to an Applicant. Notice is deemed to be given on the fifth business day following the date on which written notice is mailed to the Applicant by the Authority by certified U.S. mail. A request for reconsideration not timely or properly made will be barred. The Authority's Executive Director will promptly review each timely request for reconsideration and will recommend, at the next regular meeting of the Board, action to be taken by the Board. The Board will review and take action on the request for reconsideration and will notify the Applicant of the Board's decision, in writing, within five working days of the Board's decision. The decision of the Board is final.

[7.29.4.13 NMAC - Rp 7 NMAC 29.4.13, 12/28/01]

7.29.4.14 FINANCIAL ASSISTANCE AGREEMENT:

A. The Authority and the Eligible Entity will enter into an Agreement to establish the terms and conditions of Financial Assistance from the Authority including, as appropriate, a Contract for Services. The Agreement will include the terms of repayment and sanctions available to the Authority in the event of a default. The Authority will diligently monitor terms of the Agreement and enforce all terms and conditions thereof, including prompt notice and collection. The Department will monitor the performance of an Eligible Entity under any Contract for Services and report to the Authority quarterly on the contractor’s efforts to provide free or reduced fee Primary Care services for Sick and Medically Indigent persons. The Authority will take actions as necessary to ensure loan repayment and the integrity of the Fund.

B. The interest on any Financial Assistance extended shall be determined by the Board based on the cost of funds and ability of the Eligible Entity to pay. The interest rate shall not change during the term of the Financial Assistance unless refinanced.

C. The Agreement will contain provisions which require Financial Assistance recipients to comply with all applicable federal, state and local laws and regulations.

D. In the event of default by the qualified entity, the Authority may enforce its rights by suit or mandamus and may utilize all other available remedies under state and applicable federal law.

E. If land is to be purchased with a loan from the Fund, the Authority shall ensure that the title is merchantable and free and clear from liens or encumbrances. The state shall also require that a title insurance policy insuring the state's interest as a first lien be obtained as a condition of making the loan. The Eligible Entity shall not encumber the land purchased by granting or creating any additional security interest in the land while any amount of the loan is unpaid. The Eligible Entity shall pay immediately any encumbrance or lien against the land that attaches while any amount of the loan is unpaid. No contracts for services shall be made to purchase land.

F. If an Eligible Entity that has received a loan or Contract for Services for a Capital Project ceases to maintain its nonprofit status or ceases to deliver Primary Care services at the site of the Capital Project for twelve consecutive months, the state shall have the following remedies at its option, subject to liens having preference:

(1) order liquidation of the premises and recover any loan balance or amount due on the contract and any interest previously forgiven on the loan, imputed at the prevailing interest rate at the time of the loan; or

(2) foreclose on the property and convert it to state use or transfer title to another Eligible Entity.

G. If an Eligible Entity has received a loan or contract for service for a Capital Project, the loan or contract for service may be renegotiated if the entity is still eligible but has had a change in financial status.

[7.29.4.14 NMAC - Rp 7 NMAC 29.4.14, 12/28/01]

7.29.4.15 ADMINISTRATION OF THE PRIMARY CARE CAPITAL FUND:

A. The Fund shall be administered by the Authority as a separate account in the State Treasury, but may consist of such sub accounts as the Authority deems necessary to carry out the purposes of the Fund.

B. Money from repayments of loans or payments on securities held by the Authority for Capital Projects authorized specifically by law shall be deposited in the Fund. The Fund shall also consist of any other money appropriated, distributed or otherwise allocated to the Fund for the purpose of financing Capital Projects authorized specifically by law.

C. The Authority shall adopt a uniform accounting system for the Fund and related accounts and sub-accounts established by the Authority, based on generally accepted accounting principles.

[7.29.4.15 NMAC - Rp 7 NMAC 29.4.15, 12/28/01]

PART 5: CERTIFICATION OF COMMUNITY HEALTH WORKERS

7.29.5.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.29.5.1 NMAC - N, 1/30/15]

7.29.5.2 SCOPE:

This rule applies to any person seeking to practice as a certified community health worker in the state of New Mexico.

[7.29.5.2 NMAC - N, 1/30/15]

7.29.5.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: 1) the Department of Health Act, Subsection E of Section 9-7-6 NMSA 1978, which authorizes the secretary of the department of health to "...make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions," and; 2) the Community Health Workers Act, Sections 24-30-1 through 24-30-7 NMSA 1978, which authorizes the department to adopt regulations to carry out the provisions of the act.

[7.29.5.3 NMAC - N, 1/30/15]

7.29.5.4 DURATION:

Permanent.

[7.29.5.4 NMAC - N, 1/30/15]

7.29.5.5 EFFECTIVE DATE:

January 30, 2015, unless a later date is cited at the end of a section.

[7.29.5.5 NMAC - N, 1/30/15]

7.29.5.6 OBJECTIVE:

The objective of this rule is to implement the Community Health Workers Act. This rule governs the voluntary certification of community health workers (CHWs) in New Mexico.

[7.29.5.6 NMAC - N, 1/30/15]

7.29.5.7 DEFINITIONS:

A. "Action against a certificate" means any formal action taken by the department that adversely affects certification status, including but not limited to denial of initial certification or re-certification, suspension or revocation or a certificate, probation or reprimand.

B. "Applicant" means an individual applying for community health worker certification or recertification.

C. "Board" means the board of certification of community health workers established under these rules.

D. "Certificate" means the document issued by the department to qualified applicants who have successfully completed the application process for certification as community health workers.

E. "Certification" means the voluntary process by which the department grants recognition and use of a credential to individuals who are eligible to practice as certified community health workers.

F. "Certified community health worker" or **"CCHW"** means a community health worker to whom the department has issued a certificate to practice as a certified community health worker.

G. "Community health worker" or **"CHW"** means a public health worker, also known as a tribal community health representative or a promotora, who applies an understanding of the experience, language, and culture of the populations that the individual serves and who provides services aimed at optimizing individual, family and community health outcomes.

H. "Continuing education" means courses or training designed to develop and enhance knowledge, skills, and professional development to ensure that CCHWs are up to date with current practices in the field.

I. "Conviction" means a plea or adjudication of guilt, a plea of nolo contendre, or an Alford plea, and does not include a conditional discharge or deferred adjudication that results in dismissal of a charge.

J. "Core competencies" means a combination of qualities, practical skills and knowledge, defined by the department as essential to the provision of services by community health workers, demonstration of which is required for certification.

K. "Department" means the department of health.

L. "Recertification" means a renewal of certification.

M. "Scope of practice" means the roles and related tasks performed by CCHWs in the provision of services, including the knowledge, skills and attributes needed to perform work-related functions, as defined by the department.

N. "Secretary" means the secretary of the department of health.

[7.29.5.7 NMAC - N, 1/30/15]

7.29.5.8 BOARD OF CERTIFICATION OF COMMUNITY HEALTH WORKERS:

A. Board membership:

(1) The board shall be comprised of nine members who are residents of New Mexico, appointed by the secretary, and shall include:

(a) three currently practicing CHWs, including at least one tribal community health representative;

(b) the secretary or the secretary's designee, who shall serve as chair of the board; and

(c) five additional members that the secretary shall endeavor to appoint from community health stakeholders including but not limited to health care providers, tribal representatives, individuals from institutions of higher learning, or members of the community from various geographic regions of the state.

(2) Members of the board other than the department's representative shall serve for staggered terms of four years. The secretary shall appoint to the initial board three members to a four-year term, three members to a three-year term, and two members to a two-year term. Each member shall hold office until his or her successor is appointed.

(3) Board members shall be reimbursed as provided for in the Per Diem and Mileage Act, Section 10-8-1 *et seq*. NMSA 1978 and shall receive no other compensation, perquisite or allowance.

B. Meetings: The board shall convene at least once per quarter at the call of the chair and as frequently as reasonably necessary to review and make recommendations regarding the CHW certification process.

(1) Meetings shall be conducted in accordance with the Open Meetings Act, Section 10-15-1 through 10-15-4 NMSA 1978. A simple majority of the members of the board shall constitute a quorum for the purpose of transacting official business.

(2) Meeting arrangements and attendance requirements shall be determined by the board. The board shall recommend to the secretary removal of board members for non-participation or any other good cause.

C. Duties and responsibilities: The board shall advise the secretary on the implementation of standards, guidelines, and requirements relating to the training and regulation of persons seeking certification or practicing as CCHWs.

(1) The board shall make recommendations to the secretary on the following matters:

(a) standards and requirements for the establishment and approval or acceptance of community health worker education and training programs in the state;

(b) standards and requirements for approval or acceptance of continuing education courses and programs as the board may require for recertification every two years;

(c) minimum education, training, experience, and other qualifications that a certified community health worker shall possess to qualify as a trainer in any education, training, or continuing education program for community health workers;

(d) the process to acknowledge, document, and assess relevant education, training and experience or other qualifications acquired by CHWs practicing in the state before the effective date of the Community Health Workers Act for purposes of certification while waiving minimum training and experience requirements established by the act (also known as "grandfathering");

(e) the means to assess community health worker competency in connection with certification;

(f) the core competencies to be required for certification, in consideration of current New Mexico and national CHW workforce studies; and

(g) the scope of practice for CCHWs.

(2) The board may provide guidance to the program on issues or topics presented to the board at the program’s discretion.

(3) Board recommendations: The board shall provide to the secretary written recommendations in accordance with the duties listed in this section, including any supporting documentation or public commentary. The secretary shall make a final determination on all board recommendations.

[7.29.5.8 NMAC - N, 1/30/15]

7.29.5.9 NEW MEXICO REGISTRY OF COMMUNITY HEALTH WORKERS:

The New Mexico registry of community health workers shall be maintained at the department. The registry is voluntary and open to all persons who are CCHWs in the state of New Mexico. The registry shall contain the name, certification number, certification status, and geographic location of the CCHW. Registry information is subject to public inspection.

[7.29.5.9 NMAC - N, 1/30/15]

7.29.5.10 COMMUNITY HEALTH WORKER CERTIFICATION:

A. Initial certification:

(1) All applicants for initial certification in New Mexico shall:

(a) submit to the department a completed application in a form specified by the department to include verification that applicant has met the eligibility requirements;

(b) submit to the department the designated application fee; and

(c) if an applicant otherwise meets the eligibility requirements, then in accordance with this rule, submit a request to the department of public safety (DPS) or a DPS vendor for a state and national criminal history screening. The results of the criminal history screening shall be received by the department before a certificate can be issued.

(2) Eligibility requirements for applicants who were practicing CHWs before the effective date of the Community Health Workers Act:

(a) proof that applicant is at least 18 years of age; and

(b) verification of proficiency in the core competencies through training or experience, signed by a current or former supervisor; and

(c) two letters of reference; and

(d) documentation of 2,000 hours of work or volunteer experience as a CHW in the two years prior to application, or documentation of at least half-time paid or volunteer employment as a CHW in the five years prior to application.

(3) Eligibility requirements for applicants who were not practicing CHWs before the effective date of the Community Health Workers Act, or who otherwise do not meet the criteria for grandfathering by waiver of minimum training and experience requirements based on practice before the effective date of the Community Health Workers Act:

(a) proof that applicant is at least 18 years of age; and

(b) proof of completion of a department-approved training program that contains an examination component for each of the core competencies; and

(c) at least a high school diploma or certificate of high school equivalency.

(4) Applicants may be certified at the following levels:

(a) generalist: an applicant who provides proof of completion of a department-approved training program that contains an examination component for each of the core competencies, or an applicant who meets the requirements for certification through grandfathering;

(b) specialist I: an applicant who meets the requirements for a generalist and who demonstrates additional education or training in at least one specialty area;

(c) specialist II: an applicant who meets the requirements for a generalist and who demonstrates additional education or training in at least two specialty areas;

(d) specialist III: an applicant who meets the requirements for a generalist and who demonstrates additional education or training in three or more specialty areas;

(e) specialty areas include but are not limited to basic clinical support skills, heart health, chronic disease, behavioral health, maternal and child health or developmental disabilities.

(5) The department shall issue certificates to applicants who satisfy the requirements of this rule, unless the application is disapproved.

(6) Certificates shall be valid for two years from the date of issuance. A CCHW shall carry the CCHW certificate and present it upon request.

B. Recertification: An applicant for recertification shall:

(1) Submit to the department a completed application in a form specified by the department to include proof of current certification.

(2) Submit to the department the designated application fee.

(3) Provide proof of completion of at least 30 hours of department-approved continuing education.

(4) Every other recertification period (every four years), if an applicant otherwise meets the eligibility requirements, then in accordance with this rule, submit a

request to DPS or a DPS vendor for a current state and national criminal history screening.

C. Reinstatement after lapse, suspension, or revocation:

(1) The requirements for reinstatement of a certificate that has lapsed for one year or less are the same as those for recertification, with the payment of fees as identified for reinstatement after lapse in Subsection F of 7.29.5.10 NMAC and, if required as part of recertification, then in accordance with this rule, submission of a request to DPS or a DPS vendor for a current state and national criminal history screening.

(2) The requirements for reinstatement of a certificate that has lapsed more than one year prior to the application date are the same as those for an initial application.

(3) The requirements for reinstatement of a certificate that has been suspended or revoked are the same as those for recertification, provided that the term of suspension has been completed or terminated or approval of reinstatement after revocation has been granted. Applicant shall pay the designated fees for reinstatement after suspension or revocation in Subsection F of 7.29.5.10 NMAC and, in accordance with this rule, submit a request to DPS or a DPS vendor for a current state and national criminal history screening.

D. Disapproval:

(1) The department may disapprove an application if an applicant has not met the eligibility requirements as defined by the department or has submitted an incomplete application. The department shall send a notice of disapproval with the reasons why the applicant was disapproved and the requirements necessary to reapply.

(2) An applicant whose application has been disapproved under Paragraph (1) of Subsection D of 7.29.5.10 NMAC may not appeal the disapproval. The applicant shall be permitted to reapply and shall submit a current and complete application that meets the designated requirements within 60 days of receipt of the notice of disapproval. If the re-submitted application is received by the program within the 60 days, no new application fee is required. If the re-submitted application is received after the 60 days, applicant shall be required to pay the application fee designated in this rule.

E. Application processing:

(1) Applications, including associated fees, shall be sent to the department’s office of community health workers.

(2) The department shall review applications on a rolling basis. Applicants shall be notified in writing within 30 working days of receipt of the application by the department whether their application has been approved or disapproved.

(3) If an application has been disapproved, applicants shall be notified of their ability to reapply pursuant to Paragraph (2) of Subsection D of 7.29.5.10 NMAC.

(4) If an application has been approved, then applicants shall be directed to complete a state and national criminal history screening. For applicants with no criminal history, or with no history of felony convictions, the department shall issue a certificate within 10 working days of receipt of the criminal history screening results.

(5) Applications with an associated criminal history shall be referred to the certification review committee and reviewed according to the procedure set forth in this rule.

F. Fees:

(1) The department shall charge the following fees for certification or approval services.

(a)	initial certification: generalist	$45
(b)	initial certification: specialist I	$55
(c)	initial certification: specialist II	$65
(d)	initial certification: specialist III	$75
(e)	recertification for any level	$45
(f)	reinstatement after lapse	$75
(g)	reinstatement after suspension or revocation	$100
(h)	education, training, or continuing education program approval	$300
(i)	program approval renewal	$200

(2) If an applicant is certified as a generalist, prior to his or her recertification the applicant may apply to be a specialist at any level and pay the difference between the specialist fee and the generalist fee.

(3) Payment of fees: Payment of fees will be accepted in a form specified by the department. Fees are not refundable.

(4) Use of fees: The department shall apply any fee it collects under these rules to cover the costs of administering the community health worker certification program established pursuant to the Community Health Workers Act.

G. Unauthorized practice:

(1) In order to use the title "certified community health worker," the initials "CCHW" or other designation indicating that the individual is a certified community

health worker, an individual shall be certified pursuant to the provisions of the Community Health Workers Act and these rules.

(2) To ensure compliance, the department may issue cease-and-desist orders to persons violating the provisions of the Community Health Workers Act or these rules.

(3) A CCHW shall engage only in those activities authorized pursuant to the Community Health Workers Act and these rules. While engaging in practice as a CCHW, an individual shall not engage in or perform any act or service for which another professional certificate, license or other legal authority is required unless he or she holds the relevant professional certificate, license or other legal authority to perform that act or service.

[7.29.5.10 NMAC - N, 1/30/15]

7.29.5.11 CRIMINAL HISTORY SCREENING:

A. The department is authorized to obtain the criminal history records of applicants and to exchange fingerprint data directly with the federal bureau of investigation (FBI), DPS and any other law enforcement agency or organization. The department shall require fingerprinting of applicants for the purposes of this section.

B. Procedure:

(1) If an applicant otherwise meets the eligibility requirements, then the department shall require the applicant to submit a request to DPS or a DPS vendor for a current state and national criminal history screening.

(2) The department shall provide applicants with the department's originating agency identification (ORI) number or other department identifier for the purposes of criminal history screening.

(3) Applicant shall provide to DPS or a DPS vendor a background check request, fingerprints, and supporting documentation including an authorization for release of information to the department in accordance with DPS or the designated vendor's procedures.

(4) DPS or the designated DPS vendor shall review state records and also transmit the fingerprints to the FBI for a national screening. The results of the screening shall be made available to the department for review.

(5) The department shall make a determination whether the applicant has been convicted of a felony that bears upon the applicant's fitness to provide services.

(6) Applicant shall bear any costs associated with ordering or conducting criminal history screening. Fees are determined by and payable to DPS or the designated DPS vendor. Fees cannot be waived by the department.

(7) The department shall comply with applicable confidentiality requirements of DPS and the FBI regarding the maintenance, dissemination, and destruction of criminal background check information.

(8) For applicants with no criminal history, or with no history of felony convictions, the department shall issue a certificate in accordance with this rule if all other requirements for certification have been satisfied.

[7.29.5.11 NMAC - N, 1/30/15]

7.29.5.12 CERTIFICATION REVIEW COMMITTEE:

A. A certification review committee is hereby established. The committee shall be appointed by the secretary and shall be comprised of five employees of the public health division, to include the division director, the deputy director of programs, and the CHW program manager. The committee shall conduct an individualized review of the grounds for action against a certificate and shall determine whether to pursue action against a certificate by a majority vote. A certificate may be denied, suspended or revoked, or may be subject to any lesser action, including but not limited to reprimand or probation.

B. Grounds for action against a certificate:

(1) Conviction of a felony that bears upon the applicant's fitness to provide services.

(2) Fraud, deceit, or misrepresentation during the certification application process.

(3) Failure to possess and apply the knowledge, skill or care that is ordinarily possessed and exercised by CCHWs or as defined by the core competencies.

(4) Unprofessional conduct, which includes but is not limited to:

(a) verbally or physically abusing a client;

(b) unauthorized practice or practice which is beyond the defined scope of practice for CCHWs, including unauthorized use of the CCHW designation;

(c) unauthorized disclosure of medical or other confidential information;

(d) obtaining or attempting to obtain any fee for client services for one's self or for another through fraud, misrepresentation or deceit; or

(e) physical or mental incapacity which could result or has resulted in performance of CCHW duties in a manner which endangers the health and safety of others.

C. Committee review of criminal history screening results:

(1) The committee shall conduct an individualized review of applications with an associated history of felony convictions, and shall determine whether to pursue action against a certificate by a majority vote. Committee members shall meet any DPS or FBI requirements regarding individuals who handle criminal history information.

(2) The committee may request that applicants provide additional information in writing in order to make a final determination of certification, such as evidence of acquittal, dismissal, conviction of a lesser included crime or rehabilitation.

(3) The provisions of the Criminal Offender Employment Act, Section 28-2-1 through 28-2-6 NMSA 1978 shall govern any consideration of criminal records required or permitted by the Community Health Workers Act. The following factors may also be considered in order to make a final determination on certification:

(a) total number of felony convictions and type of crimes;

(b) time elapsed since last conviction or since discharge of sentence;

(c) circumstances of the crime including but not limited to whether violence was involved;

(d) activities evidencing rehabilitation, including but not limited to substance abuse or other rehabilitation programs;

(e) false or misleading statements in the application; and

(f) relation of crimes to the scope of practice.

(4) For the purposes of this section and pursuant to the Criminal Offender Employment Act, Section 28-2-4 NMSA 1978:

(a) if an applicant has been convicted of a felony, and the conviction does not directly relate to the scope of practice, there is a presumption of sufficient rehabilitation if the applicant has completed probation or parole supervision or a period of three years has lapsed after final discharge or release from any term of imprisonment without subsequent conviction; and

(b) if an applicant has been convicted of a felony, and the conviction directly relates to the scope of practice, then the burden is on the applicant to prove by a preponderance of the evidence that he or she has been sufficiently rehabilitated.

(5) Applicants shall be notified in writing of the decision to pursue action against a certificate based on the results of a criminal history review, including a statement of the grounds or subject upon which the action is based.

(6) An applicant whose certification or recertification is denied, suspended or revoked based on information obtained in a criminal history background check, shall be entitled to review the information obtained and to appeal the decision pursuant to the procedure in accordance with this rule.

D. Committee review of other grounds for action:

(1) The committee shall conduct an individualized review of the grounds for action against a CCHW or applicant and shall determine whether to pursue action against a certificate by a majority vote.

(2) The committee may request that applicants provide additional information in writing in order to make a final determination of certification.

(3) Applicants shall be notified in writing of the decision to pursue action against a certificate based on the results of the committee's review, including a statement of the grounds or subject upon which the proposed action is based.

(4) An applicant whose certification or recertification is denied, suspended or revoked shall be entitled to review the information obtained and to appeal the decision pursuant to the procedure in accordance with this rule.

E. An applicant who is reprimanded, placed on probation, or who is otherwise subjected to any lesser form of action against a certificate than denial, suspension, or revocation may upon good cause submit a verbal or written request to the certification review committee for a secondary review. Requests for review must be submitted within 10 working days of the original decision to take action against a certificate. All decisions by the committee after a secondary review are considered final and are not subject to appeal.

[7.29.5.12 NMAC - N, 1/30/15]

7.29.5.13 HEARINGS:

A. Right to appeal: An applicant may appeal a decision by the department to deny, suspend or revoke a certificate by requesting a hearing by mailing a certified return receipt letter to the address provided in the notice of action within 20 days after service of notice.

B. Notice: The department shall serve upon an applicant written notice containing the action against a certificate and a statement of the grounds or subject upon which the action is based and instructions for requesting a hearing.

C. Notice of hearing: Upon receipt of a timely request for a hearing, the department shall appoint a hearing officer and schedule a hearing, to be held in Santa Fe, New Mexico within 60 working days of receipt of the request.

(1) Either party may request a continuance at least 10 days prior to the scheduled hearing, to be approved or denied by the hearing officer.

(2) If an applicant fails to appear after requesting a hearing, the hearing officer may proceed to consider the matter and render a report and recommendation.

(3) If no request for a hearing is made in the time and manner specified, the committee shall take the action against the certificate and such action shall be final.

D. Hearing officer duties: The hearing officer shall preside over the hearing, administer oaths, take evidence and decide evidentiary objections and rule on any motions or other matters that arise prior to the hearing.

E. Admissible evidence: The hearing officer may admit evidence and may give probative effect to evidence that is of a kind commonly relied on by reasonably prudent persons in the conduct of serious affairs. Rules of evidence shall not apply but may be considered in determining the weight to be given to any item of evidence. Action against a certificate must not be based solely on hearsay evidence.

F. Discovery: Any party is entitled to obtain the names and addresses of witnesses who will or may be called by the other party to testify and to inspect and copy any documents or items which the other party will or may introduce in evidence at the hearing. Additional discovery may be ordered at the hearing officer's discretion.

G. Burden of proof: In accordance with the Criminal Offender Employment Act:

(1) When the action against a certificate is not based on a review of the applicant's criminal history report, the department has the burden of proving by a preponderance of the evidence the basis for the action.

(2) When the action against a certificate is based on a review of the applicant's criminal history report, and the applicant has been convicted of a felony directly related to the scope of practice, the applicant has the burden of proving sufficient rehabilitation by a preponderance of the evidence.

(3) When the action against a certificate is based on a review of the applicant's criminal history report, and the applicant has been convicted of a felony not directly related to the scope of practice, there is a presumption of rehabilitation and the

department has the burden of proving by a preponderance of the evidence that the applicant has not been sufficiently rehabilitated.

H. Conduct of hearing: Hearings shall be open to the public but may be closed at either party's request, at the discretion of the hearing officer. The hearing officer shall state on the record the reasons for holding a closed hearing.

I. Legal representation: An individual entitled to a hearing under this rule shall have the right to be represented by an attorney licensed to practice in New Mexico or by a member of his or her profession or occupation, or both.

J. Hearing officer written report and recommendation(s): The hearing officer shall issue a report and recommended finding to the department secretary within 30 working days of the final submission in the case.

K. Decision of the department: The secretary shall render a final determination in writing, including the basis for the decision, within 30 calendar days of the submission of the hearing officer's written report. A copy of the final decision shall be mailed to the applicant by certified mail, return receipt requested to the most current address provided by the applicant. It is the responsibility of the applicant to provide current contact information to the program.

L. Reinstatement of a suspended or revoked certificate:

(1) Requests for reinstatement for a revoked certificate shall not be considered by the department prior to the expiration of three years from the date of the revocation indicated in the department's final decision. Requests for reinstatement of a suspended certificate shall not be considered by the department prior to the expiration of one year from the date of the suspension indicated in the department's final decision.

(2) Individuals who request reinstatement of their certificate shall provide the department with substantial evidence to support their request in the form of notarized written reports or sworn statements from individuals who have personal knowledge of the individual's activities and progress during the time that the certificate is suspended or revoked.

(3) Reinstatement of a suspended or revoked certificate requires proof of meeting the recertification requirements as set forth in this rule including payment of the reinstatement fee designated in this rule.

(4) If reinstatement of a suspended or revoked certificate is denied, individuals have a right to appeal in accordance with the hearing procedures set forth in this rule.

[7.29.5.13 NMAC - N, 1/30/15]

7.29.5.14 INSPECTION OF RECORDS:

The following records are not subject to public inspection, and shall be maintained in a confidential manner:

A. Health information protected by state and federal laws.

B. Materials associated with reviews conducted by the certification review committee, including but not limited to criminal history information.

C. Complaints or allegations regarding a CCHW that are not substantiated following investigation.

D. Personal identifiers in applications, such as date of birth, social security numbers, home address and phone numbers.

[7.29.5.14 NMAC - N, 1/30/15]

CHAPTER 30: FAMILY AND CHILDREN HEALTH CARE SERVICES

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: TITLE X FAMILY PLANNING SERVICES [REPEALED]

[This part was repealed on June 30, 2004.]

PART 3: CHILDREN'S MEDICAL SERVICES AND ADULT CYSTIC FIBROSIS

7.30.3.1 ISSUING AGENCY:

The Department of Health, Public Health Division.

[7.30.3.1 NMAC - Rp, 7 NMAC 30.3.1, 10/30/12]

7.30.3.2 SCOPE:

General public.

[7.30.3.2 NMAC - 7 NMAC 30.3.2, 10/30/12]

7.30.3.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated by the secretary of department of health by authority of Subsections E and F of Section 9-7-6 NMSA 1978 and Section 24-2-1 NMSA 1978. Administration and enforcement of these regulations is the responsibility of the public health division of the department of health.

[7.30.3.3 NMAC - Rp, 7 NMAC 30.3.3, 10/30/12]

7.30.3.4 DURATION:

Permanent.

[7.30.3.4 NMAC - 7 NMAC 30.3.4, 10/30/12]

7.30.3.5 EFFECTIVE DATE:

October 30, 2012, unless a later date is cited at the end of a section.

[7.30.3.5 NMAC - Rp, 7 NMAC 30.3.5, 10/30/12]

7.30.3.6 OBJECTIVE:

The objective is to establish criteria for eligibility and application of services from the children's medical services program, to delineate client and provider responsibilities as well as an appeals procedure, and to set forth an index of eligible conditions.

[7.30.3.6 NMAC - Rp, 7 NMAC 30.3.6, 10/30/12]

7.30.3.7 DEFINITIONS:

A. "Application" means the written request, on forms prescribed by the division, for enrollment, and provision of supportive documentation of residence, income, age, and medical diagnosis for eligibility determination under children's medical services program.

B. "Assets" means savings accounts, stocks and bonds, checking accounts, accessible trust funds, and real property. Assets do not include loans which need to be repaid, or homestead acreage used for the production of income if this is the primary source of income, or personal property that is used in the production of income if related to the primary source of income.

C. "Care coordination" means coordination of resources across agency and professional lines to develop and attain the client's service plan with optimal client/family participation.

D. "Care coordinator" means the person employed by the children's medical services program to assist the family in planning, implementing, evaluating and

coordinating with other health care professionals to establish and carry out a service plan for the client.

E. "Child" means a person below the age of 18.

F. "Children's medical services (**"CMS")** means a unit of the public health division in the New Mexico (NM) department of health that engages in:

(1) identification of children and youth with, or at risk for having, special health care needs (CYSHCN);

(2) provision of preventive, diagnostic, and treatment services and care coordination toward the attainment of maximum health for children with special health care needs, and adults with cystic fibrosis;

(3) promotion of the development of quality health care and outcome measures for this population (children and youth with special health care needs and adults with cystic fibrosis);

(4) monitoring these outcomes and the impact of changes in the health care system for this population;

(5) technical assistance and training for individuals serving this population; and

(6) administration of the universal newborn hearing screening program and the newborn genetic screening program, and other necessary administrative services to assess the needs of this population, facilitating access to care, and providing services.

G. "Client" means the individual who is applying for or receiving services from the children's medical services program and includes the person with legal authority to consent to medical care.

H. "Consultant" means a professional licensed by the appropriate specialty board, such as audiology, ophthalmology, orthodontia, speech or psychology, who provides statements of eligibility and approves care plans within the specialty area.

I. "Date of referral" means the calendar date a child or adult in need of services first requested services by telephone, mail, written referral, or application to a representative of the children's medical services program.

J. "Department" means the NM department of health.

K. "Diagnostic services" means the provision of professional services to determine whether or not the client has a diagnosis within the medical diagnostic categories established in the medical index.

L. "Division" means the public health division of the NM department of health, Post Office Box 26110, Santa Fe, New Mexico 87502.

M. "Eligible individual" means an individual below the age of 21 who is a resident of NM and has or is at increased risk for chronic medical conditions and who requires health and related services of a type or amount beyond that required by children generally; or an adult with cystic fibrosis; or an individual of any age who requires metabolic clinic services or genetic testing.

N. "Eligibility for clinic only" means eligibility only for services at any specialty clinics sponsored by the children's medical services program.

O. "Eligibility for medical management" means eligibility for purchase of health care services approved by the children's medical services program and payment of expenses related to medical care such as lodging, meals, and transportation as outlined in the service plan and approved by the children's medical services program.

P. "Eligibility for care coordination only" means eligibility only for care coordination services.

Q. "Enrollment" means a statement, on forms prescribed by the division, and signed by the client accepting services, and acknowledging that acceptance of these services does not restrict eligibility for any other benefits or services.

R. "Expenditure" means authorization of funds and payment for services to healthcare professionals, institutions, and others.

S. "Financial eligibility" means a household income below 200% of the federal poverty guidelines which are published annually. CMS is always the payor of last resort. Any and all third party payments must be fully utilized before CMS payments are made. Clients who have two or more other payor sources such as insurance, medicare, etc., do not meet financial eligibility for payment by the children's medical services program.

T. "Health" means a state of physical and mental well-being, not merely the absence of disease.

U. "Household" means those who dwell under the same roof and are related by blood or marriage, excluding those who constitute separate economic units as determined by the service coordinator and documented in the case record.

V. "Income" means earned and non-earned gross income of all persons who reside in the household of the client, and have financial responsibility for the client, and any contributions to the household from non-household members with financial responsibility. Irregular and unpredictable contributions in insignificant amounts are not considered income for the purposes of these regulations.

W. "Medicaid" means medical assistance eligibility, pursuant to Title XIX of the Social Security Act, by the medical assistance division of the NM human services department.

X. "Medical director" means a pediatrician certified by the American board of pediatrics, licensed to practice medicine in the state of NM, who assists the program manager in the determination of medical eligibility for the children's medical services program and approves service plans and payment for eligible children and adults.

Y. "Medical index" means a listing of medical diagnoses for which an eligible individual may receive coverage by the children's medical services program.

Z. "Medical report" means the written report of a provider giving the diagnosis of the individual and the treatment recommended and provided.

AA. "Prior approval" means the requirement of approval for expenditure of funds for services before the service is rendered by a provider.

BB. "Program manager" means the person or delegate responsible for the provision of services through the children's medical services program.

CC. "Provider" means any individual or entity furnishing health care under a provider agreement with the children's medical services program.

DD. "Residence" means place where client lives with the intent to make the place his permanent and principal home.

EE. "Service plan" means a statement, developed in partnership with the family/parent/guardian, of the identified health needs of the client, how they will be met, by whom, and within a specified time frame.

FF."Third party" means any person or entity that is liable to pay all or part of the medical cost of injury, disease, or disability of a children's medical services client.

GG. "Youth" means a person at least 18 years of age and less than 21 years of age.

[7.30.3.7 NMAC - Rp, 7 NMAC 30.3.7, 10/30/12]

7.30.3.8 ELIGIBILITY:

A. Medical management eligibility: To be eligible for medical management through CMS an applicant must meet all of the following requirements:

(1) the applicant must be a resident of NM;

(2) the applicant must be financially eligible; (income below 200% of the federal poverty level). CMS is always the payor of last resort; any and all third party payments must be fully utilized before CMS payments are made; clients who have two or more other payor sources such as insurance, medicare, etc., do not meet financial eligibility for payment by the children's medical services program; and

(3) the applicant must be medically eligible as defined in the medical index and the treatment protocols and guidelines adopted by the children's medical services program, and as determined by the medical director.

B. Adult cystic fibrosis eligibility: To be eligible for medical coverage and care coordination services through the adult cystic fibrosis program, an applicant must meet all of the following requirements:

(1) the applicant must be 21 years of age or older;

(2) the applicant must be diagnosed as having cystic fibrosis by pilocarpine iontophoresis or by genetic studies;

(3) the applicant must be a resident of NM; and

(4) the applicant must meet financial eligibility criteria (income below 200% of the federal poverty level); CMS is always the payor of last resort; any and all third party payments must be fully utilized before CMS payments are made; clients who have two or more other payor sources such as insurance, medicare, etc., do not meet financial eligibility for payment by the children's medical services program.

C. Clinic only eligibility: To be eligible for clinic services, an applicant must meet the following requirements:

(1) the applicant must be under 21 years of age, except for metabolic clinics where applicant may be any age;

(2) the applicant must be a resident of NM; and

(3) the applicant must be referred by a physician, physician's assistant, or pediatric nurse practitioner.

D. No fee for clinic: There is no charge for the children's medical service sponsored clinic, however, there may be a charge for tests ordered by physicians and completed outside of the clinics. Third party payment will be sought if available.

E. Care coordination only eligibility: To the extent resources are available, care coordination shall be provided for any child with special health care needs, adult with cystic fibrosis, or individual at risk of having a child with special needs, regardless of income.

[7.30.3.8 NMAC - Rp, 7 NMAC 30.3.8, 10/30/12]

7.30.3.9 APPLICATION, ENROLLMENT AND REFERRAL:

Application for CMS services must be made in person, by telephone, or by letter from the client or another referral source to any children's medical services office, located in most counties in NM, generally in the public health division's county health offices.

A. If an application is submitted within 30 days of referral, eligibility begins on the date of referral. If the application is submitted after the 30-day time limit has expired, eligibility begins on the date the application was submitted.

B. The application shall include medical and financial information, as appropriate. Medical records and documentation of income and resources such as income tax returns, insurance policies, checks, check stubs, or deeds to real property may be required before the application will be deemed complete.

C. The care coordinator shall assist in obtaining medical and financial documentation insofar as she/he will define for the client what information is necessary to complete the application. The care coordinator may deny any application pending more than 30 days which has not been completed. Individuals whose application is denied may reapply at any time.

D. Upon receipt of a completed application, including medical records and documentation of income and assets, the division shall have 20 working days to determine eligibility for children with special health care needs or adults with cystic fibrosis. Written notification of application approval or denial will be sent to the client no later than 20 working days after receipt of a completed application.

[7.30.3.9 NMAC - Rp, 7 NMAC 30.3.9, 10/30/12]

7.30.3.10 RESIDENCY:

To be eligible for any program under children's medical services, applicant/recipients must be living in NM on the date of application or determination of eligibility and have demonstrated intent to remain in NM.

A. Establishing residence: Residence in NM is established by living in the state and carrying out the types of activities normally associated with everyday life, such as occupying a home, enrolling child(ren) in school, getting a driver's license, or renting a post office box. An applicant/recipient who is homeless is considered to have met residency requirements if he intends to remain in the state.

B. Abandonment of residence: Residence is not abandoned by temporary absences from the state. Temporary absences occur when recipients leave NM for specific purposes with time-limited goals. If a client will be absent from NM for more

than 30 days, he must notify the care coordinator of his intent to maintain residency and eligibility for CMS services. Residence is considered abandoned when any of the following occur:

(1) applicant/recipient leaves NM and indicates that he intends to establish residence in another state;

(2) applicant/recipient leaves NM for no specific purpose with no clear intention of returning;

(3) applicant/recipient leaves the state and applies for financial, food, or medical assistance in another state that makes residence a condition of eligibility; or

(4) applicant/recipient has been absent from NM for more than 30 days without notifying the care coordinator of departure and intention of returning.

[7.30.3.10 NMAC - N, 10/30/12]

7.30.3.11 CLIENT RESPONSIBILITIES:

A. Clients are responsible for providing the division with accurate information concerning their financial and medical eligibility when requested by the children's medical services program.

B. Clients must apply for and inform the service coordinator of insurance, medicaid or other possible source of payment for medical expenses. Clients who meet eligibility criteria for medicaid must apply.

C. Clients must report the following changes to their care coordinator within 10 working days of the date the client becomes aware of the change: changes in income exceeding $100.00 per month; changes in household composition, insurance or medicaid coverage; or change of address or telephone number.

D. Private donations, if regular and predictable, will be considered income. If irregular or unpredictable, private donations for the care of the child must be reported to the service coordinator within ten working days of receipt of the donation if it exceeds $1,000.00.

E. Third party tort liability: The client must notify the care coordinator within 30 working days of knowledge of potential liability if a third party may be liable for medical expenses. The client must advise the care coordinator of the name of the potentially liable third party, and the names of all attorneys representing the client.

(1) Any funds received from a third party because of liability for injuries to a client for whom the division is making medical payments must be used to repay the division for money expended on behalf of the client.

(2) Clients must assign to the division any right to recover or cause of action against a liable third party and all proceeds recovered from liable third parties to the extent that the division has made payment on behalf of the client.

(3) Failure to assign any right to recover or cause of action, or proceeds described above shall be grounds for denial of application or termination of payment for services by division for a period not to exceed six months.

(4) Failure to advise the division of anticipated court action as described above shall be grounds for termination of payment for services for a period not to exceed six months, and client shall be liable to the division for any sums expended by the division for which the client receives compensation from a third party.

F. Failure to provide correct and complete information necessary to determine eligibility and failure to report changes, third party resources, including insurance recoveries, potential liability or private donations as required above may result in termination of benefits under these regulations and disqualification from receipt of benefits for a period not to exceed six months, or civil action to recover benefits wrongfully received.

G. Eligibility review: The client receiving benefits must have his/her eligibility reviewed annually. If the client does not respond to a request for review, services may be denied, and the case may be closed 30 days after the first letter of request is sent. Closure date may be extended in certain circumstances at the discretion of the CMS program manager or medical director.

H. If a client does not follow treatment recommendations or directions made by a CMS care coordinator, consultant or provider, services may be terminated and the children's medical services program manager or medical director may refuse to pay for services because of the failure to follow treatment recommendations or directions. Prior to termination of services or failure to pay for services due to failure to follow treatment recommendations or directions, a client may request a consult to review treatment recommendations or directions he does not wish to follow.

[7.30.3.11 NMAC - Rp, 7 NMAC 30.3.10, 10/30/12]

7.30.3.12 PROVIDER RESPONSIBILITES:

A. Any person wishing to provide health care in the children's medical services program must be a medicaid provider and shall operate under a provider agreement with CMS.

B. Failure to comply with the terms of the provider agreement may result in termination of provider status and immediate cessation of payment for services rendered to the client.

C. Providers must submit legible and complete medical records for each service or set of related services authorized by the program to the care coordinator. Failure to submit medical reports may result in termination of the provider agreement. Medical reports submitted to the program are the property of the program. The program shall follow applicable federal and state laws regarding release of these reports.

D. Providers must meet standards of care established by appropriate licensing boards, certifying bodies and standards as may be established by the CMS services program manager.

E. Providers must seek and obtain prior approval for all services other than routine primary care. Prior approval is obtained through the client's CMS care coordinator and may require review of the CMS medical director.

F. Providers must submit legible and complete medical reports for each service or set of related services authorized by the program to the service coordinator. Failure to submit medical reports may result in termination of the provider agreement.

G. Violations: Sanctions may be imposed by CMS against a provider for any one or more of the following reasons.

(1) Knowingly and willfully making or causing to be made any false statement or misrepresentation of a material fact by:

(a) presenting or causing to be presented for payment under children's medical services any false or fraudulent claim for services or merchandise;

(b) submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled;

(c) submitting or causing to be submitted false information for the purpose of meeting prior approval status; and

(d) submission of a false or fraudulent application for provider status.

(2) Failure to disclose or make available to the department or its authorized agent records of services provided to children's medical services clients and records of payments for those services.

(3) Failure to provide and maintain quality services which meet professionally recognized standards of care.

(4) Engaging in a course of conduct or performing an act that is unreasonably improper or abusive of the children's medical services program, or continuing such conduct following notification that said conduct should cease.

(5) Breach of the terms of the provider agreement.

(6) Over utilizing the children's medical services program by inducing, furnishing or otherwise causing a recipient to receive service(s) or merchandise substantially in excess of the needs of the recipient.

(7) Rebating or accepting a fee or portion of a fee or charge for a children's medical services patient referral.

(8) Violating any provision of state or federal statutes or any rule or regulation promulgated pursuant thereto.

(9) Violating any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries directly relating to children's medical services.

(10) Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent or abusive practice resulting in death or injury to patients.

(11) Failure to meet standards required by state or federal law for participation, as a given type of provider (e.g., licensure or certification).

(12) Soliciting, charging, or accepting payments from recipients for services for which the provider has billed the children's medical services program.

(13) Failure to correct deficiencies in provider operations within time limits specified by program guidelines after receiving written notice of these deficiencies from the human services department.

(14) Formal reprimand or censure by a professional association of the provider's peers for unethical practices or malpractice.

(15) Suspension or termination from participation in another governmental medical program such as, but not limited to, worker's compensation, medicaid, rehabilitation services, and medicare.

(16) Indictment for fraudulent billing practices, or negligent practice resulting in physical, emotional or psychological injury or death to the provider's patients.

(17) Failure to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

H. Sanctions: One or more of the following sanctions may be invoked against a provider:

(1) termination from participation in the children's medical services program;

(2) suspension of participation in the children's medical services program;

(3) suspension or withholding of payments to a provider;

(4) referral to peer review;

(5) one-hundred percent review of the provider's claims prior to payment; and

(6) referral to the appropriate state licensing board or other appropriate authority for investigation.

I. A provider found by the division to have committed a violation shall be given notice and an opportunity for hearing in accordance with this rule.

[7.30.3.12 NMAC - Rp, 7 NMAC 30.3.11, 10/30/12]

7.30.3.13 PROVIDER BILLING:

A. Providers must seek payment from insurance, medicaid, and other sources, if known, prior to billing the children's medical services program. This includes billing the medicaid program using the child's recipient medicaid identification number and not the CMS billing number.

B. Inpatient care shall be paid at the negotiated per diem rate and under the term established by the provider participation agreement. For other services covered under the program; including approved inpatient days, providers must agree to accept as payment in full the amounts established by the division.

C. If a provider receives a payment from a source other than the program which is equal to or exceeds the amount of the program fee schedule for the authorized services rendered, the provider is prohibited from seeking additional payment from either the client or the division.

D. Providers must submit all bills to the fiscal agent for payment on forms prescribed by the program and within the billing time limits established by the program. Unless the provider receives a waiver of the time limit from the program manager and medical director, failure to comply with the time limits may result in denial of claim. Providers may not hold clients responsible for bills denied because of failure to meet time limits. Providers must also follow all billing instructions in submitting claims for payment to the fiscal agent. If claims are denied due to not following instructions, providers may not hold clients responsible for payment of these bills.

[7.30.3.13 NMAC - N, 10/30/12]

7.30.3.14 EXPENDITURE OF FUNDS:

A. Expenditure of children's medical services program funds are based on the availability of funds, the eligibility of the client for services, and the receipt of prior approval by the provider for the services, if required.

B. Emergency services may be paid for if:

(1) the care coordinator is notified of the services rendered and the necessity of the services before the end of the fifth working day after the emergency expense is incurred; or

(2) the medical director determines that the services were consistent with the service plan, if applicable, are eligible for payment, and were rendered in an emergency.

C. Limit on yearly expenditure of funds:

(1) children's medical services program shall not expend more than $15,000.00 per client per year for medical management; or

(2) the CMS program manager in concurrence with the medical director may raise the $15,000.00 financial limit to provide additional coverage for good cause when monies are available.

D. Purchase of services related to educational activities is excluded under these regulations.

E. Purchase of services related to psychiatric disorders is excluded under these regulations except for psychological problems specifically related to an eligible condition, and with approval from the psychological consultant or medical director.

F. Children's medical services program shall be the last resource after other available sources of payment, such as insurance, medicaid, tortfeasors, the UNM care plan, and the NM department of education.

G. Children's medical services program shall not pay for any eligible services provided more than five working days before the date of referral.

H. Clients who have two or more other payor sources, such as insurance, medicare, or medicaid are not eligible for payment by CMS.

[7.30.3.14 NMAC - Rp, 7 NMAC 30.3.12, 10/30/12]

7.30.3.15 OUT-OF-STATE PROVIDER POLICY:

Services must be purchased within the state of NM, unless the need to purchase services elsewhere is documented and approved by the CMS medical director.

A. Services may be purchased outside the state of NM when:

(1) the specific service is not available in NM; or

(2) an eligible client is temporarily out of state and does not qualify for medical assistance in the state of temporary residence, and the health of the client would be endangered if services were postponed until return to NM or by travel to NM; or

(3) excessive time, distance, and expense would be involved in order to obtain outpatient services in NM. Inpatient services are eligible out of state if urgent or emergency hospitalization is needed when distance is excessive or in-state tertiary centers are full.

B. Services may not, under any circumstances, be purchased out of state without approval of the medical director or designee.

C. Out-of-state providers are subject to the same fee schedule, time limitations, standards, and requirements, including operating under a provider agreement, as in-state providers.

[7.30.3.15 NMAC - Rp, 7 NMAC 30.3.13, 10/30/12]

7.30.3.16 CONFIDENTIALITY:

Information shall be released by the program only as permissible per state and federal law.

[7.30.3.16 NMAC - Rp, 7 NMAC 30.3.14, 10/30/12]

7.30.3.17 NOTICE AND APPEALS PROCEDURE:

A. Record review. All applicants whose application for services from CMS has been denied and all clients who have been denied requested services by the program may request a record review from CMS.

B. Procedure for requesting informal administrative review.

(1) The applicant or client may submit a written request for a record review. To be effective, the written request shall:

(a) be made within 30 calendar days, as determined by the postmark, from the date of the notice of action issued by CMS;

(b) be properly addressed to CMS;

(c) state the applicant's name, address, and telephone numbers; and

(d) provide a brief narrative rebutting the circumstances of the denial.

(2) If the applicant or client wishes to submit additional documentation for consideration, such additional documentation must be included with the request for a record review.

C. Record review proceeding. The review proceeding is intended to be an informal, non-adversarial administrative review of written documentation. It shall be conducted by an administrative review committee designated for that purpose by CMS. In cases where the administrative review committee finds the need for additional or clarifying information, the review committee shall request that the applicant or client supply such additional information within the time set forth in the committee's request.

D. Final determination.

(1) Content: the administrative review committee shall render, sign, and enter a written decision within 60 days setting forth the reasons for the decision and the evidence upon which the decision is based.

(2) Effect: the decision of the administrative review committee is the final decision of the informal administrative review proceeding.

(3) Notice: a copy of the decision shall be mailed by registered or certified mail to the applicant.

E. Judicial review. Judicial review of the administrative review committee's final decision is permitted to the extent provided by law. The party requesting the appeal shall bear the cost of such appeal.

[7.30.3.17 NMAC - Rp, 7 NMAC 30.3.15, 10/30/12]

7.30.3.18 ELIGIBLE MEDICAL CONDITIONS:

The division shall periodically issue an index of conditions which identifies eligible medical conditions. The index shall be reviewed at least annually and revised as necessary. Coverage may change dependent upon available funds. Coverage is provided subject to the further guidelines in the index of children's medical services eligible conditions and treatment protocols. Conditions that are similar in course and outcome to those in the index may be eligible pending review by the medical director. The current index of children's medical services eligible conditions is attached hereto as attachment A.

[7.30.3.18 NMAC - Rp, 7 NMAC 30.3.19, 10/30/12]

7.30.3.19 PEDIATRIC SUBSPECIALISTS:

For children age 18 years and under with chronic, complex cardiac, endocrine, neurology, and pulmonary conditions, the CMS program will authorize payment for consultation and follow up services only to board certified pediatric subspecialists when they are available within the state.

[7.30.3.19 NMAC - Rp, 7 NMAC 30.3.20, 10/30/12]

7.30.3.20 VOLUNTEERS:

The children's medical services program may use volunteers as allowed by program, division, and department guidelines.

[7.30.3.20 NMAC - Rp, 7 NMAC 30.3.22, 10/30/12]

7.30.3.21 SEVERABILITY:

If any part or application of the children's medical services program regulations is held invalid, the remainder, or its application to other situations or persons, shall not be affected.

[7.30.3.21 NMAC - Rp, 7 NMAC 30.3.23, 10/30/12]

PART 4: COUNTY MATERNAL AND CHILD HEALTH PLAN ACT REQUIREMENTS

7.30.4.1 ISSUING AGENCY:

New Mexico Department of Health, Public Health Division, Maternal and Child Health Bureau.

[8/4/92, 10/31/96; Recompiled 10/31/01]

7.30.4.2 SCOPE:

County Maternal and Child Health Plan Act Regulations shall apply to the use of the funds available pursuant to the County Maternal and Child Health (MCH) Plan Act, Chapter 24 Article 1B NMSA 1978.

[8/4/92, 10/31/96; Recompiled 10/31/01]

7.30.4.3 STATUTORY AUTHORITY:

The County Maternal and Child Health Plan Act Regulations are adopted by the secretary of the health department pursuant to the authority of Chapter 24 Article 1B Section 7 NMSA 1978. The mailing address is: New Mexico Department of Health, Public Health Division, Maternal and Child Health Bureau, P.O. Box 26110, Santa Fe, New Mexico 87502-6110.

[8/4/92, 10/31/96; Recompiled 10/31/01]

7.30.4.4 DURATION:

Permanent.

[8/4/92, 10/31/96; Recompiled 10/31/01]

7.30.4.5 EFFECTIVE DATE:

August 4, 1992, unless a different date is cited at the end of the section or paragraph.

[8/4/92, 10/31/96; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.30.4.6 OBJECTIVE:

The purpose of the County Maternal and Child Health Plan Act is to encourage the development of comprehensive, family centered, community-based, culturally competent, maternal and child health plans designed to coordinate available resources to meet the needs of childbearing women and their families and thereby improve the long-term health of New Mexicans across the state. The purpose will be accomplished through, but not be limited to, the following activities:

A. assisting counties in the creation and development of county maternal and child health planning councils for the purpose of developing a county maternal and child health plan which will identify needed services, current resources and service gaps in the county;

B. providing training and technical assistance to the appointed county maternal and child health planning councils; and

C. distributing financial assistance to eligible programs in order to sustain or provide optimal levels of maternal and child health services.

[8/4/92, 10/31/96; Recompiled 10/31/01]

7.30.4.7 DEFINITIONS:

A. "Act" means the County Maternal and Child Health Plan Act, Chapter 24 Article 1B NMSA 1978.

B. "Approved plan" means a comprehensive maternal and child health services plan which has been approved by the public health division of the department of health and is described in definitions:"Plan".

C. "Board" means board of county commissioners.

D. "Council" means the county maternal and child health planning council as established by the boards of commissioners of the participating counties of the state of New Mexico.

E. "Department" means the New Mexico department of health.

F. "Director" means the director of the public health division.

G. "Division" means the public health division of the department of health.

H. "Maternal and child health (MCH)" means those arenas and services designed to support the health of child-bearing women and their families which may include, but are not limited to: general health and social risk assessment for women; tot to teen health checks for child health and development; well child care and immunization; prenatal health care and family planning; dental health and services; social support groups; food and nutrition services; parenting skills education and support; children with special needs; injury and violence prevention; case management/service coordination; home visiting; and health education and health promotion.

I. "Plan" means a comprehensive strategy of health and social services identified as supportive to maternal and child health and containing the following:

(1) assessment of health and social services needed for childbearing individuals and their families with the county;

(2) identification of maternal and child high risk indicators and populations found in the county;

(3) inventory of resources and capacities available in the county to provide needed services and identification of duplication of services;

(4) identification of gaps and barriers to service accessibility and delivery; and development of a prioritized plan to meet the MCH service needs of the county with estimated costs and local commitments of human resources and other in-kind donations from county and local sources.

J. "Qualified" means a provider of services who is fully certified or licensed to practice in New Mexico in accordance with the applicable laws and regulations of the appropriate professional governing boards or licensing agencies.

K. "Tot to teen health check" means early periodic screening, diagnosis and treatment which is a comprehensive assessment procedure for determining the health of a child.

[8/4/92, 1/24/95, 10/31/96; Recompiled 10/31/01]

7.30.4.8 PLANNING CONTRACTS:

A. Duty of the department: The department may contract with boards of county commissioners in New Mexico to assist counties in the creation and development of a Plan for meeting the MCH service needs of the county. Such efforts must be consistent with the requirements set out in the Act. All applicable division and department procurement procedures and the New Mexico Procurement Code will be followed.

(1) The department will monitor and evaluate the performance of the contractor to ensure compliance with the intent of the Act.

(2) The department will publish definitions of services that set an acceptable minimum standard for the services provided.

(3) The department will develop a program and training materials for leadership development which shall be made available to all MCH councils and their contracted staff.

B. Eligibility: - In order to contract pursuant to this part of the regulations, the contractor must meet the following requirements:

(1) It must be a New Mexico board of county commissioners;

(2) It must have the capability to carry out the purposes described in Section 6, Objective [now 7.30.4.6 NMAC] including employment of and/or professional service contracts with qualified professional staff;

(3) It must follow division procedures and guidelines.

C. County MCH council composition: The board of county commissioners shall create a county maternal and child health council and appoint members that represent a broad spectrum of interests that may include county officials, community-based program providers, childbearing and parenting families, local school administrators, local political leaders, employees of the income support office, employees of the county field health office, maternal and child health care providers, obstetricians, family physicians, nurses, mid-level providers and hospital administrators. The membership shall also represent

the geographic areas and ethnic populations within the county. Council members who are, or could be potential contractors or employees or independent contractors of a potential contractor under Section 9.2.1 [now Paragraph (1) of Subsection B of 7.30.4.9 NMAC] must meet further requirements including:

(1) They should serve only in an advisory capacity to the council;

(2) They should not participate in executive decisions of the council relating to the county MCH plan update, approval of proposals that are competing for a service contract, awarding of contracts for which they have competed, internal personnel decisions of contractors, and any other decision that can be determined to constitute a conflict of interest or apparent conflict of interest.

D. Eligible items of expenditure: Funds made available under the Act may be used for the following types of expenditures:

(1) professional service contracts, including payment for gross receipts tax for a coordinator of planning and for consultants as needed;

(2) purchase of office supplies and other property under $500.00;

(3) mileage for coordinator, consultants and council members according to guidelines established by the department of finance and administration, DFA Rule 92-1, Section 6 [now 2.42.2 NMAC];

(4) per diem expenses for coordinator, consultants and council members according to guidelines established by the department of finance and administration, DFA Rule 92-1, Section 4 A-B, D-G and J-N [now 2.42.2 NMAC;

(5) advertising expenses to attract qualified applicants for professional service contracts.

E. Ineligible items of expenditures: Costs which are not eligible for funding include:

(1) land;

(2) building and construction;

(3) capital equipment and office furniture and other property depreciated over a period of more than one year;

(4) debt amortization;

(5) salaries and fringe benefits for county employees.

F. Reports: The division shall monitor the performance of the contractor(s) to ensure compliance with the intent of the act. The contractor shall submit to the division the following reports on or before deadlines specified in the contract.

(1) The contractor shall submit all reports required by the division for payments including reports of costs incurred by individual cost categories reflected in the contract budget.

(2) The contractor shall submit a quarterly narrative progress report which identifies all services provided and activities performed according to the scope of work.

(3) The contractor shall submit a comprehensive MCH plan on or before the specified deadline as required by the contract and as defined in Section 7 [now 7.30.4.7 NMAC], Definitions.

(4) The department shall review, evaluate and approve or reject the county maternal and child health plans based on its comprehensive inclusion of all components of maternal and child health services in Section 7 [now 7.30.4.7 NMAC], Definitions.

[8/4/92, 1/24/95, 10/31/96; Recompiled 10/31/01]

7.30.4.9 SERVICES CONTRACTS:

A. Duty of the department: The department may contract with a New Mexico county commission or qualified service providers to assist counties in the provision of critical maternal and child health services in underserved areas of the state. Such efforts must be consistent with priorities set out in the Act. All applicable division and department procurement procedures and the New Mexico Procurement Code will be followed.

(1) The department shall award contracts for county maternal and child health services based upon:

(a) the amount of legislatively appropriated funds for the purpose of carrying out the provisions of the County Maternal and Child Health Plan Act;

(b) the county's need for services as measured in the plan by:

(i) common and accepted maternal and child health indicators, including but not limited to: a) infant and child mortality and morbidity indicators, b) maternal mortality and morbidity indicators, c) adolescent pregnancy rates, and d) MCH provider availability and capacity;

(ii) the county's demonstration that services in its maternal and child health plan conform to the comprehensive outline of community-based MCH services described in Subsection D of Section 5, 24-1B-5, NMSA 1978 of the County Maternal and Child Health Plan Act.

(2) The department will monitor and evaluate the performance of the contractor to ensure compliance with the intent of the Act.

(3) The department will publish definitions of services that set an acceptable minimum standard for the services provided.

B. Eligibility: In order to contract for service provision or evaluation of such services pursuant to this part of the regulations, the contractor must meet the following requirements:

(1) it must be a New Mexico board of county commissioners or a qualified organization or individual provider of services providing a service identified as needed in the county MCH Plan;

(2) it must be in a county which has a current division approved county maternal and child health plan according to the provisions of the Act;

(3) it must have the capability to carry out the purposes of the Act, including qualified professional staff;

(4) it must be an entity whose director, employees, contractors or board members do not serve in an executive or decision making capacity on the county MCH council;

(5) It must have received the written endorsement of the county MCH Council and of the written approval of the board of county commissioners of the county in which services are proposed;

C. Eligible items of expenditure: Funds made available for provision of health care services under the Act may be used for the following types of expenditures:

(1) salaries and benefits for employees of the Contractor;

(2) purchase of supplies;

(3) purchase, repair and/or maintenance of equipment;

(4) mileage and per diem expenses according to the department of finance and administration rule 90-2, Section 7 [now 2.42.2 NMAC];

(5) professional services contracts;

(6) advertising expenses to attract interested MCH provider candidates;

(7) malpractice insurance premiums;

(8) other approved general operating expenses;

D. Ineligible items of expenditures: Costs which are not eligible for funding include:

(1) land;

(2) building and construction;

(3) emergency medical services personnel, training or equipment;

(4) school nurses;

(5) in patient hospital care;

(6) debt amortization.

E. Reports: The division shall monitor the performance of the contractor(s) to ensure compliance with the intent of the act. The contractor shall submit to the division the following reports on or before deadlines specified in the contract:

(1) The contractor shall submit all reports required by the division for payments including reports of costs incurred by individual cost categories reflected in the contract budget;

(2) The contractor shall submit a quarterly narrative progress report which identifies all services provided and activities performed according to the scope of work;

(3) The contractor shall participate in data collection, needs and capacities assessment, and monitoring and evaluation in coordination with the department's efforts in this arena;

(4) Payment of all funds under the Act is subject to division approval of all invoices and/or reports.

F. Selection of Providers: The contractor must conduct all employment and professional services contracting activities based upon the following considerations:

(1) All providers shall be considered on an equal opportunity basis according to state and federal laws and regulations which prohibit discrimination;

(2) All candidates must be licensed or certified in New Mexico in accordance with the applicable laws and regulations of the appropriate professional governing boards or licensing agencies.

[8/4/92, 1/24/95, 10/31/96; Recompiled 10/31/01]

7.30.4.10 FUND DISTRIBUTION:

A. Duty of the department: To the extent funds are made available for the purposes of the County Maternal and Child Health Plan Act, the department shall provide for the distribution of financial assistance to eligible organizations which have applied for and demonstrated a need for assistance in order to sustain the delivery of planning and health care services according to the specifications set forth in Chapter 24-1B NMSA 1978. The department may apply a formula for county contribution to the implementation of its plan based on legislative appropriation and the county's relative worth as measured by its population, per-capita income, gross receipts tax base and average property value.

B. Eligibility: In order to be eligible to receive financial assistance through the Act, the following requirements, in addition to the requirements in Section 8.2 and Section 9.2 [now Subsection B of 7.30.4.8 NMAC and Subsection B of 7.30.4.9 NMAC], must be met by an eligible program:

(1) It must be a New Mexico board of county commissioners or an eligible provider of services who is fully certified or licensed to practice in New Mexico in accordance with the applicable laws and regulations of the appropriate professional governing boards or licensing agencies.

(2) It must be an entity whose director, employees, contractors or board members do not serve in an executive or decision making capacity on the county MCH council.

(3) It must have policies and procedures which assure that no person will be denied services because of inability to pay. The program must also have billing policies and procedures which maximize patient accessibility to its services.

(4) It must agree to submit for payment by the department only the services which have been division approved in the plan for the county and designated in the contract.

(5) It must maximize other sources of funding.

C. Distribution of financial assistance: In any fiscal year, the distribution of financial assistance for maternal and child health services to an eligible county or other eligible contractor selected pursuant to these regulations shall be determined according to the following guidelines. The relative need of an eligible county or other eligible provider for financial assistance shall be determined by taking into consideration the following primary criteria:

(1) the relative need of the county for financial assistance as demonstrated in the approved plan and the application process;

(2) the priority of the need as addressed in the county's approved plan;

(3) the commitment made by the county to implement its approved plan;

(4) the amount of available funds available from the department for provision of services.

(5) The comprehensive county MCH plan shall be completely reviewed and updated at the request of the board if the plan as implemented is not achieving the stated goals or if the needs of the local population have changed. The department may request that the plan be reviewed and updated for the same or other appropriate and pertinent reasons. All reviews and updates shall be done according to the guidance and format provided in the county MCH Plan Act request for proposal.

D. Funding authority: At the discretion of the department, selection among proposals which have shown need under 10.3 [now Subsection C of 7.30.4.10 NMAC] will be made based on the following criteria:

(1) proposals which demonstrate measures to increase the productivity and/or improve the efficiency of the applicant's maternal and child health care services;

(2) proposals which demonstrate coordination and/or innovative relationships with public health offices and other health care services;

(3) proposals which demonstrate innovative methods for eliminating or reducing access barriers to services;

(4) proposals which demonstrate utilization of other sources of funding.

E. Award of contracts: The division will award contracts in accordance with the New Mexico Procurement Code and applicable department regulations. Opportunities for application for contracts will be provided according to the New Mexico Procurement Code and applicable department regulations.

F. Protest procedure: Any offeror or contractor who is aggrieved in connection with the award process must use the protest procedure established by the New Mexico Procurement Code and applicable department regulations. Extension of Time: No extension of the time for the filing of any pleading or document shall be granted, unless the person seeking the extension can show, to the satisfaction of the secretary or the secretary's designated representative, that there is good cause for the extension. Requests for extension of time must be received in advance of the date on which the pleading or document is due to be filed.

G. Duplicate funding disallowed: Applications for financial assistance through the Act must be accompanied by a certified statement that the eligible program shall not

claim or be reimbursed by any Act monies for items or program expenditures paid for by clients, insurance, state, federal or other grant funds.

H. Expenditure plans: All contractors must submit to the department, for approval, plans which show how awarded funds will be expended during the contract period. The department may, at its discretion, amend or terminate any contract if either the contractor's plan or its progress is not satisfactory to the department.

I. Redistribution of Funds - Funds becoming available subsequent to the initial distribution made pursuant to Section 10.7 [now Subsection G of 7.30.4.10 NMAC], or recouped pursuant to Section 10.8 [now Subsection H of 7.30.4.10 NMAC] may be awarded to eligible programs by contract or contract amendment at any time at the discretion of the department, and shall not be required to be carried over to the next fiscal year.

[8/4/92, 1/24/95, 10/31/96; Recompiled 10/31/01]

7.30.4.11 OTHER PROVISIONS:

A. Severability: If any part or application of the County Maternal and Child Health Plan Act regulation is held invalid, the remainder or its application to other situations or persons shall not be affected.

B. Effect of departmental regulations - These regulations are subject to various general regulations of the department of health as and when promulgated, including regulations governing regulation promulgation, and regulations on public access to information.

[8/4/92, 10/31/96; Recompiled 10/31/01]

PART 5: SHAKEN BABY SYNDROME PREVENTION

7.30.5.1 ISSUING AGENCY:

New Mexico Department of Health, Epidemiology and Response Division and Division of Health Improvement.

[7.30.5.1 NMAC - N, 10/15/2019]

7.30.5.2 SCOPE:

These regulations apply to all hospitals and freestanding birth centers licensed to operate in New Mexico.

[7.30.5.2 NMAC - N, 10/15/2019]

7.30.5.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated by the secretary of the New Mexico department of health, pursuant to Section 24-1-13.2 NMSA 1978 and the general authority granted under Subsection E of Section 9-7-6 NMSA 1978, Department of Health Act, as amended; and Subsection I of Section 24-1-3 and Section 24-1-5 NMSA 1978, Public Health Act, as amended.

[7.30.5.3 NMAC - N, 10/15/2019]

7.30.5.4 DURATION:

Permanent.

[7.30.5.4 NMAC - N, 10/15/2019]

7.30.5.5 EFFECTIVE DATE:

October 15, 2019 unless a later date is cited at the end of a section.

[7.30.5.5 NMAC - N, 10/15/2019]

7.30.5.6 OBJECTIVE:

To establish rules that require hospitals and freestanding birth centers to provide training and education to prevent shaken baby syndrome to every parent of every newborn before discharge.

[7.30.5.6 NMAC - N, 10/15/2019]

7.30.5.7 DEFINITIONS:

A. "Department" means the New Mexico department of health.

B. "Epidemiology and response division" means the epidemiology and response division of the New Mexico department of health.

C. "Facility" means both a licensed hospital and a licensed freestanding birth center.

D. "Licensing authority" means the New Mexico department of health’s division of health improvement.

E. "Parent" means any known individual with a mother-child relationship or father-child relationship as determined under section 40-11A-201 NMSA 1978.

F. "Survey" means a monitoring visit by the licensing authority to examine a licensed facility's premises and records and to interview the facility's patients and staff.

[7.30.5.7 NMAC - N, 10/15/2019]

7.30.5.8 STANDARD OF COMPLIANCE:

A. The degree of compliance required throughout these regulations is designated by the use of the words "shall" or "must" or "may".

(1) "Shall" or **"must"** means mandatory.

(2) "May" means permissive.

B. The words "adequate", "proper", and other similar words mean the degree of compliance that is generally accepted throughout the professional field by those who provide services to the public in facilities.

[7.30.5.8 NMAC - N, 10/15/2019]

7.30.5.9 INITIAL LICENSE PROCEDURES:

In the application packet for a facility's licensure, the applicant will include an attestation letter signed by its chief administrator of the facility pledging ongoing compliance with this regulation.

[7.30.5.9 NMAC - N, 10/15/2019]

7.30.5.10 LICENSE RENEWAL:

Upon submitting an annual renewal, applicants for renewed facility licensure will include an updated attestation letter signed by the applicant's facility administrator, regardless of whether the facility submitted a letter upon initial license application or in any previous year.

[7.30.5.10 NMAC - N, 10/15/2019]

7.30.5.11 PROGRAM SERVICES:

Facilities must provide training and education to prevent shaken baby syndrome to every parent of every newborn before discharging a newborn from the health facility.

A. The training program must be approved by the department in conjunction with the university of New Mexico health sciences center department of pediatrics.

B. The training curriculum must be in English and Spanish.

C. Training shall include the use of shaken baby simulation dolls.

D. The training program may be developed in-house, provided it otherwise meets the requirements of this section.

E. Training may occur as a pre-natal or post-natal course.

[7.30.5.11 NMAC - N, 10/15/2019]

7.30.5.12 TRAINING PROGRAM APPROVAL PROCESS:

The training and instructional materials must be approved by the department in collaboration with the university of New Mexico health sciences center department of pediatrics.

A. Each facility shall submit a proposed training curriculum to the epidemiology and response division of the New Mexico department of health.

B. The department will consult with the department of pediatrics on training materials.

C. Once a facility receives notification from the department that the curriculum is approved by the department and the university of New Mexico, the facility may utilize the approved curriculum.

[7.30.5.12 NMAC - N, 10/15/2019]

7.30.5.13 CLIENT CLINICAL RECORD:

Facilities must store paper or electronic records of the training of each parent or parents conducted under these regulations.

[7.30.5.13 NMAC - N, 10/15/2019]

7.30.5.14 REPORTING TO THE HEALTH DEPARTMENT:

A. Annually, each hospital and freestanding birth center shall send a report to the epidemiology and response division noting the total number of births and the number of parents who attended trainings.

(1) The number of parents attending training shall, for statistical and reporting purposes, include only one parent per birth.

(2) This report is due annually by January 31 of the succeeding year.

(3) For a new facility, or one that did not previously track these data, the report shall include total births since the training and reporting process began for the first year.

B. Facilities must make records of the trainings available to the licensing authority during a survey.

[7.30.5.14 NMAC - N, 10/15/2019]

PART 6: NEWBORN GENETIC SCREENING PROGRAM

7.30.6.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.30.6.1 NMAC - Rp, 7 NMAC 30.6.1, 10/30/12]

7.30.6.2 SCOPE:

Universal screening of all infants born in New Mexico (NM) for the congenital conditions listed and defined herein shall be done through a statewide screening program established through the public health division. The department shall institute and carry on such laboratory services or may contract with another agency or entity to provide such services as are necessary to detect the presence of congenital disorders.

[7.30.6.2 NMAC - Rp, 7 NMAC 30.6.2, 10/30/12]

7.30.6.3 STATUTORY AUTHORITY:

The statutory authority for these regulations is contained in Section 9-7-6 NMSA 1978 and Section 24-1-6 NMSA 1978 as amended Laws 1981, Chapter 95, Sec. 1.

[7.30.6.3 NMAC - Rp, 7 NMAC 30.6.3, 10/30/12]

7.30.6.4 DURATION:

Permanent.

[7.30.6.4 NMAC - Rp, 7 NMAC 30.6.4, 10/30/12]

7.30.6.5 EFFECTIVE DATE:

October 30, 2012, unless a later date is cited at the end of a section.

[7.30.6.5 NMAC - Rp, 7 NMAC 30.6.5, 10/30/12]

7.30.6.6 OBJECTIVE:

The purpose of these regulations is to establish standards and procedures to assure congenital metabolic conditions and other genetic disorders which can cause significant mental or physical retardation or significant morbidity or mortality can be detected by screening newborn infants. Early detection and prompt referral for treatment may help prevent death and alleviate the effects of these disorders. These rules provide for screening tests to be performed on every newborn except where, in accordance with these rules, the parents or guardians waive this requirement in writing.

[7.30.6.6 NMAC - Rp, 7 NMAC 30.6.6, 10/30/12]

7.30.6.7 DEFINITIONS:

A. "Children's medical service" ("CMS") is a unit of the public health division in the NM department of health that engages in:

(1) identification of children and youth with, or at risk for having, special health care needs (CYSHCN);

(2) provision of preventive, diagnostic, treatment services and care coordination toward the attainment of maximum health for children with special health care needs, and adults with cystic fibrosis;

(3) promotion of the development of quality health care and outcome measures for this population (children and youth with special health care needs);

(4) monitoring these outcomes and the impact of changes in the health care system for this population;

(5) technical assistance and training for individuals serving this population; and

(6) administration of the universal newborn hearing screening program and the newborn genetic screening program, and other necessary administrative services to assess the needs of this population, facilitating access to care, and providing services.

B. "Hospital" means a hospital or other institution having facilities for childbirth.

C. "Neonatal intensive care unit" ("NICU") means an intensive care unit specializing in the care of ill or premature newborn infants.

D. "Newborn genetic screening program" means a unit of the public health division under children's medical services department that engages in:

(1) surveillance, assurance and policy development;

(2) public and provider education;

(3) follow-up (both short-term and long-term) to assure quality of care for infants who have abnormal results on screening; and

(4) provision of efficient service coordination between families and their infants, between the contracted laboratory and other involved entities.

E. "Primary care physician" ("PCP") means a family practitioner, pediatrician, physicians assistant, nurse practitioner, general practitioner, or midwife that will be assuming the continuing care of the infant after discharge from the birth facility or after homebirth.

F. "Parents or guardians" means persons with legal decision making authority for the child.

[7.30.6.7 NMAC - Rp, 7 NMAC 30.6.7, 10/30/12]

7.30.6.8 DISORDERS:

A. Disorders for which screening shall be performed include the following:

(1) 3-mthylcrotonyl-CoA deficiency;

(2) 3-OH 3-CH3 glutaric aciduria;

(3) argininosuccinic academia;

(4) mitochondrial acetoacetyl-CoA;

(5) biotinidase deficiency;

(6) carnitine uptake defect;

(7) citrullinemia;

(8) congenital adrenal hyperplasia;

(9) congenital hypothyroidism;

(10) cystic fibrosis;

(11) galactosemia;

(12) glutaric academia type I;

(13) Hb S/beta-thalassemia;

(14) hearing deficiency;

(15) homocystinuria;

(16) isovaleric academia;

(17) long-chain L-3-OH acyl-CoA dehydrogenase deficiency;

(18) maple syrup urine disease;

(19) medium chain acyl-CoA dehydrogenase deficiency;

(20) methylmalonic academia;

(21) multiple carboxylase deficiency;

(22) phenylketonuria;

(23) proponic academia;

(24) sickle cell anemia;

(25) trifunctional protein deficiency;

(26) tyrosinemia type I; and

(27) very long-chain acyl-CoA dehydrogenase deficiency.

[7.30.6.8 NMAC - N, 10/30/12]

7.30.6.9 NEWBORN BLOOD SAMPLE COLLECTION:

A. Every newborn infant, whether born in a hospital, birthing center, or at home shall receive tests on two newborn screening blood samples; unless the parents or guardians, after being informed of the reasons for the tests, waive the requirements for the tests in writing.

(1) The first blood sample shall be obtained, between 24-48 hours of age.

(2) The second blood sample shall be obtained between the 10th and 14th day after birth.

(3) Second screens may be taken at a hospital, outpatient medical clinic and facility, outpatient laboratory, primary care provider’s office or by a midwife.

B. All birthing facilities, and midwives, in NM are required to practice uniform discharge screening regardless of the age or feeding status of the newborn.

C. Prematurity and transfusion status will be noted on the collection form in the space provided. Newborns who require any anticipated blood transfusion shall have a blood sample taken before the procedure. In those rare events where a screen was obtained after a transfusion, the facility is still required to submit the specimen for screening.

D. All birthing hospitals, birthing centers, and midwives will inform the parents of the requirement for a second screen prior to discharge. The PCP, birthing hospital, midwives, nurses, nurse practitioner or physician shall give the parents educational brochures supplied by program, and shall advise them where the test may be obtained.

E. In the case of inter-hospital transfer of an infant, the transferring hospital shall provide written notification to the receiving hospital indicating whether or not a specimen has been taken prior to transfer.

(1) Infants who are transferred to another facility within 48 hours of birth shall be tested by the receiving facility.

(2) If a newborn screening kit has been issued by the birth hospital to the infant, it shall be sent with the infant ensuring that both facilities are notified of the results.

(3) Following transfer, the receiving hospital shall assume responsibility for collection of the specimen in accordance with these rules.

[7.30.6.9 NMAC - Rp, 7 NMAC 30.6.8, 10/30/12]

7.30.6.10 WAIVER:

A. Pursuant to Section 24-1-6 NMSA 1978, parents or guardians may waive the requirements for newborn screening tests in writing.

B. The department’s newborn screening program will provide the hospital, birthing centers, and midwives with forms for waiver.

C. The infant’s PCP, midwife, or nurse shall provide parents or guardians with both written and oral explanations before the parents or guardians may sign a waiver for newborn screening test. The decision to waive screening will be acknowledged by signature of the parents or guardian on the form provided by the department. The document of waiver shall be placed in the child’s hospital medical record and a copy shall be sent to the children’s medical services newborn screening program and a copy to the parent(s).

D. The waiver will not be used for the purpose of changing the times of the screening or for submitting only a single screen; it is used to waive the newborn screening tests in their entirety. No modifications can be placed on the form.

[7.30.6.10 NMAC - Rp, 7 NMAC 30.6.9, 10/30/12]

7.30.6.11 COLLECTION AND SCREENING PROCEDURES:

A. Newborn screening collection kits shall only be purchased from the NM department of health's children's medical services newborn screening program.

B. The department of health's newborn screening program shall set the rate for newborn screening kits. The fees collected from purchase of the kits shall be utilized by the program for testing, quality assurance, and follow up of newborn screening conditions.

C. Each newborn screening kit shall be completely filled out for each blood sample. The following is required to be completed on each newborn screening kit:

(1) demographic area. All contact information for mother must be completed as well as additional contact information for the mother or a relative;

(2) name and phone number of PCP or provider who will be following the newborn after discharge;

(3) specimen date and time; and

(4) name and signature of person collecting specimen.

D. Types of kits that can be used.

(1) Hospitals, birthing centers, and midwives may only purchase newborn screening double kits.

(2) NICUs, outpatient laboratories, clinics, and PCP offices may purchase a limited number of newborn screening single kits at a time.

(3) NICUs in NM shall purchase triple kits to be used in their units only, and they shall be used in accordance with clinical and laboratory standards institute guidelines for collection of newborn screening for pre-term, low birth weight, and sick newborns.

(4) Newborn screening single kits are only to be used in NICUs for additional screening, or only in the event a parent misplaces kits, or the birthing facility does not give the kit to the parent at discharge.

(5) Each newborn screening double kit is for one newborn and is not to be split between two newborns.

(6) A limited number of single kits will be placed at public health offices across the state as a safety net for parents to obtain kits in the event they misplace, lose a kit, or the birthing facility in error does not send the second half of the double kit home with the parent.

E. All first newborn screens will be shipped by overnight courier assigned by the department of health newborn genetic screening program. Specimens will be shipped to the address indicated on the collection form within 24 hours of the time that the sample is taken.

[7.30.6.11 NMAC - N, 10/30/12]

7.30.6.12 FOLLOW-UP PROCEDURES:

A. All results will be reported to the hospital and infants PCP for placement in the child's medical record.

B. In the event of positive or questionable screening test results, the department of health's children's medical services newborn screening program and or contracted outreach lab short-term follow-up program will immediately contact and inform the PCP of the need for further testing. The primary care physician will be responsible for contacting and informing the parents or guardians of the need for further testing.

C. In the event no PCP is named on the newborn screening form the newborn screening program will pursue follow-up with the parents or guardians directly.

[7.30.6.12 NMAC - N, 10/30/12]

7.30.6.13 STORAGE OF NEWBORN SCREENING SPECIMENS:

A. The newborn screening program of the department of health or contracted laboratory may store the blood samples of newborns collected for the screening of genetic disorders for up to one year. After that time, the blood samples shall be destroyed.

B. The newborn screening program may change the length and conditions of storage if the program determines that such a change is necessary.

C. Bloodspot cards shall not be disseminated after blood spot testing for any purpose unrelated to newborn screening, except to parents or guardians who may request them in writing during the retention period.

[7.30.6.13 NMAC - N, 10/30/12]

PART 7: PREVENTION OF INFANT BLINDNESS

7.30.7.1 ISSUING AGENCY:

New Mexico Department of Health.

[1/31/98; Recompiled 10/31/01]

7.30.7.2 SCOPE:

These regulations are intended to designate mandatory treatment to all newborns for the prevention ophthalmia neonatorum.

[1/31/98; Recompiled 10/31/01]

7.30.7.3 STATUTORY AUTHORITY:

The statutory authority for these regulations is contained in Sections 9-7-6(E) and 24-1-3(F) NMSA 1978 authorizing the department of health to adopt regulations to prevent infant mortality, birth defects and morbidity.

[1/31/98; Recompiled 10/31/01]

7.30.7.4 DURATION:

Permanent.

[1/31/98; Recompiled 10/31/01]

7.30.7.5 EFFECTIVE DATE:

January 31, 1998, unless a later date is cited at the end of a section or paragraph.

[1/31/98; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.30.7.6 OBJECTIVE:

The purpose of these regulations is to establish mandatory guidelines which assure that the eyes of newborns are treated in a manner which ensures protection against Neisseria gonorrhea.

[1/31/98; Recompiled 10/31/01]

7.30.7.7 DEFINITIONS:

A. **"Conjunctiva"** is the mucous membrane covering the anterior portion of the globe of the eye, reflected upon the lids and extending to their free edges.

B. **"Conjunctivitis"** is inflammation of the conjunctiva of the eye.

C. **"Gonococcal Ophthalmia Neonatorum"** an acute or severe form of purulent conjunctivitis, caused by infection from Neisseria gonorrhea which may result in blindness if left untreated.

D. **"Neisseria gonorrhea"** A genus of gram-negative, aerobic diplococci of the family Neisseria; specifically the causative agent of gonorrhea and gonococcal ophthalmia neonatorum.

E. **"Prophylaxis"** the prevention of disease; use of measures or agents to prevent the development or spread of disease.

F. **"1 percent Silver Nitrate"** AGNO3; a colorless or white crystal, 1 gram of which is soluble in 0.4cc of water and in 30cc. of alcohol; a prophylactic agent used against gonococcal ophthalmia neonatorum.

G. **"0.5 percent Erythromycin ophthalmic ointment"** an antibiotic that is an effective and acceptable agent for prophylaxis of gonococcal ophthalmia neonatorum.

H. **"1 percent Tetracycline ophthalmic ointment"** an antibiotic that is an effective and acceptable agent for prophylaxis of gonococcal ophthalmia neonatorum.

[1/31/98; Recompiled 10/31/01]

7.30.7.8 RESPONSIBILITY FOR ADMINISTRATION:

A. Every physician, midwife, nurse or other person in professional attendance to a birth in this state shall be required to administer for prophylaxis of gonococcal ophthalmia neonatorum, a 1 percent silver nitrate solution in single-dose ampules or single use tubes of an ophthalmic ointment containing 0.5 percent erythromycin or 1 percent tetracycline into both eyes of a newborn infant as soon as possible after birth.

B. Prior to administration of local prophylaxis, each eyelid should be wiped gently with sterile cotton.

C. Two drops of a 1 percent silver nitrate solution or a one to two cm ribbon of either erythromycin or tetracycline ointment are placed in the lower conjunctival sac of each eye. The eyelids are then gently massaged to spread the medication.

D. After one minute, the excess drops or ointment can be wiped away with sterile cotton.

E. No attempts should be made to flush the eyes after installation of the medication because flushing will decrease the effectiveness of the treatment.

F. In cases where a parent specifically objects to the use of silver nitrate solution in the eyes of their newborn infant, the hospital, physician, midwife, or other professional person charged with the administration of prophylaxis, must administer an alternative ophthalmic ointment containing 0.5 percent erythromycin or 1 percent tetracycline. These compounds are the only compounds recognized by the New Mexico health department as safe and effective agents for prevention of gonococcal ophthalmia neonatorum.

G. Providers should use universal precautions in administering eye prophylaxis as with all medication administration.

H. Hospitals in which prophylaxis is delayed should establish a check system to ensure that all infants are treated.

I. Any residual medication instilled in the eyes of newborns for the prevention of gonococcal ophthalmia neonatorum is to be discarded and not sent home with the infant at the time of discharge.

[1/31/98; Recompiled 10/31/01]

PART 8: REQUIREMENTS FOR FAMILY INFANT TODDLER EARLY INTERVENTION SERVICES [REPEALED]

[This part was repealed on July 1, 2024.]

PART 9: BIRTHING WORKFORCE RETENTION FUND

7.30.9.1 ISSUING AGENCY:

New Mexico Department of Health, Public Health Division, Family Health Bureau, Maternal/Child Health Program.

[7.30.9.1 NMAC - Rp, 7.30.9.1 NMAC, 6/30/2016]

7.30.9.2 SCOPE:

These rules apply to certified nurse-midwives and physicians licensed in New Mexico who provide birthing services and apply for funds from the birthing workforce retention fund.

[7.30.9.2 NMAC - Rp, 7.30.9.2 NMAC, 6/30/2016]

7.30.9.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated by the secretary of the department of health by authority of Section 9-7-6E NMSA 1978, and implement Section 41-5-26.1 NMSA 1978.

[7.30.9.3 NMAC - Rp, 7.30.9.3 NMAC, 6/30/2016]

7.30.9.4 DURATION:

Permanent.

[7.30.9.4 NMAC - Rp, 7.30.9.4 NMAC, 6/30/2016]

7.30.9.5 EFFECTIVE DATE:

June 30, 2016, unless a later date is cited at the end of a section.

[7.30.9.5 NMAC - Rp, 7.30.9.5 NMAC, 6/30/2016]

7.30.9.6 OBJECTIVE:

These rules are promulgated pursuant to statute for the purpose of establishing criteria for the application for and award of money from the birthing workforce retention fund.

[7.30.9.6 NMAC - Rp, 7.30.9.6 NMAC, 6/30/2016]

7.30.9.7 DEFINITIONS:

A. "Certified nurse-midwife (CNM)" means an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of American College of Nurse-Midwives Certification Council, Inc. (ACC) certification.

B. "Department" means the New Mexico department of health.

C. "Fund" means the birthing workforce retention fund, as established by Section 41-5-26.1 NMSA 1978, which provides malpractice insurance premium assistance to eligible awardees.

D. "Indigent" means those individuals having a household income under two hundred thirty-five percent of federal poverty guidelines who are not covered by any private third-party health insurance and who are not eligible for medicaid coverage.

E. "Physician" means a medical doctor licensed under the New Mexico Medical Practice Act to practice medicine in New Mexico.

F. "Program" means the maternal/child health program of the family health bureau of the public health division of the New Mexico department of health.

G. "Secretary" means the secretary of the department of health.

H. "Tail coverage" means insurance coverage providing an extended reporting period for any claims related to conduct that occurred during the period covered by the claims-based medical malpractice policy after it has expired or been canceled.

[7.30.9.7 NMAC - Rp, 7.30.9.7 NMAC, 6/30/2016]

7.30.9.8 ELIGIBILITY:

In order to be eligible for award of money from the fund, the applicant must:

A. be a certified nurse-midwife licensed in New Mexico or a physician licensed in New Mexico;

B. demonstrate need by showing that medicaid or indigent patients constitute at least one-half of the obstetric practice of the applicant;

C. have a current malpractice liability insurance policy covering birthing services;

D. show intent to continue his/her obstetrics practice in New Mexico during the period covered by the award; and

E. provide attestation statement stating that award will not be used to provide premium assistance for tail coverage purchased upon applicant’s termination from his/her work practice.

[7.30.9.8 NMAC - Rp, 7.30.9.8 NMAC, 6/30/2016]

7.30.9.9 APPLICATIONS:

A. Requirements: The applicant shall present to the program, via mail or fax, a completed department application which is available on the department’s website at http://nmhealth.org/about/phd/fhb/mwp/or by contacting the program at (505) 476-8907. Along with the application the applicant must submit:

(1) a copy of the applicant’s current New Mexico license to practice certified nurse-midwifery or medicine;

(2) proof of the applicant's current malpractice liability insurance policy premium covering birthing services;

(3) proof of both the number and the percentage of medicaid and indigent patients seen in the applicant's birthing practice in each of the previous two years;

(4) proof of all payments and any funding the applicant received for delivery services for each of the previous two years; and

(5) proof that the applicant provides both prenatal and birthing services in his/her practice.

B. Deadline for application: Deadline for application will be available through the program and will be listed on the application.

[7.30.9.9 NMAC - Rp, 7.30.9.9 NMAC, 6/30/2016]

7.30.9.10 COMMITTEE TO REVIEW APPLICATIONS:

The secretary or the secretary's designee shall appoint a committee to evaluate applications and select awardees. The committee shall consist of such members as chosen by the secretary or the secretary's designee, including, at a minimum:

A. a member of the maternal child health program of the department; and

B. a member of the health systems bureau of the department.

[7.30.9.10 NMAC - Rp, 7.30.9.10 NMAC, 6/30/2016]

7.30.9.11 EVALUATION OF APPLICATIONS:

A. Basis for disbursal: Awards shall be disbursed based on the percentage of the CNM or physician's patients seen for birthing services who are covered by medicaid or are indigent, with a minimum of fifty percent of the practitioner's obstetric practice consisting of medicaid or indigent patients.

B. Criteria upon which the committee shall evaluate and prioritize the need of the applicant and the merits of the application:

(1) the relative availability of birthing services for medicaid and indigent patients in the applicant's community, based on the department's annual study of geographic access to birthing care providers;

(2) the number of medicaid and indigent patients seen in the practice for birthing services;

(3) the ratio of the revenue received from deliveries to the liability insurance premium; and

(4) the provision of comprehensive prenatal and delivery services to clients who present for them.

[7.30.9.11 NMAC - Rp, 7.30.9.11 NMAC 6/30/2016]

7.30.9.12 PRIORITY OF AWARDS:

Priority for the award of money from the birthing workforce retention fund shall be in the following order:

A. to certified nurse-midwives; and

B. to family practice physicians and obstetricians.

[7.30.9.12 NMAC - Rp, 7.30.9.12 NMAC 6/30/2016]

7.30.9.13 AWARDS:

Subject to availability of funds, each award shall be a minimum of five thousand dollars ($5,000) and shall not exceed ten thousand dollars ($10,000).

A. Awardees will be notified within 45 days after the application deadline.

B. Awardees shall submit proof of payment of a malpractice liability insurance policy covering birthing services to the program within nine months of receipt of the award.

[7.30.9.13 NMAC - Rp, 7.30.9.13 NMAC 6/30/2016]

PART 10: AWARD OF FUNDS FROM SAVE OUR CHILDREN'S SIGHT FUND

7.30.10.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.30.10.1 NMAC - N, 10/29/2010]

7.30.10.2 SCOPE:

This rule applies to any parent (guardian) notified by the school that the results of vision screening of his/her child indicate the need for further evaluation, and it establishes criteria for applying for financial support from the save our children's sight fund and award of these funds.

[7.30.10.2 NMAC - N, 10/29/2010]

7.30.10.3 STATUTORY AUTHORITY:

This rule is promulgated pursuant to Sections 9-7-6, 24-1-31, 24-1-32 and 22-13-30 NMSA 1978.

[7.30.10.3 NMAC - N, 10/29/2010]

7.30.10.4 DURATION:

Permanent.

[7.30.10.4 NMAC - N, 10/29/2010]

7.30.10.5 EFFECTIVE DATE:

October 29, 2010 unless a later date is cited in the history at the end of a section.

[7.30.10.5 NMAC - N, 10/29/2010]

7.30.10.6 OBJECTIVE:

To establish a mechanism by which a parent (guardian) of eligible New Mexico students can apply to the save our children's sight fund.

[7.30.10.6 NMAC - N, 10/29/2010]

7.30.10.7 DEFINITIONS:

A. **"Administering agent"** means the office of school and adolescent health of the New Mexico department of health or its successor.

B. **"Eligible student"** means a student whose parent (guardian) may apply to the save our children's sight fund because the student's vision screening indicates the need for further evaluation and the student is not already covered by health insurance for a comprehensive eye examination.

C. **"Eyewear"** means equipment prescribed for the treatment of vision limitations including but not limited to polycarbonate lenses and frames and contact lenses.

D. **"Funds"** means money from save our children's sight fund.

E. **"Participating provider"** means any optometrist, ophthalmologist or optician with a provider agreement to supply comprehensive eye examinations, prescribed treatment eyewear, or both for students awarded funds.

[7.30.10.7 NMAC - N, 10/29/2010]

7.30.10.8 ELIGIBILITY FOR FUNDS:

Regardless of family income, any parent (guardian) of an eligible student as defined by Subsection B of 7.30.10.7 NMAC may apply for funds for the following expenses:

A. cost of a comprehensive eye examination by a participating optometrist or ophthalmologist through referral;

B. cost of polycarbonate lenses and frames for eyeglasses or for contact lenses; and

C. cost of replacement insurance for lost or broken lenses.

[7.30.10.8 NMAC - N, 10/29/2010]

7.30.10.9 APPLICATION FOR FUNDS:

A. Application for funds shall be made by parent (guardian) of an eligible student to the administering agent via mail, email, fax or hard copy using the application and referral forms approved by the administering agent.

B. Applicants shall provide the administering agent with proof of lack of insurance coverage for a comprehensive eye examination when applying for funds. A copy of insurance benefits which demonstrate the insurance does not include a comprehensive eye examination or a sworn affidavit attesting to lack of coverage shall be acceptable.

[7.30.10.9 NMAC - N, 10/29/2010]

7.30.10.10 REVIEW OF APPLICATIONS:

A. The administering agent or its designee shall review applications for referral criteria and verification of insurance status to establish client eligibility for award of funds.

B. The administering agent shall approve award of funds on the basis of client eligibility and availability of funds according to the agent’s established program guidelines for distribution of the funds.

[7.30.10.10 NMAC - N, 10/29//2010]

7.30.10.11 DISTRIBUTION OF FUNDS:

A. Distribution of funds shall follow the reimbursement schedule for costs designated in participating provider agreements established with the administering agent.

B. Reimbursement costs for polycarbonate lenses and contact lenses as described in 7.30.10.8 NMAC shall follow criteria as defined by medicaid services rules (Subsection G of 8.310.6.12 NMAC and Subsection C of 8.310.6.14 NMAC).

C. If funds become exhausted, the administering agent shall maintain a waiting list of eligible applicants.

D. Services purchased with awarded funds shall be purchased within the state of New Mexico unless the need to purchase services elsewhere is documented and approved by the administering agent.

E. Funds shall be distributed by the administering agent in voucher form for direct payment to the participating provider for services delivered to approved applicants in accordance with participating provider agreements.

F. The award of funds shall be limited to one-time use per student per school year.

[7.30.10.11 NMAC - N, 10/29/2010]

PART 11: VISION SCREENING TEST STANDARDS FOR STUDENTS

7.30.11.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.30.11.1 NMAC - N, 10/29/2010

7.30.11.2 SCOPE:

This rule applies to vision screeners and students enrolled in public schools in New Mexico in pre-kindergarten, kindergarten, first grade and third grade and transfer and new students in those grades unless a parent (guardian) affirmatively prohibits the vision screening.

[7.30.11.2 NMAC - N, 10/29/2010]

7.30.11.3 STATUTORY AUTHORITY:

This rule is adopted pursuant to Sections 9-7-6, 24-1-32 and 22-13-30 NMSA 1978.

[7.30.11.3 NMAC - N, 10/29/2010]

7.30.11.4 DURATION:

Permanent.

[7.30.11.4 NMAC - N, 10/29/2010]

7.30.11.5 EFFECTIVE DATE:

October 29, 2010 unless a later date is cited in the history at the end of a section.

[7.30.11.5 NMAC - N, 10/29/2010]

7.30.11.6 OBJECTIVE:

To establish standards for required vision screening of students in New Mexico public schools.

[7.30.11.6 NMAC - N, 10/29/2010]

7.30.11.7 DEFINITIONS:

A. **"The department"** means New Mexico department of health.

B. **"Student"** means an individual enrolled in a New Mexico public school in one of the following grades: pre-kindergarten, kindergarten, first or third.

C. **"Photoscreening"** means a method of vision screening with a machine with automated technique that uses red reflex of the eye to screen for eye problems and produces immediate readable results and timely report of the results thereafter.

D. **"Vision pre-screening observation"** means any observation listed in New Mexico vision screening standards that requires follow-up as a potential result of vision limitation.

E. **"Vision screening standards"** means the department's approved manner of vision screening for students in New Mexico, established pursuant to report from an advisory committee appointed by the secretary of the department.

F. **"Vision screening test"** means any vision test administered in accordance with vision screening standards in New Mexico schools.

G. **"Vision screener"** means a school nurse or the nurse's designee, a primary care health provider or a lay screener trained to administer a vision screening test to students in New Mexico schools in accordance with vision screening standards.

[7.30.11.7 NMAC - N, 10/29/2010]

7.30.11.8 REQUIREMENTS:

A. **Target population for required screening:** All public school students enrolled in pre-kindergarten, kindergarten, first grade and third grade including new students and transfer students in those grades shall have a vision screening test administered unless the parent (guardian) affirmatively prohibits the screening.

B. **Parental notification:** The parent (guardian) shall be provided notification of school vision screening to include the date and location of screening. The parent (guardian) shall have an opportunity to prohibit the screening for the student.

C. **Vision screener:** A school nurse or the nurse's designee, a primary care health provider or a trained lay eye screener shall administer the screening tests.

D. **Vision screening standards:**

(1) Vision screening standards for pre-screening observations and screening tests in the school setting are established by the department and shall be reviewed periodically as determined by the secretary of the department.

(2) Vision pre-screening observation standards shall include but are not limited to eye appearance and visual behaviors.

(a) Eye appearance observations shall include at a minimum the following:

(i) cloudy or milky appearance,

(ii) keyhole pupil,

(iii) sustained eye turn inward or outward,

(iv) droopy eyelids,

(v) absence of eyes moving together,

(vi) abnormal pupil constriction or dilation,

(vii) difference in size and shape of eyes, and

(viii) excessive tearing,

(ix) jerky eye movements (nystagmus).

(b) Visual behavior observations shall include at a minimum the following:

(i) inconsistent visual behavior,

(ii) visually inattentive or uninterested,

(iii) difficulty sustaining eye contact,

(iv) holding objects close to face,

(v) bending close to view objects,

(vi) tilting head,

(vii) staring at lights and ceiling fans,

(viii) high sensitivity to room light or sunlight,

(ix) appearing to look beside, under or above an object or person,

(x) bumping into things, and

(xi) tripping over objects.

(3) Vision screening test standards in the school setting for the target population shall include but is not limited to distance visual acuity, ocular alignment, and color vision. Ocular alignment and color vision testing are required only once in any one of the targeted grades.

(4) Referral criteria for the required screening tests shall be in alignment with failure to meet the following test passing criteria:

(a) distance visual acuity passing criteria shall be identification of test line 20/40 for 3-5 years of age and 20/30 for 6 years of age and older;

(b) ocular alignment passing criteria shall be identification of the testing tool object; and

(c) color vision passing criteria shall be meeting passing criteria for any standard color vision test.

E. **Screening methods:** Acceptable screening methods include traditional screening and photoscreening as outlined in the department approved vision screening standards. These methods shall adhere to the testing tools approved and adopted for use in the most current vision screening standards.

F. **Results notification:** Based on the school-based vision screening test results, the student's school shall notify the student's parent (guardian) if the need for further evaluation is indicated and shall provide information on application to the save our children's sight fund (7.30.10 NMAC).

G. **Referral process:** A standardized referral form approved by the administering agent of the save our children's sight fund shall be used for referring a student for further evaluation. The form shall include screening results held in the student's school health record. Any information resulting from a comprehensive vision evaluation reported back to the school on this referral form may be used for the purpose of completing the school health record and to collect information to evaluate the school vision screening program. Information on this form shall be treated as confidential medical information, and its use shall comply with all applicable federal and state laws.

[7.30.11.8 NMAC - N 10/29/2010]

PART 12: EMERGENCY MEDICATIONS IN SCHOOLS

7.30.12.1 ISSUING AGENCY:

New Mexico Department of Health.

[7.30.12.1 NMAC - N, 02/27/2015]

7.30.12.2 SCOPE:

This rule applies to public, private, or charter schools in New Mexico unless otherwise expressly limited.

[7.30.12.2 NMAC - N, 02/27/2015]

7.30.12.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: (1) the Department of Health Act, Section 9-7-6(E) NMSA 1978, which authorizes the secretary of the department of health to "...make and adopt such reasonable and procedural rules and regulations as may be necessary to carry out the duties of the department and its divisions;" (2) the Public Health Act, Section 24-1-3(G) and (O) NMSA 1978 and Section 24-31-1 NMSA 1978, which authorize the department to prescribe the duties of school nurses to maintain and enforce rules to carry out the provisions of the Public Health Act; and to promulgate rules pursuant to the Emergency Medication in Schools Act; and (3) the Emergency Medication in Schools Act, Sections 22-33-1 through 22-33-4 NMSA 1978, which authorizes the department to adopt regulations to carry out the provisions of the Emergency Medication in Schools Act.

[7.30.12.3 NMAC - N, 02/27/2015]

7.30.12.4 DURATION:

Permanent.

[7.30.12.4 NMAC - N, 02/27/2015]

7.30.12.5 EFFECTIVE DATE:

February 27, 2015, unless a later date is cited at the end of a section.

[7.30.12.5 NMAC - N, 02/27/2015]

7.30.12.6 OBJECTIVE:

The purpose of this rule is to allow access to emergency medications in the school setting for the treatment of respiratory distress with albuterol and the treatment of anaphylactic reactions with epinephrine. Stock emergency medications are intended for students who have not previously been diagnosed with conditions leading to respiratory distress or anaphylaxis or who have a history of these conditions and do not have medications on their person or stored at school.

[7.30.12.6 NMAC - N, 02/27/2015]

7.30.12.7 DEFINITIONS:

A. "Adverse event form" is a department form used by school nurses to report events with potential impact on the health of the students or the school, including administration of stock albuterol or epinephrine.

B. "Albuterol" includes albuterol or another inhaled bronchodilator, as recommended by the department of health, for the treatment of respiratory distress.

C. "Albuterol aerosol canister" means a portable drug delivery device packaged with multiple premeasured doses of albuterol.

D. "Anaphylaxis" or "anaphylactic reaction" means a sudden, severe, and potentially life-threatening whole-body allergic reaction.

E. "BOP" refers to the board of pharmacy.

F. "Class D Medication Room" is specific for schools and is used only for emergency medications. The Class D Medication Room criteria is established by the board of pharmacy. The criteria includes requirements for procurement of medications, storage, tracking, and disposal of expired medications.

G. "Department" means department of health.

H. "Emergency medication" means albuterol or epinephrine.

I. "Epinephrine" includes epinephrine or another medication, as recommended by the department of health, used to treat anaphylaxis until the immediate arrival of emergency medical system responders.

J. "Epinephrine auto-injector" means a portable, disposable drug delivery device that contains a premeasured single dose of epinephrine.

K. "Governing body" means a governing body of a private school.

L. "Health care practitioner" means a person authorized by the state to prescribe emergency medication.

M. "PED" means the public education department.

N. "Respiratory distress" includes impaired oxygenation of the blood or impaired ventilation of the respiratory system.

O. "School" means a public school, charter school, or private school.

P. "Spacer" means a holding chamber that is used to optimize the delivery of albuterol to a person's lungs.

Q. "Stock supply" means an appropriate quantity of emergency medication, as recommended by the department of health.

R. "Trained personnel" means a school employee, agent, or volunteer designated by the school nurse to administer epinephrine on a voluntary basis outside of the scope of employment and who has completed department approved epinephrine administration training that has been documented by the school nurse, school principal, or school leader.

[7.30.12.7 NMAC - N, 02/27/2015]

7.30.12.8 EMERGENCY MEDICATIONS:

A. Standing Orders.

(1) A physician employed or authorized by the department, may prescribe a standing order in the name of the school or school district for a stock supply of albuterol aerosol canisters and spacers, or a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors for use in accordance with this rule.

(2) Each local school board or governing body may request a standing order for and may provide to schools within its jurisdiction stock supplies of albuterol and epinephrine. In order to request a standing order, the school board must review and acknowledge in writing the rules and recommendations developed by the department

for emergency medication use. All requests for standing orders must be in writing to a department approved physician. When the standing order is issued by the department approved physician, it will be sent to the requesting school district or governing body within one week of the request. A copy of the order will be kept by the department school health advocate for his or her assigned region.

(3) A pharmacist may dispense a stock supply of albuterol aerosol canisters and spacers or a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors pursuant to a standing order prescribed in accordance with this section. Medications may be directly obtained from the pharmacy by a school nurse or delivered to the school in accordance with the school's established procedure.

(4) All standing orders are renewed annually.

B. Storage provisions: School districts that decide to maintain and administer emergency medications will establish a Class D Medication Room in each school that stocks emergency medications in compliance with New Mexico BOP regulations. School nurses who maintain a Class D Medication Room license will be required to complete an annual medication room audit and submit it to the BOP.

(1) Albuterol - Each school that obtains a stock supply of albuterol aerosol canisters and spacers shall store them:

(a) in a secure location that is unlocked and readily accessible to a school nurse to administer albuterol;

(b) pursuant to BOP regulations, including requirements for storage, record maintenance, and medication room audits or consulting pharmacist's visits;

(c) within the manufacturer-recommended temperature range; and

(d) albuterol will be secured in a manner consistent with the procedure employed by the school nurse for other emergency medications; the medication cabinet, which is kept in the school nurse's office, is kept unlocked when the school nurse or school health assistant are present in the office; if the school nurse or school health assistant are not present, the school nurse's office will be locked.

(2) Epinephrine - Each school that obtains a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors shall store them:

(a) in a secure location that is unlocked and readily accessible to trained personnel;

(b) pursuant to BOP regulations including requirements for storage, record maintenance, and medication room audits or consulting pharmacist's visits;

(c) within the manufacturer-recommended temperature range; and

(d) epinephrine will be stored in a secure, unlocked location determined by the school nurse and principal; this location should be easily accessed by trained school personnel in the event of an emergency situation; a location is considered secure for the purposes of epinephrine storage if school staff are present full-time in that location; for example, the secretary's office or the main office.

C. Disposal: Albuterol and epinephrine - Each local school board or governing body shall dispose of expired emergency medication pursuant to BOP regulations. Expired medications will be placed in a separate, quarantined section of the medication room and disposed of per the Class D Medication Room regulations.

(1) The school nurse will be responsible for proper disposal of expired medications.

(2) The BOP is a resource for direction in proper disposal of expired medications.

(3) Expired medications may be disposed of either by using a consultant pharmacist or by transferring the medications to a pharmacy with an appropriate transfer log.

D. Procurement and maintenance of emergency medications.

(1) A local school board or a school within its jurisdiction of a governing body may accept gifts, grants, bequests, or donations from any source to carry out the provisions of this rule, including:

(a) albuterol aerosol canisters and spacers or epinephrine auto-injectors from a manufacturer or wholesaler; or

(b) epinephrine or albuterol, or such other medication as the department deems appropriate, from a manufacturer or wholesaler of such medication; and

(c) this type of donation can be accepted if the medications are not expired and have been maintained properly.

(2) School districts or governing bodies may buy prescribed medications directly from pharmacies after obtaining a standing order.

(3) Schools will keep a record of any grants, gifts, bequests, or donations. The record is to be held at the school in the school office for three years and can be inspected by BOP, department personnel, and school administrative personnel upon request. The records will be kept in the school health office by the school nurse. Records may be kept electronically or in hard copy.

(4) Schools will maintain a supply of emergency medications:

(a) the supply will be replenished as medications are used according to the procedure in 7.30.12.8 NMAC; and

(b) medications in stock will be checked to verify that medications are not expired.

[7.30.12.8 NMAC - N, 02/27/2015]

7.30.12.9 TRAINING:

School districts that decide to maintain and administer emergency medications will follow the department rules and recommendations, according to the following guidelines:

A. Use of albuterol:

(1) PED licensed school nurses will complete training on administering albuterol reviewed and approved by the department;

(2) current school nurses will complete the training at a minimum of one time and as determined by the department; new school nurses will complete the training as part of their orientation process, and then as determined by the department; and

(3) refresher trainings on albuterol may be recommended by the department, at a minimum of every five years.

B. Use of epinephrine:

(1) school personnel, including non-licensed personnel, will complete training on administering epinephrine that is reviewed and approved by the department;

(2) current school nurses will complete the training one time and new school nurses will complete the training as part of their orientation process;

(3) non-licensed personnel will complete the training annually; and

(4) refresher trainings on epinephrine for PED licensed school nurses may be recommended by the department, at a minimum of every five years.

C. Training will be documented and a training log will be kept at each school in the school health office for a minimum of five years. Training records may be maintained electronically or in hard copy.

[7.30.12.9 NMAC - N, 02/27/2015]

7.30.12.10 ADMINISTRATION OF EMERGENCY MEDICATIONS:

A. Use of albuterol:

(1) only a PED licensed school nurse, who has completed the requisite training, will administer inhaled albuterol on an emergency basis;

(2) if no school nurse is available, immediately call 911;

(3) inhaled stock albuterol will be given for treatment of respiratory distress only when the student is experiencing respiratory distress, per criteria that will be covered in training, and does not have medication available; albuterol may be administered to students who have not previously been diagnosed with conditions leading to respiratory distress and students who have a history of respiratory disease but do not have medication at school;

(4) when stock albuterol is used, 911 will be called immediately to activate the emergency response system;

(5) after administration of albuterol, the student's condition will be continuously monitored, and any additional treatment indicated will be given until an emergency medical system responder arrives;

(6) as soon as practicable, the parent, guardian, or legal custodian of the student having respiratory distress will be notified by phone or in accordance with contact information on file at the school;

(7) a log will be kept of when albuterol is used and the outcome of the student; these logs will be kept in the school health office at least five years; logs will be available for review upon request, per applicable federal and state privacy laws; logs will be maintained by the school nurse; logs may be either electronic or hard copy; and

(8) an adverse events form will be completed when albuterol is administered on an emergency basis; the form will be submitted within three working days to the regional school health advocate or the regional health officer; adverse events forms will be maintained by the department for a minimum of five years.

B. Use of epinephrine:

(1) school personnel, including non-licensed personnel, who have completed the requisite training, may administer epinephrine on an emergency basis;

(2) epinephrine will be given for treatment of severe anaphylactic reactions only when the student is experiencing signs of anaphylaxis, per criteria that will be covered in training, and does not have medication available; this includes students who

have not previously been diagnosed with conditions leading to anaphylaxis and students who have a history of anaphylaxis and who do not have medication at school;

(3) each school that receives a stock supply of standard-dose and pediatric-dose epinephrine auto-injectors shall:

(a) develop and implement a plan to have one or more trained personnel on the school premises during operating hours, which includes class time and after school activities; and

(b) follow an anaphylactic reaction prevention protocol, as recommended by the department, to minimize an allergic student's exposure to food allergies.

(4) when stock epinephrine is used, 911 will be called immediately to activate the emergency response system;

(5) after administration of epinephrine, the student's condition will be continuously monitored and any additional treatment indicated will be given until an emergency medical system responder arrives;

(6) as soon as practicable, the parent, guardian, or legal custodian of the student will be notified by phone or in accordance with contact information on file at the school;

(7) a log will be kept of when epinephrine is used and the outcome of the student; these logs will be kept in the school health office at least five years; logs will be available for review upon request, per applicable federal and state privacy laws; logs will be maintained by the school nurse; logs may be either electronic or hard copy;

(8) an adverse events form will be completed when epinephrine is administered on an emergency basis; the form will be submitted within three working days to the regional school health advocate or the regional health officer; adverse events form will be maintained by the department for a minimum of five years.

[7.30.12.10 NMAC - N, 02/27/2015]

7.30.12.11 PREVENTION:

A. A vital part of the emergency medication in schools programs is preventing respiratory distress and severe allergic reactions.

B. Recommendations will be developed by the department for school districts to use in the development of policies and procedures addressing both the use of the medications and prevention of respiratory distress and severe allergic reactions. The recommendations document will be issued upon request to interested school districts

and governing bodies. The document will be available online through the office of school and adolescent health's website at http://nmhealth.org/about/phd/hsb/osah/.

C. The following resources are available for school districts to use in developing prevention strategies, and can be obtained from the office of school and adolescent health's website at http://nmhealth.org/about/phd/hsb/osah/ or by contacting the office at 300 San Mateo Blvd. NE, Suite 902, Albuquerque, NM 87108:

(1) the environmental protection agency's "indoor air quality: tools for schools;"

(2) the centers for disease control and prevention's "voluntary guidelines for managing food allergies in schools and early care and education programs;" or

(3) the centers for disease control and prevention's toolkit "initiating change: creating an asthma-friendly school."

D. Other resources are available through the department's asthma control program as well as the office of school and adolescent health.

[7.30.12.11 NMAC - N, 02/27/2015]

PART 13: CRISIS TRIAGE CENTERS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.321.11 NMAC.]

PART 14: MANDATORY CONCUSSION RECOGNITION, RESPONSE ADN PREVENTION EDUCATION

7.30.14.1 ISSUING AGENCY:

Department of Health, Epidemiology and Response Division, 1190 St. Francis Drive, P.O. Box 26110, Santa Fe, New Mexico 87502-6110.

[7.30.14.1 NMAC - N, 10/15/2019]

7.30.14.2 SCOPE:

This regulation applies to all non-scholastic teams, clubs, or other entities providing youth athletic activities as defined in this rule, coaches participating in youth athletic activities, youth athletes, and youth athletes' parents or guardians.

[7.30.14.2 NMAC - N, 10/15/2019]

7.30.14.3 STATUTORY AUTHORITY:

This regulation is adopted pursuant to Section 22-13-31.1 NMSA 1978, and the general authority granted under Subsection E of Section 9-7-6 NMSA 1978, Department of Health Act, as amended.

[7.30.14.3 NMAC - N, 10/15/2019]

7.30.14.4 DURATION:

Permanent.

[7.30.14.4 NMAC - N, 10/15/2019]

7.30.14.5 EFFECTIVE DATE:

October 15, 2019, unless a later date is cited at the end of a section.

[7.30.14.5 NMAC - N, 10/15/2019]

7.30.14.6 OBJECTIVE:

The objective of this rule is to establish uniform brain injury protocols to be used by coaches for brain injuries received by youth athletes in non-scholastic athletic activities, training of coaches and youth athletes, and information to be provided to coaches, youth athletes, and youth athletes' parents or guardians; to require acknowledgement of training and information by participants in youth athletic activities; and to achieve brain injury protocol compliance and certification.

[7.30.14.6 NMAC - N, 10/15/2019]

7.30.14.7 DEFINITIONS:

A. "Brain injury" means a body-altering physical trauma to the brain, skull, or neck, caused by blunt or penetrating force, a concussion, a diffuse axonal injury, hypoxia-anoxia, an electrical charge, or other trauma;

B. "Brain injury educational materials" means educational materials related to brain injuries, including at least materials that are produced or approved by the centers for disease control and prevention (CDC) for athletes under the age of 19 years of age and those athletes' parents that includes information regarding brain injuries and their potential consequences; the signs and symptoms of a concussion; best practices for removal of an athlete from an athletic activity after a suspected brain injury; and steps for returning an athlete to athletic activity after a brain injury.

C. "Licensed health care professional" means:

(1) a practicing physician or physician's assistant licensed pursuant to the Medical Practice Act;

(2) a practicing osteopathic physician licensed pursuant to the Osteopathic Medicine Act;

(3) a practicing certified nurse practitioner licensed pursuant to the Nursing Practice Act;

(4) a practicing osteopathic physician's assistant licensed pursuant to the Osteopathic Medicine Act;

(5) a practicing psychologist licensed pursuant to the provisions of the Professional Psychologist Act;

(6) a practicing athletic trainer licensed pursuant to the provisions of the Athletic Trainer Practice Act; or

(7) a practicing physical therapist licensed pursuant to the Physical Therapy Act.

D. "Parent" means a mother or father having the applicable parent-child relationship as set forth in Section 40-11A-201 NMSA 1978.

E. "Youth athlete" means an individual under 19 years of age who engages in, is eligible to engage in, or seeks to engage in a youth athletic activity.

F. "Youth athletic activity" means an organized athletic activity in which the participants, a majority of whom are under 19 years of age, are engaged in an athletic game or competition against participants in other in youth sports organizations. "Youth athletic activity" does not include elementary school, middle school, high school, college, or university activities or activities incidental to a non-athletic program.

G. "Youth sports organization" means a team, club, or entity that organizes athletic games or competitions against other teams, clubs, or entities, or in practice or preparation for an organized athletic game or competition against another team, club or entity.

[7.30.14.7 NMAC - N, 10/15/2019]

7.30.14.8 REQUIREMENTS:

A. All teams, clubs or other entities providing youth athletic activity must provide brain injury educational materials to each coach and administrator of the youth sports organization on an annual basis.

(1) All youth athletic activity teams, clubs, and other similar entities must require their coaches to review the brain injury education materials at least once per year, pass a post-test, and print the certificate of completion to be included in their records before the coach supervises a youth athlete in a youth athletic activity of the entity.

(2) Both youth athletes and their parents or guardians shall sign a concussion training completion form confirming they have taken a center for disease control and prevention (CDC) approved concussion training, unless the athlete is under 11 years of age, in which case only the parent or guardian shall sign the concussion training completion form.

(3) Any deviation from the use of a centers for disease control and prevention (CDC)-produced or approved materials must be approved by the New Mexico department of health.

B. All teams, clubs or other similar entities providing one or more youth athletic activities must provide the brain injury educational materials to each youth participant on an annual basis. The training, which is through the use of the brain injury educational materials, can be completed online or via printed copy of the online training.

C. Each team coach must collect all signature forms or certificates of completion from youth athletes and parents or guardians upon completion of the brain injury education and submit them to the league president before practice sessions can begin. Each league president must maintain files for each year, documenting that the training is complete for coaches, youth athletes, and parents or guardians.

D. A youth athlete who is suspected by a coach, a league official, or a youth athlete of sustaining a brain injury in a youth athletic activity shall immediately be removed from the youth athletic activity and shall remain out of play until a licensed health care professional provides the youth athlete a written clearance to return to the youth athletic activity. When a youth athlete suffers a suspected brain injury, the athletic activity team, club, or other similar entity the youth sports organization must:

(1) On the date and time of the suspected brain injury, notify the youth athlete’s parent or guardian of the youth athlete with the suspected brain injury that the youth athlete has a suspected brain injury and the symptoms observed; and

(2) Within 72-hours of a suspected brain injury, notify the youth athlete’s parent or guardian of any treatment provided in response to the suspected brain injury.

E. A coach shall not allow a youth athlete to participate in a youth athletic activity on the same day that the youth athlete:

(1) exhibits signs, symptoms, or behaviors consistent with a brain injury after a coach, a league official or a youth athlete reports, observes, or suspects that a youth athlete exhibiting these signs, symptoms, or behaviors has sustained a brain injury; or

(2) has been diagnosed with a brain injury.

F. A coach may allow a youth athlete, who has been prohibited from participation in a youth athletic activity, to participate in a youth athletic activity no sooner than 240 hours or 10 days from the time at which the youth athlete received a brain injury and may only do so after the youth athlete meets the following two criteria:

(1) no longer exhibits any sign, symptom, or behavior consistent with a brain injury; and

(2) receives a written medical release from a licensed health care professional.

[7.30.14.8 NMAC - N, 10/15/2019]

CHAPTER 31: HEALTH NUTRITION PROGRAMS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN INFANTS AND CHILDREN VENDOR REQUIREMENTS

7.31.2.1 ISSUING AGENCY:

New Mexico Department of Health, Public Health Division, Family Health Bureau.

[10-31-96, 10-31-96; 7.31.2.1 NMAC – Rn, 7 NMAC 31.2.1, A, 5-31-2000]

7.31.2.2 SCOPE:

These regulations will establish requirements and conditions under which grocery stores and pharmacies may become and remain authorized to participate in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) as retail vendors to supply authorized foods to WIC participants.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.2 NMAC – Rn, 7 NMAC 31.2.2, 5-31-2000]

7.31.2.3 STATUTORY AUTHORITY:

The regulations set forth herein are promulgated by the Secretary of the New Mexico Department of Health, by authority of N.M. Stat. Ann. 1978, Section 9-7-6E, and pursuant

to the Special Supplemental Nutrition Program for Women, Infants and Children established under Section 17 of the Child Nutrition Act of 1966, as amended, 42 USC Section 1786, and laws and regulations set forth in 7 CFR Section 246, 7 CFR Section 278.1, 7 CFR Section 15, and N.M. Stat. Ann. 1978, Section 30-16-7 (Cum.Supp. 1987); and other applicable provisions of state and federal law. These regulations shall be administered and enforced by the New Mexico Department of Health, Public Health Division.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.3 NMAC – Rn, 7 NMAC 31.2.3, 5-31-2000]

7.31.2.4 DURATION:

Permanent.

[8-30-89, 10-31-96; 7.31.2.4 NMAC – Rn, 7 NMAC 31.2.4, 5-31-2000]

7.31.2.5 EFFECTIVE DATE:

October 31, 1996, unless a later date is cited at the end of a Section.

[8-30-89, 10-31-96; 7.31.2.5 NMAC – Rn, 7 NMAC 31.2.5, A, 5-31-2000]

7.31.2.6 OBJECTIVES:

It is the purpose of these regulations to establish requirements and conditions under which grocery stores and pharmacies may become and remain authorized to participate in the Special Supplemental Nutrition Program for Women, Infants and Children (hereinafter, the "WIC" program or "WIC"), as vendors to supply authorized WIC Foods and/or infant formulas to WIC participants.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.6 NMAC – Rn, 7 NMAC 31.2.6, 5-31-2000]

7.31.2.7 DEFINITIONS:

A. "Applicant" means a grocery store or pharmacy which applies to the State WIC Office to be an authorized vendor.

B. "Authorized Food List" means the list of authorized foods approved by the State WIC Office.

C. "Authorized Foods" or **"WIC Authorized Foods"** means only those types, brands or varieties of foods and infant formulas which meet requirements specified under 7 CFR 246 and the WIC policy manual, are approved by the State WIC Office, and are listed on the authorized food list in the Vendor Manual, and on the Vendor Grocery Food Price Record Form and Special Infant Formula Price Form.

D. "Change of Ownership" means any transfer of the right to control the assets or management of a vendor, or any majority changes in ownership of a sole proprietorship, of a partnership or of the stock of a corporation which owns a vendor location.

E. "Check" means a WIC Food Instrument.

F. "Clinic Service Area" means the geographic area or population group served by a local clinic.

G. "Customer Area" means the portion of a grocery store or pharmacy which is normally frequented by customers, exclusive of storage or other areas.

H. "Department" means the State of New Mexico Department of Health.

I. "Disqualification" means cancellation of a vendor's authority to participate in the WIC program.

J. "Food Vendor Agreement" means a completed agreement and application that has been approved and signed by the State WIC Office and by the vendor. This agreement incorporates by reference the provisions and program requirements set forth in the Vendor Manual, the authorized food price record, periodic newsletters, and other formal instructions which may from time to time be issued by the State WIC Office to vendors.

K. "Food Vendor Agreement Period" means a period of two years beginning October 1 and ending on September 30 of the second year.

L. "Food Instrument" or **"WIC Food Instrument"** means a voucher, check, electronic benefits transfer card (EBT), or other document which is used by participants in the WIC program to obtain WIC authorized foods and or infant formulas.

M. "Food Stamps" means an assistance program under the Food Stamp Act of 1964, as amended, 7 U.S.C. Section 2011 (1964), that may use paper stamps or electronic means to provide benefits.

N. "Full Service Grocery or Pharmacy" means a grocery vendor location that provides a variety of food items that allow WIC's nutrition education component to be utilized at will by WIC participants, or a duly licensed New Mexico pharmacy vendor location that provides pharmaceuticals and nutritional supplements. The nutrition education component includes, but is not limited to, improving family nutrition, and teaching economical shopping techniques. A variety of food items shall include dairy products (eggs, milk, cheese, etc.), meats (beef, chicken, pork), fresh fruits and vegetables (to include, but not limited to – oranges, apples, bananas, potatoes, tomatoes, carrots, lettuce), other foods (to include basic baking products, pastas, crackers, bread, tortillas, margarine, canned fruits/vegetables/meats), household items (cleaning supplies, paper goods, etc), and foods required per minimum inventory of WIC foods.

O. "Grocery Store" means a retail store in a fixed and permanent location that is open and operating and whose primary business is the sale of food.

P. "Incidence" means 1 instance of conduct.

Q. "Investigation" means 3 positive compliance buys out of 5, or other investigative means to detect fraud or abuse. A "compliance buy" is a purchase from a vendor by an agent of the State agency to test a vendors compliance with state and federal regulations governing the WIC program.

R. "Minimum Stock Requirement" means the minimum quantities and varieties of authorized foods and/or infant formulas a grocery store or pharmacy is required to keep in the customer area as specified on the vendor authorized food price record, or special infant formula price record and in the Vendor Manual.

S. "Participant(s)" means only the following classes of persons certified eligible to receive supplemental food, nutrition education, and counseling services under the WIC program:

(1) A pregnant woman;

(2) A woman up to 12 months after giving birth who is breastfeeding her infant;

(3) A woman up to 6 months after a pregnancy has ended who is not breastfeeding her infant;

(4) An infant from birth to one year of age; or

(5) A child from one to five years of age.

T. "Participant access" means provision of 1 vendor per every 225 participants. The state agency may vary this ratio if the state agency determines that participant access would be improved. Other criteria may include but not be limited to: new clinic site opening, participant caseload increases, new participant population center recognized, problems with WIC Program compliance, etc.

U. "Pattern" means 3 or more instances of conduct.

V. "Participant access determination criteria" means the State agency shall consider, at a minimum, the availability of other authorized vendors in the same area as the violative vendor and any existing practical barriers, such as distance, availability of transportation, to using other authorized vendors. The State agency may consider other criteria as it deems appropriate.

W. "Pharmacy" means an establishment issued a license to operate as a pharmacy under New Mexico laws.

X. "Sanction" means a penalty for violation of, or non-compliance with, federal and/or state WIC Program policies and regulations which may include disqualification, suspension, or civil monetary penalties assessed in lieu of disqualification.

Y. "Standardized Combination of Foods" means a group of specific types of authorized foods and/or infant formulas identified on commonly-used food instruments which are selected by the State WIC Office for the purpose of calculating average prices charged by vendors and vendor applicants.

Z. "State Plan" means a plan of program operation and administration that describes the manner in which the State Agency intends to implement and operate all aspects of program administration within its jurisdiction in accordance with 7 CFR 246.4.

AA. "State WIC Office" means the Division of the Department which administers the WIC program.

BB. "Suspension" means temporary disqualification from the WIC program.

CC. "Unlawful Dealing in WIC Checks" means buying, selling, trading, bartering or possessing WIC checks with the intent to obtain an economic benefit not allowed under these regulations. Unlawful dealing in WIC checks is a criminal offense punishable under state and federal law.

DD. "USDA" means the United States Department of Agriculture.

EE. "Vendor" means a full service retail grocery store or pharmacy in a fixed and permanent location authorized by the WIC office by signed agreement to sell authorized foods and/or infant formulas to WIC participants.

FF. "Vendor Manual" is a publication developed by the State WIC Office for the guidance of vendors as a supplement to these regulations. This manual describes the WIC program, program policies and requirements, and explains vendor obligations and sanctions. Copies of the Vendor Manual may be obtained from the State WIC Office, Department of Health, Public Health Division, Family Health Bureau – WIC, 525 Camino de los Marquez, Suite 6, Santa Fe, NM 87501.

GG. "Vendor Number" is the unique WIC identification number used to validate food instruments which is issued to a vendor when authorized to redeem New Mexico WIC Food Instruments.

HH. "Vendor Stamp" means the rubber stamp with the vendor's name, store number, if any, and authorized vendor number on it, which is provided to vendors by the State WIC Office, and is required to be used for validating food instruments.

II. **"WIC"** means the Special Supplemental Nutrition Program for Women, Infants and Children authorized by Section 17 of the Child Nutrition Act of 1966, as amended, 42 USC Section 1786 (1966).

JJ. **"WIC Policy Manual"** is a publication developed by the State WIC Office for internal use, and approved by the Department of Health and USDA. This manual details the policies and procedures necessary to operate the State WIC program.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.7 NMAC – Rn, 7 NMAC 31.2.7, A, 5-31-2000]

7.31.2.8 SEVERABILITY:

If any part or application of these regulations is held invalid, the remainder, or its application to other situations or vendors shall not be affected.

[8-30-89, 10-31-96; 7.31.2.8 NMAC - Rn, 7 NMAC 31.2.8, 5-31-2000]

7.31.2.9 STANDARD OF COMPLIANCE:

The degree of compliance required by these regulations is designated by the use of the words "shall" and "may". "Shall" designates mandatory requirements. "May" designates permissive requirements.

[8-30-89, 10-31-96; 7.31.2.9 NMAC - Rn, 7 NMAC 31.2.9, 5-31-2000]

7.31.2.10 VENDOR AUTHORIZATION REQUIRED:

Only full service retail grocery stores and pharmacies that are authorized as vendors by the State WIC Office may accept WIC food instruments and redeem them through the State WIC Office for foods provided to participants. Food instruments accepted by unauthorized grocery stores, pharmacies, or others will not be redeemed.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.10 NMAC - Rn, 7 NMAC 31.2.10, 5-31-2000]

7.31.2.11 VENDOR SELECTION:

In accordance with the State Plan and federal regulations, the State WIC Office shall authorize only a sufficient number and distribution of full service retail grocery and pharmacy vendors in fixed and permanent locations to assure reasonable participant convenience and access, and to permit effective management of the program. Details of the specific selection criteria will be furnished upon written request to the State WIC Office.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.11NMAC - Rn, 7 NMAC 31.2.11, 5-31-2000]

7.31.2.12 NONDISCRIMINATION:

The State WIC Office shall not discriminate against an applicant or vendor on the basis of race, color, national origin, age, sex, handicap or disability, or other impermissible basis as set forth in applicable state or federal law.

[8-30-89, 10-31-96; 7.31.2.12 NMAC - Rn, 7 NMAC 31.2.12, 5-31-2000]

7.31.2.13 CONDITIONS OF ELIGIBILITY:

To be authorized as a vendor, a full service retail grocery store or pharmacy shall, at a minimum, meet the following criteria at the time of application:

A. FAVORABLE HISTORY OF COMPLIANCE: If the vendor has had prior involvement with WIC or any other Food and Consumer Service Programs of the USDA, it must have demonstrated an acceptable history of compliance with these programs. A history of suspension, termination or noncompliance with these programs, or a history of doing business with these programs without authorization, may constitute grounds for denial of the application for a period of up to three years from the date of notice of denial;

B. The applicant must be authorized to participate in the USDA Food Stamp Program;

C. The applicant location must be open, operating and accepting cash sales;

D. The applicant must be a full service grocery or pharmacy and must meet minimum requirements for stocking a variety of WIC authorized foods and/or infant formulas;

E. The applicant must be in compliance with all applicable health, safety and sanitation codes;

F. All WIC authorized foods and/or infant formulas stocked by the applicant must be fresh, with no out-of-date foods or infant formulas available for sale to the public;

G. The applicant must charge a price for a standardized combination of foods and/or infant formulas which is less than or competitive with the average price charged for those foods or infant formulas by authorized vendors doing a similar dollar volume of business; and

H. The applicant must demonstrate a knowledge and understanding of WIC program requirements, and be found satisfactory to the State WIC Office following a pre-authorization site visit or other review.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.13 NMAC - Rn, 7 NMAC 31.2.13, A, 5-31-2000]

7.31.2.14 SPECIAL ELIGIBILITY REQUIREMENTS FOR PHARMACIES:

Pharmacies must comply with the terms of the Vendor Agreement and with all other applicable state and federal regulations in the same manner as other vendors. At the

request of a pharmacy, and in the discretion of the State WIC Office, the minimum stocking criteria as outlined in Section 7.31.2.13.D above, may be waived or modified. However, pharmacies must at all times be able to provide adequate quantities of special infant formula to meet participant needs.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.14 NMAC - Rn, 7 NMAC 31.2.14, 5-31-2000]

7.31.2.15 APPLICATION FOR AUTHORIZATION:

Any owner of a full service grocery store or pharmacy in a fixed and permanent location in New Mexico that is open fully operational may request a vendor application from the State WIC office through December 31 and return the completed application packet to the State WIC office no later than January 31**.** Reapplying vendors may apply for reauthorization as a vendor by submitting an application to the State WIC Office during the month of July on forms provided by the office. Information provided in applications shall be accurate and complete. Applicants shall promptly provide additional information relating to the conditions of eligibility upon request by the State WIC Office. The State WIC Office may deny an application if false or incomplete information is submitted. Applications rejected as incomplete may be resubmitted within 15 days of the vendor's receipt of denial of its application**.** Failure to resubmit within this period may result in denial of authorization.

A. MINIMUM REQUIREMENTS: An application shall include at a minimum the following information:

(1) Sole Proprietors: the name and address of each owner and of each applicant location.

(2) Partnerships: the names and addresses of all general partners; the addresses of the principal and each subsidiary place of business; and of the New Mexico agent for service of process if a foreign partnership.

(3) Corporations: the name of the corporation; the addresses of its principal and each subsidiary place of business; and of the New Mexico agent for service of process if a foreign corporation.

(4) The square footage of each applicant location.

(5) The annual gross receipts for applicant sales separated into food and non-food categories.

(6) The applicant's Federal Food Stamp Authorization Number.

(7) A description of the applicant's participation in Food and Consumer Service Programs of the USDA.

(8) A detailed description of each instance in which the applicant or its owners or managers have been suspended or disqualified from the WIC, Food Stamp, or other USDA Food and Consumer Service Programs.

(9) The applicant's state tax identification number.

(10) The applicant's federal tax identification number.

(11) An identification by types and non-sale prices of all authorized WIC foods and/or infant formulas on shelves or in the coolers in customer areas of each applicant location on the date of the application.

(12) All other information as requested on the application form, or by the State WIC Office upon request.

B. REVIEW OF APPLICATIONS:

(1) New applicants. The State WIC Office shall either approve or deny a completed application for initial authorization within 60 days of receipt or of the date the vendor opens to the public for business, whichever is later.

(2) Reapplying vendors. Applications for continued authorization shall be the same as those for new applicants, except that the State WIC Office may, in its discretion, waive the requirement of a site visit. The State WIC Office shall either approve or deny a completed application for continued authorization within 90 days of receipt.

(3) Approved applications. If the application for a new applicant is approved, a signed agreement, vendor stamp, sign and a New Mexico Non-Taxable Transaction Certificate shall be furnished to the vendor. If the application is approved for a reapplying vendor, a signed agreement is furnished to the vendor.

(4) Duration of Authorization. All authorizations shall expire on September 30 of the second calendar year of each two year agreement period regardless of when initial authorization was granted. A new application shall be submitted for each two year agreement period during the month of July of the second calendar year of the current two year agreement period.

(5) Resubmission of applications. If an application for authorization is denied, the applicant may resubmit its application following correction of the deficiency(ies) which resulted in the denial, except that an applicant who furnishes false or misleading information in an application shall not reapply until the next new vendor application period. The State WIC Office may deny resubmitted applications if requirements have not been met by the second site visit, or if the basis for the initial denial was unfavorable history with other USDA Food and Consumer Service Programs.

C. PREAUTHORIZATION SITE VISITS: All site visits may be announced or unannounced.

(1) New applicants. A site visit shall be required for all new applicants. The State WIC Office shall not be required to make more than two pre-authorization site visits per applicant per 12 month period.

(2) Reapplying vendors. A site visit may be made to verify the existing conditions at reapplying vendors. The State WIC Office shall not be required to make more than two pre-authorization site visits per applicant per 12 month period.

D. GROUNDS FOR DENIAL OF AUTHORIZATION: Grounds for selection are set forth in 7.31.2.11 NMAC. In addition, authorization may be denied for reasons including, but not limited to, the following, if at the time of the site visit or application:

(1) The applicant does not have WIC foods and/or infant formulas meeting the minimum stock and variety requirements on shelves or in coolers in the customer area;

(2) Prices are not marked on food or infant formula containers, or otherwise posted in the immediate area where the foods or infant formulas are kept in the customer area of the store;

(3) Prices are substantially different from those listed on the food price record or the special infant formula price record;

(4) The applicant is in violation of applicable federal, state or local health protection laws or ordinances; **(5) A**uthorized foods and/or infant formulas are older than the expiration date indicated on the package, or are otherwise not fresh;

(6) It is determined that the applicant provided false or misleading information on the application.

(7) The applicant has an unfavorable history with the Food Stamp Program or other USDA Food and Consumer Service Programs.

E. SUSPENSION OR TERMINATION OF AUTHORIZATION: As set forth more specifically in 7.31.2.20 NMAC, below, the State WIC Office may suspend or terminate a vendor's authorization at any time during the agreement period, and may deny renewal of authorization for failure to comply with program requirements.

[8-30-89, 10-31-96; 7.31.2.15 NMAC - Rn, 7 NMAC 31.2.15, A, 5-31-2000]

7.31.2.16 CHANGE OF OWNERSHIP:

A. EXISTING OWNERS: Authorization of a vendor location shall terminate automatically upon a change of ownership. Vendor location authorization is non-

assignable and non-transferrable. Vendors shall immediately report a change of ownership or of location to the State WIC Office. All food instruments accepted prior to the change shall be deposited in the vendor's bank immediately, and WIC business shall cease until an application has been submitted by the new owner and approved by the State WIC Office. The vendor shall return the vendor stamp to the State WIC Office immediately.

B. NEW OWNERS: A new owner shall have 30 days from the date of transfer of ownership in which to apply for authorization to continue an authorization held by a previous owner. New owners who fail to apply within 30 days may apply during the next new vendor application period.

[8-30-89, 10-31-96; 7.31.2.16 NMAC – Rn, 7 NMAC 31.2.15, 5-31-2000]

7.31.2.17 TRAINING:

The State WIC Office shall provide training designed to assist the vendor in preventing program errors or abuse, and to improve program services. The owner of each vendor location, or his designated agent shall participate in all training sessions designated as mandatory by the State WIC Office. Failure of an owner or his agent to appear without good cause for a mandatory training session shall be grounds for minor sanctions as deemed appropriate to the circumstances by the State WIC Office. It shall be the responsibility of the owner or his agent to ensure that all employees who process food instruments are trained in WIC procedures, and a claim of lack of training or knowledge of procedures shall not be a defense to adverse action by the State WIC office against a vendor.

[8-30-89, 10-31-96; 7.31.2.17 NMAC – Rn, 7 NMAC 31.2.17, 5-31-2000]

7.31.2.18 VENDOR RESPONSIBILITIES:

A. COMPLIANCE WITH FEDERAL, STATE AND LOCAL REQUIREMENTS: Vendors shall comply with all applicable federal, state and local laws, ordinances and regulations. Specifically, but without limitation, vendors shall comply with all WIC program requirements set forth herein, and as codified in the Code of Federal Regulations, which are incorporated herein by reference. In addition to sanctions set forth below, failure to comply with applicable WIC regulations may result in loss of federal food stamp program authorization.

B. FOOD INSTRUMENT REDEMPTION: Vendors shall:

(1) Provide to participants, in exchange for food instruments, only the foods and/or infant formulas specified on the authorized food and/or infant formula list, and in quantities less than or equal to those specified on the food instrument;

(2) Accept food instruments only for foods and/or infant formulas included in the agreement; and

(3) Comply with food instrument processing and redemption procedures as set forth by the State WIC Office.

C. VENDOR STAMPS:

(1) Liability for loss or misuse. Vendors are responsible for the vendor stamps with their unique identification number that are issued to them. Vendors shall keep the vendor stamp in a safe place, and shall promptly notify the State WIC Office of a lost, stolen, or damaged vendor stamp. Failure to promptly notify the State WIC Office of such loss may result in the vendor being held liable for reimbursement of illegally negotiated food instruments**.** A vendor shall pay the cost plus certified mailing fees for any additional vendor stamps.

(2) Duplication. A vendor shall not duplicate a vendor stamp.

(3) Authorized uses. The vendor stamp shall be used only to validate those food instruments accepted at the vendor location for actual purchases of authorized foods. Use of a vendor stamp for any other purpose is strictly prohibited.

(4) Return. Vendors shall return issued vendor stamps to the State WIC Office immediately upon a change in ownership, upon going out of business, upon bankruptcy, upon suspension or termination of authorization, or upon demand by the State WIC Office.

D. STOCK: Vendors shall at all times maintain fresh WIC authorized foods and/or infant formulas meeting the minimum stock and variety requirements on the shelves or in coolers in the customer area of the store.

E. PRICES: Vendors shall:

(1) Charge participants prices that are equal to or lower than prices charged to other customers;

(2) Charge participants no sales tax;

(3) Promptly provide price lists to the State WIC Office upon request;

(4) Maintain competitive prices consistent with prices charged by other vendors doing a comparable dollar volume of business;

(5) Display the prices of authorized foods and/or infant formulas on the foods or formulas, or on the shelves or coolers in proximity to the foods or infant formulas, or in the immediate area where the foods or infant formulas are kept in the customer area of the store;

(6) Enter the actual price of the food and/or infant formula purchased on the food instrument at the time of purchase, and provide the WIC participant with an itemized receipt; and

(7) Enter the actual redemption date on the food instrument at the time of purchase.

F. INFORMATION REQUIRED TO BE ON DISPLAY OR IN FILE: Vendors shall:

(1) Maintain on file at each vendor location at all times a copy of the Vendor Manual, the approved Food Vendor Agreement, the Non-Taxable Certificate, newsletters and other updates and instructions received from the State WIC Office;

(2) Display a sign, sticker or other conspicuous notice of authorization as a State WIC vendor visible to participants in the customer area of the store, and;

(3) Ensure that current State WIC Office authorized food lists are readily accessible to cashiers.

G. EQUAL ACCESS/NONDISCRIMINATION: Vendors shall make available to WIC participants the same services offered to all other customers; shall extend the same courtesies to WIC participants as to all other customers; and shall otherwise accord participants the same treatment as all other customers.

H. ACTS OF EMPLOYEES: Vendors have an affirmative duty to train employees in WIC procedures. Vendors are responsible for the acts or omissions of their employees in transacting WIC-related business.

I. DUTY TO REPORT: Vendors shall promptly notify the State WIC Office of suspected instances in which a participant has failed to comply with WIC program requirements, or engaged in fraud or abuse of the program.

[8-30-89, 10-31-96; 7.31.2.18 NMAC – Rn, 7 NMAC 31.2.18, A, 5-31-2000]

7.31.2.19 MONITORING VISITS:

The State WIC Office may conduct one or more on-site monitoring visits during an agreement period in order to verify vendor compliance with program requirements. Such visits may be unannounced, and may occur at any time during vendor business hours. Independently or in conjunction with such on-site visits, the State WIC Office may also audit a vendor's records to verify compliance with program requirements. Upon request, a vendor shall produce copies of any and all documents necessary to this audit within 30 days. The State WIC Office may implement any other monitoring procedure to verify vendor compliance with program requirements as is deemed appropriate under the circumstances. The vendor shall comply and cooperate with all such monitoring procedures. [8-30-89, 10-31-96; 7.31.2.19 NMAC – Rn, 7 NMAC 31.2.19, 5-31-2000]

7.31.2.20 VENDOR SANCTIONS:

A. GENERALLY: The State WIC Office may impose sanctions upon a vendor for non-compliance with the program. Sanctions may include immediate disqualification from the program, or such other lesser penalties, in addition to or in lieu of disqualification, as the State WIC Office deems appropriate to the nature and severity of the violation(s). In addition to sanctions which may be imposed by the state WIC office, a vendor who commits fraud or abuse of the system, or who deals unlawfully in WIC food instruments, or who aids and abets another in so doing, is liable to prosecution and fines under state and federal law.

B. PENALTIES & OFFENSES:

(1) Disqualification. Grounds for outright disqualification of a vendor from the program include, but are not limited to, the following:

(a) Redeeming WIC food instruments while the vendor is suspended or disqualified.

(b) Charging WIC customers tax on WIC purchases.

(c) Failing to enter the actual purchase price of authorized foods and/or infant formulas purchased on WIC food instruments at the time of redemption.

(d) Redeeming WIC food instruments for fixed amounts that do not reflect actual authorized food package costs.

(e) Redeeming WIC food instruments for dollar amounts greater than actual authorized food package costs.

(f) Causing or permitting unfair or discriminatory treatment of WIC participants, or otherwise violating the civil rights of WIC participants.

(g) Price fixing of WIC authorized foods and/or infant formulas.

(h) Altering WIC food instruments for fraudulent or unlawful purposes.

(i) Providing valuable consideration other than WIC authorized foods or formulas, in exchange for WIC food instruments, or negotiating WIC food instruments for cash, credit or non-food items.

(j) Submitting falsified WIC food price information to the State WIC Office.

(k) Aiding or abetting WIC participants in fraud or abuse of the program, or in the unlawful dealing in WIC food instruments.

(l) Negotiating stolen or counterfeit food instruments.

(m) Providing materially false or misleading information in an application.

(n) Failing to submit timely applications or re-applications.

(o) Otherwise committing fraud or abuse of the WIC program.

(p) Criminal conviction of fraud or abuse related to the WIC program or the Food Stamp Program.

(q) If the Food Stamp Program disqualifies a vendor, WIC shall disqualify the vendor for the same length of time as the Food Stamp Program disqualification. (Disqualification from the WIC program may also result in a vendor being disqualified from the Food Stamp Program).

(r) If the Food Stamp Program assesses a civil monetary penalty (CMP) to a vendor in lieu of disqualification, WIC may disqualify for the length of time the vendor would otherwise have been disqualified in the Food Stamp Program.

(s) Criminal conviction for trafficking in food instruments or selling firearms, ammunition, explosives, or controlled substances in exchange for food instruments.

(t) One incidence of buying or selling food instruments for cash (trafficking); or one incidence of selling firearms, ammunition, explosives, or controlled substances in exchange for food instruments.

(u) One incidence of the sale of alcohol or alcoholic beverages or tobacco products in exchange for food instruments.

(v) A pattern of claiming reimbursement for the sale of an amount of a specific supplemental food item which exceeds the stores documented inventory of that supplemental food item for a specific period of time.

(w) A pattern of charging participants more for supplemental food than non-WIC customers or charging participants more than the current shelf or contract price.

(x) A pattern of receiving, transacting and/or redeeming food instruments outside of authorized channels, including the use of an unauthorized vendor and/or unauthorized person.

(y) A pattern of charging for supplemental food not received by the participant.

(z) A pattern of providing credit or non-food items, other than alcohol, alcoholic beverages, tobacco products, cash, firearms, ammunition, explosives or controlled substances in exchange for food instruments.

(aa) A pattern of providing unauthorized food items in exchange for food instruments, including charging for supplemental foods provided in excess of those listed on the food instrument.

(2) Denial of redemption of WIC food instruments. Grounds for denial of redemptions of a vendor include, but are not limited to, the following:

(a) Repeated failure to use the WIC vendor stamp on WIC food instruments before bank deposit.

(b) Accepting WIC food instruments with non-matching participant signatures.

(c) Failing to obtain participant counter signatures on WIC food instruments at the time of redemption.

(d) Accepting pre-signed WIC food instruments.

(e) Accepting altered WIC food instruments.

(f) Accepting WIC food instruments before valid issue date.

(g) Accepting WIC food instruments after the 30 day time limit for redemption.

(h) Depositing WIC food instruments after the 90 day time limit for deposit.

(i) Forwarding food instruments to the State WIC Office for replacement after their expiration date.

(j) Failing to promptly notify the State WIC Office of a missing vendor stamp if such loss results in the submission of unauthorized food instruments for redemption.

(k) Food instruments forwarded by anyone other than an authorized vendor for an authorized vendor location to the State WIC Office for redemption.

(3) Vendor Suspension. Grounds for vendor suspension from the program include, but are not limited to, the following:

(a) Providing outdated authorized foods and/or infant formulas to WIC customers.

(b) Failing to maintain the minimum stock and variety requirements of authorized foods and/or infant formulas.

(c) Failing to submit or failing to timely submit vendor and food or infant formula price information as required or requested by the State WIC Office.

(d) Failing to furnish WIC participants with itemized receipts at the time of purchase.

(e) Requiring WIC participants to countersign WIC food instruments prior to entering the dollar purchase amount on the food instruments.

(f) Providing a "raincheck," or otherwise allowing a WIC participant to make more than one transaction with a single food instrument.

(g) Redeeming WIC food instruments for greater quantities of authorized foods and/or infant formulas than those specified on the food instruments.

(h) Accepting or soliciting payment from WIC participants for dollar amounts that exceed actual authorized costs of foods and/or infant formulas.

(i) Accepting or soliciting payment from WIC participants for dollar amounts that exceed the maximum redemption value specified on the food instruments.

(j) Soliciting payment from WIC participants for food instruments which the State WIC Office has refused to redeem or has otherwise dishonored.

(k) Failing to enter the redemption date on WIC food instruments.

(l) Entering an incorrect redemption date on WIC food instruments.

(m) Duplicating a vendor stamp.

(n) Providing false or misleading information in an application.

(o) Failing to display prices on shelves, coolers or foods and formulas.

(p) Engaging in participant discrimination.

(q) Failing to report participant fraud or abuse of the WIC program.

(r) Failing to maintain competitive prices.

(s) Failing to maintain required information in files or on display.

(t) Failing to appear for mandatory training without good cause.

(u) Violation of health, safety or sanitation codes.

(v) Failing to produce requested records in a timely manner.

(4) Miscellaneous provisions.

(a) Program fraud or abuse/unlawful dealing in WIC food instruments. The State WIC Office may share findings of its investigation and monitoring activities with law enforcement, Food Stamp program authorities, or other WIC authorities, if it suspects fraud or abuse of the WIC Program, unlawful dealing in WIC food instruments, or if Food Stamp Program violations have occurred; and will cooperate fully with such authorities in their investigation.

(b) Combination of offenses. Nothing in these regulations shall preclude the State WIC Office from charging a vendor with multiple offenses, or from simultaneously imposing sanctions for offenses in different categories, subject to the limitations imposed by sub-section A of 7.31.2.21 NMAC and sub-section B of 7.31.2.22 NMAC below.

(c) Repeated violations. The State WIC Office may impose sanctions up to and including vendor disqualification for violations which would not of themselves constitute grounds for disqualification, but which recur after opportunity to cure and warnings have been provided to the vendor. The State WIC Office may also impose lesser sanctions, such as suspension from the program, denial or redemption of food instruments, or denial of replacement of food instruments for repeated instances of vendor non-compliance with program requirements.

(d) Civil penalties. The State WIC Office may demand reimbursement from a vendor for offenses which result in overcharges to the program, and may otherwise avail itself of all civil remedies available under New Mexico and federal law.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.20 NMAC – Rn, 7 NMAC 31.2.20, A, 5-31-2000]

7.31.2.21 DURATION OF SANCTIONS:

A. DISQUALIFICATION: A vendor may be disqualified from the program for state agency violations for a period of time not to exceed one year per investigation**,** or for such shorter periods of time as are deemed reasonable and appropriate by the State WIC Office to the nature and severity of the offense. The exception to this are the time periods for the federally mandated sanctions which shall control for federal violations:

(1) A vendor shall be permanently disqualified for violation of sub-paragraph (s) of paragraph (1) of sub-section B of 7.31.2.20 NMAC.

(2) A vendor shall be disqualified for 6 years for violation of sub-paragraph (t) of paragraph (1) of sub-section B of 7.31.2.20 NMAC.

(3) A vendor shall be disqualified for 3 years for any of the violations listed in sub-paragraphs (u) through (z) of paragraph (1) of sub-section B of 7.31.2.20 NMAC.

(4) A vendor shall be disqualified for one year for violation of sub-paragraph (aa) of paragraph (1) of sub-section B of 7.31.2.20 NMAC.

(5) For any of the violations listed in sub-paragraphs (t) through (aa) of paragraph (1) of sub-section B of 7.31.2.20 NMAC, a vendor shall receive double the sanction for a second occurrence of any violation listed, except that a Civil Monetary Penalty (CMP) may only be doubled up to the amounts allowed in sub-section B of 7.31.2.22 NMAC.

(6) For any of the violations listed in sub-paragraph (t) through (aa) of paragraph (1) of sub-section B of 7.31.2.20 NMAC, a vendor shall receive double the sanction for a third or subsequent occurrence of any violation, except that a Civil Monetary Penalty (CMP) shall not be imposed in lieu of disqualification.

(7) For multiple violations investigated as part of a single investigation, the State WIC Office shall disqualify the vendor for the period corresponding to the most serious federal violation. All violations shall be included in the notice of federally mandated administrative action. If a sanction is not upheld on appeal, then the State WIC Office may impose a state agency established sanction.

B. SUSPENSION OF VENDORS: A vendor may be suspended from the program for a period of time not to exceed one year, or for such shorter periods of time as are deemed reasonable and appropriate by the State WIC Office to the nature and severity of the offense.

C. VOLUNTARY WITHDRAWAL: The state shall not accept voluntary withdrawal or non-renewal of the vendor agreement as an alternative to disqualification for violations listed in sub-paragraph (s) through (aa) of paragraph (1) of sub-section B of 7.31.2.20 NMAC.

D. DENIAL OF REPLACEMENT OF FOOD INSTRUMENTS: The State WIC Office may deny replacement of a vendor's submitted food instruments for a period of time not to exceed six months, or for such shorter periods of time as are deemed reasonable and appropriate by the State WIC Office to the nature and severity of the offense.

E. DENIAL OF REDEMPTIONS: Food instruments denied for redemption shall be permanently voided and shall not be paid or replaced at any time.

[8-30-89, 10-31-96, 10-31-96; 7.31.2.21 NMAC – Rn, 7 NMAC 31.2.21, A, 5-31-2000]

7.31.2.22 DISPUTE RESOLUTION/WAIVER OF SANCTIONS:

A. ALTERNATIVE DISPUTE RESOLUTION: If it finds that a vendor has committed an offense warranting sanctions, the State WIC Office may elect to issue a warning letter to the vendor, specifying a time frame and requirements for cure of the deficiency(ies). Timely compliance shall operate to purge the vendor of the offense. Exercise of this option by the State WIC Office shall not constitute a waiver of the Office's right to sanction the vendor for the same or similar offenses in the future, nor of the right to sanction other vendors for any offense(s) at any time.

B. CIVIL MONETARY PENALTY IN LIEU OF DISQUALIFICATION: The State WIC Office may elect to offer a vendor the option of payment of monetary penalties not to exceed $10,000 per violation up to a maximum of $40,000 for violations investigated as part of a single investigation, or such lesser amounts as may be deemed reasonable and appropriate considering the nature and severity of the offense(s), in lieu of outright disqualification from the program.

(1) For any of the violations listed in sub-paragraphs (q) and (s) through (aa) of paragraph (1) of sub-section B of 7.31.2.20 NMAC, the State shall impose a Civil Monetary Penalty (CMP) in lieu of WIC disqualification if such disqualification of the vendor would result in inadequate participant access; or, with respect to violations listed in sub-paragraph (s) of paragraph (1) of sub-section B of 7.31.2.20 NMAC, if the vendor had, at the time of the violation, an effective program and policy in effect to prevent trafficking, and if the ownership of the vendor was not aware of, did not approve of, and was not involved in the conduct of the violation.

(2) The CMP shall be calculated by using the following formula:

(a) Determine the vendor’s average monthly redemptions for at least the 6-month period ending with the month immediately preceding the month during which the notice of administrative action is dated;

(b) Multiply the average monthly redemptions figure by ten percent (.10);

(c) Multiply the product from sub-paragraph (b) of paragraph (2) of sub-section B of 7.31.2.22 NMAC by the number of months for which the store would have been disqualified. This is the amount of the CMP, provided that the CMP shall not exceed $10,000 for each violation. For a violation that warrants disqualification, the amount of the CMP shall be $10,000.

(3) Exercise of this option by the State WIC Office shall not constitute a waiver of the Office's right to disqualify the vendor for the same or similar offenses in the future, nor of the right to disqualify other vendors for any offense(s) at any time.

C. WAIVER OF SANCTIONS: For good cause or exigent circumstances, the State WIC Office may waive imposition of sanctions for offenses. Such waiver shall not constitute a waiver of the Office's right to impose sanctions for the same violation on the same vendor at a future time, nor to waive the Office's right to impose sanctions on other vendors for the same offense at any time.

[8-3-89, 10-31-96; 7.31.2.22 NMAC – Rn, 7 NMAC 31.2.22, A, 5-31-2000]

7.31.2.23 HEARING PROCESS AND PROCEDURES:

A. RIGHT TO HEARING – SCOPE: Vendors may appeal decisions of the State WIC Office which adversely affect their participation in the program, including but not limited to the following actions:

(1) Denial of a vendor's application to participate in the program;

(2) Suspension of a vendor's authorization to participate in the program;

(3) Termination of a vendor's authorization to participate in the program;

(4) Denial of redemption of food instruments submitted to the State WIC Office.

(5) The following determinations are not subject to review: Disqualification of a vendor as result of disqualification from the Food Stamp Program, expiration of a contract or agreement with a vendor, and the State Agency's determination regarding participant access.

B. NOTICE OF PROPOSED SANCTIONS: Vendors shall be informed in writing of any action adversely affecting their participation in the WIC program. Notice shall be to all parties whose names and addresses are on file by certified mail or personal service. The notice shall:

(1) Describe the offense(s) and the proposed sanction(s);

(2) Inform the vendor of the effective date of proposed sanction(s) and their duration; and

(3) Inform the vendor of the right to request an evidentiary hearing.

C. REQUEST FOR HEARING: Hearing requests must be made in writing and mailed to the New Mexico Department of Health, Public Health Division, Family Health Bureau - WIC, 525 Camino de los Marquez, Suite 6, Santa Fe, New Mexico 87501, and received by the State WIC Office within 30 days after the vendor's receipt of the notice of proposed sanctions. Untimely requests may be grounds for dismissal. A request for hearing shall not operate to stay the imposition of proposed sanctions against a vendor. The State WIC Office may, within its discretion, implement proposed sanctions at any time after fifteen (15) days from the date of service of a notice of proposed sanctions upon a vendor.

D. PRE-HEARING PROCEDURE:

(1) Impartial Hearing Officer: Upon receipt of a timely request for hearing, the Secretary of the Department, or his designee, shall appoint an impartial Hearing Officer to preside over the case. The Hearing Officer shall not have been involved in the action in question, or in any way be affiliated with the State WIC Office. The Hearing Officer should be familiar with the WIC program and procedures, and with evidentiary rules and adjudicatory proceedings. The Hearing Officer need not be an attorney.

(2) Scheduling of Hearings: The Hearing Officer shall schedule a hearing on the matter to be held in Santa Fe, and shall provide all parties with written, advance notice of the date, time and place of the hearing, a minimum of seven (7) calendar days prior to the hearing, unless otherwise agreed to. The notice shall identify the proposed Hearing Officer. A hearing date shall be scheduled no later than thirty (30) days after receipt of a timely request for hearing by the State WIC Office.

(3) Rescheduling: Either party may, without cause, request that the initial hearing be rescheduled. Subsequent requests to reschedule shall be granted only for good cause or exigent circumstances, upon motion by a party or upon the Hearing Officer's own motion. Upon timely motion, and upon a showing of undue hardship and burden, the Hearing Officer may order the hearing changed to another in-state location. Notice of rescheduling shall be furnished to both parties reasonably in advance of the previously scheduled date.

(4) Discovery:

(a) Initial discovery – Documents: Upon request, vendors shall have the right to review their case record in advance of the hearing, and shall be furnished copies of requested documents contained therein at cost.

(b) Initial discovery –Witnesses: Each party shall disclose to the other orally or in writing the names of prospective witnesses and the general subject matter of their anticipated testimony, not less than three (3) days before the hearing. Affidavits may be presented instead of live testimony, upon a showing that the witness is not available in the state, or that compelling the witness to appear at the hearing would present undue hardship. Such affidavits, to be admissible at the hearing, must be submitted to the opposing party and the Hearing Officer no less than seven (7) days prior to the hearing.

(c) Additional discovery in complex cases: Upon written request of a party setting forth reasons why additional discovery may be necessary or desirable, and at the Hearing Officer's discretion, further discovery in the form of document production or informal witness interviews may be permitted. Formal depositions are not allowed. Factors to be weighed in the Hearing Officer's decision concerning whether additional discovery is merited include whether the complexity of fact or law surrounding a particular case requires further discovery to reasonably assure a full and fair hearing, the timeliness of the request, and whether such requests granted would unreasonably delay the hearing, or the rendering of a final decision. If additional discovery is allowed, the Hearing Officer may reschedule the hearing in accordance with paragraph (3) of sub-section D of 7.31.2.23 NMAC above. Rescheduling for discovery purposes tolls the time period for the Hearing Officer's rendering of a final decision in the matter, as set forth in sub-section F of 7.31.2.23 NMAC below.

(5) Motions and pre-hearing conferences: Either party may file motions at least ten (10) days in advance of the hearing which are intended to narrow or dispose of anticipated issues. The Hearing Officer may rule on such motions as a preliminary matter

at the hearing itself, or may set a pre-hearing conference, if it would serve to narrow or dispose of issues in advance of the hearing. Copies of all motions shall be mailed to the opposing party at or before the time of mailing to the Hearing Officer.

E. HEARING PROCEDURE:

(1) Right to counsel: Vendors may represent themselves at the hearing, or may be represented by legal counsel or other designated representative, provided such representative has made a written entry of appearance prior to the hearing.

(2) Hearing Officer powers and duties: The Hearing Officer shall have the power to issue subpoenas and compel the appearance of witnesses, shall administer oaths to witnesses, take testimony, rule on the admissibility of evidence, schedule pre-hearing conferences if helpful to narrow issues, rule on motions, schedule hearings, and otherwise assure full development of the issues. The Hearing Officer may consolidate hearings of different parties if they involve common questions of law and fact. Before rendering a final decision, the Hearing Officer shall not communicate with any party concerning the subject matter of the hearing outside of the presence of the opposing party. The Hearing Officer is responsible for recording the proceedings. A Hearing Officer may not be disqualified except by agreement of both parties, or upon the Hearing Officer's own motion.

(3) Conduct of the Hearing: Hearings shall be conducted in an orderly manner such that both parties shall have the opportunity to present witnesses, to establish all facts pertinent to the case or defense, to introduce exhibits and documentary evidence through qualified witnesses, to advance arguments without undue interference, to confront, impeach, and cross-examine witnesses, and to refute adverse testimony or evidence.

(4) Procedure and evidence: The technical rules of evidence and civil procedure shall not apply in these hearings. Where such rules would be helpful to an understanding or resolution of a point or issue, non-binding reference to the Federal Rules of Evidence and the Federal Rules of Civil Procedure may be permitted. The Hearing Officer may admit all relevant evidence including hearsay, if it is of such a nature that ordinary, reasonable and prudent persons would rely on the information in the conduct of serious business affairs. The Hearing Officer may consider the hearsay nature of testimony in assessing the weight it should be accorded.

(5) Mechanics and burden of proof: The State WIC Office shall have the burden of proving by a preponderance of the evidence one or more of the allegations cited in the notice of proposed sanctions. The State WIC Office may make an opening statement and shall present its evidence first. Either party may invoke the rule. Both parties may make objections or raise defenses generally recognized under law in civil cases. The State WIC Office is entitled to a representative's presence in the hearing room throughout the proceeding, even if that representative will testify in the hearing. The vendor may make an opening statement either before or after the State WIC Office's evidence is presented, and shall present its evidence after the State WIC Office rests its case. Oral evidence shall be

taken only upon oath or affirmation. In the discretion of the Hearing Officer, closing arguments may be made orally after the vendor's presentation of the case, or in writing within a time specified by the Hearing Officer. Hearings shall be recorded by a sound recording device.

(6) Failure to appear: Failure of a party to appear at the hearing without good cause shall constitute a default, and the Hearing Officer shall so inform both parties.

(7) Open hearings: Hearings are open to the public unless all parties agree otherwise.

F. HEARING OFFICER'S DECISION: The Hearing Officer shall, as soon as practicable after the conclusion of the hearing and submission of closing arguments, render a written decision in the matter, state the basis for the decision, and specify the effective date of the decision. The Hearing Officer's decision shall be based exclusively on evidence and testimony introduced at the hearing. The decision need not contain findings of fact or conclusions of law. The Hearing Officer's decision shall be final. The Hearing Officer shall, within 60 days of the date of the State WIC Office's receipt of a request for hearing from a vendor, issue written notification of the decision in the matter. If the hearing in the matter is continued for any reason from its originally scheduled setting, this time period is tolled for the period of the continuance.

G. JUDICIAL REVIEW: Any party may appeal the Hearing Officer's final decision pursuant to the provisions of Section 39-3-1.1 NMSA 1978. Filing for judicial review does not stay or dissolve enforcement of the final decision. The reviewing court shall set aside the final order only if it is found to be:

(1) Arbitrary, capricious, or an abuse of discretion;

(2) Not supported by substantial evidence in the record;

(3) In excess of the authority of the State WIC Office; or

(4) Otherwise not in accordance with law.

[8-30-89, 10-31-96; 7.31.2.23 NMAC – Rn, 7 NMAC 31.2.23, A, 5-31-2000]

7.31.2.24 OTHER REGULATIONS:

These regulations are subject to the provisions of the New Mexico Department of Health's Regulations for Regulation Promulgation (H.E.D. 78-5-1 (1978) or its most current version, and laws governing inspection of public records (N. M. Stat. Ann. 1978, 14-2-1 et. seq. (Rep. Pamp. 1988). Copies of these regulations may be obtained by writing to the New Mexico Department of Health, Public Health Division, Family Health Bureau – WIC, 525 Camino de los Marquez, Suite 6, Santa Fe, NM 87501.

[8-30-89,10-31-96, 10-31-96; 7.31.2.24 NMAC – Rn, 7 NMAC 31.2.24, A, 5-31-2000]

CHAPTER 32: ALCOHOL AND DRUG ABUSE

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: ADMISSION CRITERIA FOR ALCOHOL AND SUBSTANCE ABUSE SERVICES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.321.8 NMAC.]

PART 3: [RESERVED]

PART 4: [RESERVED]

PART 5: PROCUREMENT OF PROFESSIONAL SERVICES FOR ALCOHOL AND SUBSTANCE ABUSE SERVICES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.321.9 NMAC.]

PART 6: COUNTY DWI PLAN GUIDELINES

7.32.6.1 ISSUING AGENCY:

Department of Health, Behavioral Health Services/Division of Substance Abuse.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.2 SCOPE:

All New Mexico counties.

[1/1/97; Recompiled 10/31/01]

7.32.6.3 STATUTORY AUTHORITY:

The Community Alcoholism and Alcohol Abuse Prevention, Screening and Treatment Act, Section 43-3-11A(2) NMSA 1978 (as amended by Laws 1993, Chapter 65), which requires the department to adopt rules to provide for "the format and guidelines for county DWI plans and the criteria for evaluating them."

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.4 DURATION:

Permanent.

[1/1/97; Recompiled 10/31/01]

7.32.6.5 EFFECTIVE DATE:

January 1, 1997, unless a later date is cited at the end of a Section or Paragraph.

[1/1/97; Recompiled 10/31/01]

[Compiler's note: The words *or paragraph*, above, are no longer applicable. Later dates are now cited only at the end of sections, in the history notes appearing in brackets.]

7.32.6.6 OBJECTIVE:

To establish the format and guidelines for county DWI plans and the criteria for evaluating them.

[1/1/97; Recompiled 10/31/01]

7.32.6.7 DEFINITIONS:

A. "Alternative sentencing program" means a program that provides the courts with a sentence alternative to incarceration while providing access to intervention services in an environment which is consistent with the "least restrictive" principle (e.g. non-residential intensive supervision) for the DWI offender.

B. "Board" means the board of county commissioners of a county.

C. "Continuum of care" means linkage of services including prevention, crisis intervention, intervention, treatment and aftercare.

D. "Department" means the New Mexico department of health.

E. "DFA" means the New Mexico department of finance and administration.

F. "DWI" means driving while intoxicated/impaired whether because of alcohol or other drug use.

G. "DWI program" means a community program specifically designed to provide treatment and/or prevention regarding driving while under the influence of alcohol or drugs.

H. "Planning council" means a county DWI planning council that represents a broad spectrum of interests.

I. "Prevention program" means any program which has as its objective the amelioration of conditions known to motivate excessive or abusive use of alcohol and other drugs or to increase the ability of the individual to resist pressures from other people to use or abuse alcohol and other drugs, through such techniques as effective education, values clarification, saying no to peer pressure, recreational alternatives to substance abuse, and wilderness experience.

J. "Screening program" means a program that provides screening or examination by alcoholism treatment professionals of persons charged with or convicted of driving while intoxicated or of other offenses to determine whether the individual is:

(1) physically dependent on alcohol and thus suffering from the disease of alcoholism;

(2) an alcohol abuser who has not developed the alcoholism disease syndrome but has an entrenched pattern of pathological use of alcohol and social or occupational impairment in function from alcohol abuse;

(3) neither an alcoholic nor an alcohol abuser whereby alcoholism treatment is not necessary; and

(4) that provides referral or recommendation of such persons to the most appropriate treatment.

K. "Statewide substance abuse prevention and treatment services plan" means the comprehensive plan for a statewide services network developed by the department that documents the extent of New Mexico's alcoholism, and alcohol and drug abuse problems. The plan also documents statewide needs for prevention, screening, detoxification, short-term and long-term rehabilitation, outpatient programs and DWI programs. The plan shall be based on the continuum of care concept of a comprehensive substance abuse prevention and treatment system.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.8 INTRODUCTION:

The 1993 New Mexico legislature enacted Laws 1993, Chapter 65 (SB 341, etc., as amended) to address DWI issues in the state. The law increases the rate of the liquor excise tax to provide for state and local programs for the prevention, screening, assessment, treatment and other alternative sentencing services relating to DWI. A portion of the law creates the local DWI grant program, providing for county and municipal funding. Counties must establish a planning council which must adopt a county DWI plan; municipal activities can be submitted only as part of the official county DWI plan. With the advice of the planning council, the board or its designee shall prepare the county DWI plan. Upon approval of the county DWI plan by the board and the planning council, the board shall submit the county DWI plan to the department for

approval and integration into the statewide substance abuse prevention and treatment services plan.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.9 DWI GRANTS:

The purpose of all available DWI grants to local communities is to fund new, innovative or model programs, services or activities of any kind designed to prevent or reduce the incidence of DWI, whether related to alcoholism and alcohol or other drug abuse, as described below.

A. Prevention is an active process for developing conditions and personal attributes that promote the well-being of people. Prevention activities are designed to promote the personal, holistic and social growth of individuals to support those aspects of the community and culture which promote positive behaviors and healthy lifestyles. Prevention programs focus on providing information, education and alternatives in an effort to reduce the inclination toward DWI behavior. Community participation is critical to promote a healthy safe environment and must involve individuals, family and community groups.

B. New or pilot screening and assessment services shall be designed to become self-sustaining. Screening programs shall be established in collaboration with the district, magistrate, metropolitan and municipal courts to be served by the screening program. Where feasible, screening programs shall not be operated by alcoholism treatment programs serving judicial districts in order to avoid conflicts of interest when recommending offenders for treatment.

C. DWI treatment programs shall be specifically designed to reduce the incidence of DWI and to successfully reduce repeat DWI offenses.

D. DWI alternative sentencing programs shall be specifically designed to reduce the incidence of DWI, and successful in reducing repeat DWI offenses.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.10 ELIGIBILITY FOR COUNTY DWI PLANS:

A. County DWI plans shall be accepted only from counties that have established a planning council which has adopted a county DWI plan; municipal activities shall be submitted only as part of the official county DWI plan.

B. Multi-county DWI plans may be submitted.

C. County DWI plans shall be signed by the chairperson of the board, the chair of the planning council and by the authorizing agent for each municipality, if any,

participating in the plan. Each entity shall sign the official county DWI plan certification form in the application packet.

D. All counties participating in a multi-county DWI plan must submit letters of agreement confirming their role in a multi-county DWI service system. Letters of agreement shall be signed by the chairperson of the board in all counties participating in a multi-county plan.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.11 SUBMISSION REQUIREMENTS FOR COUNTY DWI PLANS:

Counties shall adhere to the following submission requirements in order to be eligible for consideration for funding during the fiscal year July 1, 1993 through June 30, 1994 by the local government division of DFA. The county DWI plan period for subsequent years shall run from July 1 through the following June 30, unless otherwise determined by the department.

A. The county DWI plans shall be received by the department by the close of business on October 15, 1993 for the first year of the plan. The submission date for subsequent years will be August 31 unless otherwise specified by the department.

B. Counties shall submit one original and ten copies of their county DWI plan to: New Mexico Department of Health, Division of Substance Abuse, Room N-3300 Harold Runnels Building, P.O. Box 26110, 1190 St. Francis Drive, Santa Fe, New Mexico 87502-6110.

C. Each county DWI plan shall be received by the above date and time or it will not be considered for review.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.12 PLANNING COUNCIL COMPOSITION AND PURPOSE:

A. A board may create and, if created, appoint the members of a planning council. The members of the planning council shall be selected to represent a broad spectrum of interests and may include, but not be limited to, one representative from each of the following: county government, incorporated municipal government and, where applicable, tribal government, DWI prevention, screening and treatment programs, law enforcement, alcohol counselors/therapists, public schools, court/judicial officials, emergency medical services, local public health offices, community partnerships, community DWI task forces, and, where applicable, local maternal and child health councils and healthier communities councils and other interested community based organizations.

B. The board shall develop policies and procedures for selection of council members, terms of office and scope of authority of the council. These policies and procedures shall be developed to avoid conflict of interest issues.

C. The board shall demonstrate a good faith effort to solicit the participation of the entities listed in paragraph 12.1 [now Subsection A of 7.32.6.12 NMAC] above.

D. Each council member shall certify his or her participation in the development of the county DWI plan. A certification signature sheet shall be included in the county DWI plan application (included in the county DWI plan packet).

E. Counties are encouraged to utilize their local DWI task force as a base for developing their planning council.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.13 SCOPE OF COUNTY DWI PLANS:

A. The county DWI plan shall be a comprehensive plan for a county-wide services network that documents the extent of the county's alcoholism problem and all county needs regarding DWI, alcoholism and alcohol or other drug abuse issues, including prevention, screening, assessment, treatment and/or alternative sentencing programs.

B. The county DWI plan shall be based on the continuum of care concept.

C. The county DWI plan shall be consistent with the statewide substance abuse prevention and treatment services plan.

D. The county DWI plan shall document how proposed services will adhere to department regulations that specify minimum standards concerning prevention, screening, assessment and treatment programs.

E. The county DWI plan shall adhere to the format and guidelines specified in the county DWI plan application provided by the department to each county.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.14 COUNTY DWI PLAN COMPONENTS:

The county DWI plan shall contain the following components as outlined in subsections 14.1 through 14.7 [now Subsections A through G of 7.32.6.14 NMAC]. The department will provide forms and/or a format for development of each section of the county DWI plan corresponding to subsections 14.1 through 14.7 [now Subsections A through G of 7.32.6.14 NMAC]. If preparing a multi-county DWI plan, separate information for each county must be submitted with a description of the proposed integration of services into a multi-county DWI service system.

A. Problem description: Describe county problems related to DWI, alcoholism and alcohol or other drug abuse issues, using county-specific data.

B. County resource assessment: List the available resources in your county regarding the prevention of DWI, alcoholism and alcohol or other drug abuse issues.

C. Summarize the **gaps** in prevention, screening, assessment, treatment and alternative sentencing of DWI, alcoholism and alcohol or other drug abuse in your county. Limit this section to two pages.

D. List the **priority needs** of your county in the areas of prevention, screening, assessment, treatment and alternative sentencing of DWI, alcoholism and alcohol or drug abuse.

E. Action plan: Develop goals and objectives based upon the prioritized needs and gaps cited in subsection 14.4 [now Subsection D of 7.32.6.14 NMAC]. Describe the proposed activities and explain how this activity is expected to impact the DWI problem in the county, what will be measured, what changes are expected and the estimated costs associated with each activity.

F. Process and outcome evaluation:

(1) Process evaluation: Applicants shall include a plan for the evaluation of the procedures used to implement and conduct the proposed project.

(2) Outcome evaluation: Applicants shall include a plan for the evaluation of the impact of the proposed activities on the local DWI condition.

G. Budget development:

(1) List current funding levels and sources, including in-kind resources, for all current DWI, alcoholism and alcohol or other drug abuse prevention, screening, assessment, treatment and alternative sentencing programs in the county(ies) covered by the county DWI plan.

(2) Document projected funding needed to address gaps in prevention, screening, assessment, treatment and/or alternative sentencing. This is not your request for funding, but rather documents the needs based on the continuum of care concept for a comprehensive substance abuse prevention and treatment system. This information will be used for long-range planning.

(3) List requested funding levels from the county DWI plan fund for prevention, screening, assessment, treatment and/or alternative sentencing that specifically relate to reducing the incidence of DWI.

(4) The department shall provide budget forms for paragraphs 14.7.1, 14.7.2 and 14.7.3 [now Paragraphs (1), (2) and (3) of Subsection G of 7.32.6.14 NMAC] above.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.15 REVIEW AND APPROVAL OF COUNTY DWI PLANS:

A. The county DWI plans shall be approved or disapproved by the secretary of the department, based on the review process and the recommendations made by the department county DWI plan review committee. The department review committee may include, but need not be limited to, representatives from the behavioral health services division, the public health division, the division of mental health, the division of epidemiology, evaluation and planning of the department; the division of local government, DFA; and the traffic safety bureau of the highway and transportation department.

B. The department shall submit the county DWI plans as approved or disapproved to the division of local government, DFA. Funding decisions for county DWI projects will be made by the DWI grant council with recommendations from DFA.

C. Technical assistance for the preparation of the county DWI plan may be requested from the department. A resource inventory will be provided by the department to each county. The resource inventory lists specific areas of technical assistance and resources for preparation of county DWI plans.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.16 COUNTY DWI PLAN REVIEW CRITERIA:

The county DWI plan shall be evaluated on the following criteria:

A. Services/activities description: The extent to which the county DWI plan documents the current availability of prevention activities, screening, assessment, treatment and alternative sentencing programs in the county.

B. Demonstration of the assessment of alcohol problems and issues in the county: The extent to which the county DWI plan utilizes data to assess the county's DWI, alcoholism, alcohol and other drug abuse problems.

C. Needs/gaps: The extent to which the county DWI plan adequately describes needs/gaps within the county relating to DWI, alcoholism and alcohol or other drug abuse prevention activities, screening, assessment, treatment and alternative sentencing programs.

D. Goals, objectives, strategies and activities: The extent to which the county DWI plan develops a comprehensive set of goals, objectives, strategies and activities based on the assessed needs and gaps.

E. Activities requested: The extent to which the county DWI plan demonstrates that the activities requested in the action plan will enhance and/or improve DWI programming, and will not supplant existing programs.

F. Process and outcome based measures: The extent to which the county DWI plan describes appropriate evaluation methods to be used to assess the short-term and long-term effects of prevention, screening, assessment, treatment and alternative sentencing programs on the reduction of DWI. The county DWI plan must cite data sources to be utilized as well as the methods for evaluating changes in incidence, behavior, attitude and knowledge as the result of implementation of the plan's activities.

G. Budget: The extent to which the county DWI plan's budget reflects reasonable and justified costs as well as demonstrating sound, economical use of other resources in the county.

H. Planning council: The extent to which the county DWI plan demonstrates inclusion of a broad spectrum of the community on the planning council, including the suggested representatives listed in these guidelines.

I. Collaborative efforts: The extent to which the county DWI plan demonstrates collaboration in the plan preparation with local entities involved in DWI - related issues, such as county DWI task forces, other substance abuse-related committee/task forces, local maternal and child health councils, substance abuse prevention partnerships, and screening, prevention and treatment programs in the county.

J. Municipalities and county government collaboration: the extent to which the county DWI plan documents collaboration among the county and participating municipalities and tribal governments, where applicable.

[10/8/93, 1/1/97; Recompiled 10/31/01]

7.32.6.17 COUNTY DWI PLAN UPDATE:

The county DWI plan shall be updated at the request of the department if the plan, as implemented through the statewide substance abuse prevention and treatment services plan is not achieving its stated goals; if the needs of the county have changed; or if it is determined that the distribution of funds is not having an impact on the incidence of driving while intoxicated/impaired.

[10/8/93, 1/1/97; Recompiled 10/31/01]

PART 7: OVERDOSE PREVENTION AND EDUCATION PROGRAM AUTHORIZATION FOR OPIOD ANTAGONISTS

7.32.7.1 ISSUING AGENCY:

Department of Health; Public Health Division; Infectious Disease Prevention and Control Bureau.

[7.32.7.1 NMAC - Rp, 7.32.7.1 NMAC, 7/15/2016]

7.32.7.2 SCOPE:

This rule applies to all New Mexico department of health registered overdose prevention and education programs that obtain, prescribe, dispense, distribute, or administer an opioid antagonist.

[7.32.7.2 NMAC - Rp 7.32.7.2 NMAC, 7/15/2016]

7.32.7.3 STATUTORY AUTHORITY:

The statutory authority for adopting these rules is found in Subsection E of Section 9-7-6 NMSA 1978 (Department of Health Act) and Subsection J of Section 24-23-1 NMSA 1978 which requires the secretary of health to "promulgate rules relating to overdose prevention and education programs."

[7.32.7.3 NMAC - Rp 7.32.7.3 NMAC, 7/15/2016]

7.32.7.4 DURATION:

Permanent.

[7.32.7.4 NMAC - Rp, 7.32.7.4 NMAC, 7/15/2016]

7.32.7.5 EFFECTIVE DATE:

July 15, 2016, unless a later date is cited at the end of a section.

[7.32.7.5 NMAC - Rp, 7.32.7.5 NMAC, 7/15/2016]

7.32.7.6 OBJECTIVE:

The objective of these regulations is to reduce mortality due to opioid overdose by increasing the administration, distribution, prescription and dispensation of opioid antagonists to individuals who are at risk of opioid overdose and to individuals, such as family members, friends or other persons, who may be in a position to assist individuals who are experiencing an overdose. These regulations shall set standards for the

establishment of standing orders to obtain, store, distribute and administer an opioid antagonist; the establishment of overdose prevention and education programs and standards for them to register, obtain, store, and distribute naloxone; the establishment of standards for overdose prevention curricula, training and the certification of individuals to store and distribute opioid antagonists for the overdose prevention and education programs.

[7.32.7.6 NMAC - Rp, 7.32.7.6 NMAC, 7/15/2016]

7.32.7.7 DEFINITIONS:

A. "Administration of opioid antagonist" means the direct application of an opioid antagonist to the body of an individual by injection, inhalation, ingestion or any other means.

B. "Department" means the New Mexico department of health.

C. "Dispense" means to evaluate and implement a prescription for an opioid antagonist, including the preparation and the delivery of a drug or device to a patient or patient's agent;

D. "Distribute" means to deliver an opioid antagonist drug or opioid antagonist device by means other than by administering or dispensing;

E. "Enrollment form" means the form approved by the department to register an individual as a trained targeted responder.

F. "Licensed prescriber" means any individual who is authorized by law to prescribe an opioid antagonist in the state.

G. "Medication log" means the form used to track the storage and distribution of the opioid antagonist.

H. "Opioid" means any substance containing or derived from opium including, but not limited to morphine and heroin, and any morphine-like synthetic narcotic that produces the same effects as substances derived from the opium poppy.

I. "Opioid antagonist" means a drug approved by the federal food and drug administration that, when administered, negates or neutralizes in whole or in part the pharmacological effects of an opioid in the body. "Opioid antagonist" shall be limited to naloxone or other like medications that are indicated for use in reversing an opioid overdose and are approved by the department for such purpose.

J. "Overdose prevention and education program (OPE)" means any community-based organization, law enforcement agency, detention facility or school that has registered with the department in accordance with department rules and uses an

approved department curriculum to teach overdose prevention and opioid antagonist administration.

K. "Overdose response educator" means any staff or volunteer who is registered with an *overdose prevention and education program* who are trained and certified by the department in the *overdose response education curriculum*.

L. "Overdose response educator curriculum" means a department approved curriculum to train and certify overdose response educators, which must be repeated every two years.

M. "Possess" means to have physical control or custody of an opioid antagonist.

N. "Record of use form" means the department designated report for the use or loss of an opioid antagonist, the response to a suspected opioid overdose or the re-issuance of an opioid antagonist to a trained targeted responder.

O. "Standing order" means a licensed prescriber's instruction or prescribed procedure that is either patient specific or non-patient specific that can be exercised by other persons until changed or canceled by a licensed prescriber.

P. "Storage" means possession of an opioid antagonist with the intent to dispense or distribute it.

Q. "Trained targeted responder" means a person who is trained by overdose response educators to possess and administer an opioid antagonist to a person who is experiencing an opioid overdose, and has completed the *trained targeted responder curriculum*.

R. "Trained targeted responder curriculum" means a department approved curriculum for trained targeted responders.

[7.32.7.7 NMAC - Rp, 7.32.7.7 NMAC, 7/15/2016]

7.32.7.8 REQUIREMENTS FOR OVERDOSE PREVENTION AND EDUCATION PROGRAMS, OVERDOSE RESPONSE EDUCATORS AND TRAINED TARGETED RESPONDERS:

A. Overdose prevention and education program requirements: An *overdose prevention and education program* is a program which facilitates the distribution of opioid antagonists and provides education related to overdoses, overdose prevention and the administration of opioid antagonists. An *overdose prevention and education program* shall:

(1) register with the department using the form approved by the department which shall include at a minimum:

(a) date of registration;

(b) *overdose prevention and education program* name; and

(c) name, address, e-mail and telephone number of *overdose prevention and education program* contact;

(2) identify who will be overdose response educators;

(3) train or verify overdose response educators have successfully completed and maintained a current certification in the *overdose response educator curriculum*;

(4) enroll trained targeted responders using the enrollment form;

(5) train or verify trained targeted responders have completed the trained targeted responder curriculum;

(6) identify and maintain a secure location for the storage of the opioid antagonists designated for distribution in accordance with these regulations;

(7) label the opioid antagonist in accordance with these regulations;

(8) utilize the record of use form to report all known uses or losses of an opioid antagonist, responses to a suspected opioid overdose, or the re-issuance of an opioid antagonist to a trained targeted responder;

(9) maintain personal protective equipment and response equipment at training locations;

(10) provide trained targeted responders with necessary response equipment; and

(11) be prepared for scheduled and unscheduled site visits by the department where the department may review the maintenance of enrollment forms, record of use forms, medication logs and any other information required to be maintained pursuant to these rules.

B. Overdoes response educators shall:

(1) successfully complete the *overdose response educator curriculum* and maintain this certification;

(2) comply with the terms of a standing order issued by a licensed prescriber, which may include possession of opioid antagonists and distribution of the opioid antagonist to trained targeted responders;

(3) teach trained targeted responders the *trained targeted responder curriculum*; and

(4) complete medication log, enrollment forms and record of use forms for trained targeted responders.

C. Trained targeted responders:

(1) are trained in the *trained targeted responder curriculum*; and

(2) shall report all known responses to suspected opioid overdoses to an *overdose prevention and education program* using the record of use form.

[7.32.7.8 NMAC - Rp, 7.32.7.9 & 10 NMAC, 7/15/2016]

7.32.7.9 REQUIREMENTS FOR DISTRIBUTION OF OPIOID ANTAGONIST:

A. The New Mexico department of health public health division pharmacy warehouse can distribute the opioid antagonist to any registered *overdose prevention and education program*.

B. Standing orders from a department licensed prescriber for the distribution of an opioid antagonist shall include at a minimum:

(1) authorization to maintain supplies of opioid antagonists for the purposes of distributing them as part of the department's overdose prevention efforts;

(2) authorization for overdose response educators to possess and distribute the opioid antagonist to trained targeted responders;

(3) instructions for overdose response educators to educate and advise clients of overdose prevention methods, recognizing an overdose, and potential contraindications and precautions.

C. Medication log, enrollment forms and record of use forms shall be utilized by an *overdose prevention and education program* in order to document the distribution and administration of opioid antagonists.

[7.32.7.9 NMAC - Rp, 7.32.7.10 NMAC, 7/15/2016]

7.32.7.10 REQUIREMENTS FOR STORAGE OF THE OPIOID ANTAGONIST:

A. Any opioid antagonist designated for distribution by an *overdose prevention and education program* must be stored in a secure designated location.

(1) The location must be locked with entry limited to overdose response educators and other individuals as designated by the *overdose prevention and education program*.

(2) A medication log of the opioid antagonist must be maintained, and include the following information, at minimum:

(a) lot numbers of the opioid antagonist;

(b) expiration dates of the opioid antagonist;

(c) date, quantity of opioid antagonist doses and the name of the individual who is removing the opioid antagonist from the secured location for distribution;

(d) date, quantity of opioid antagonist doses and the name of the individual who is returning doses of the opioid antagonist to the secured location if they have not been distributed; and

(e) for doses of the opioid antagonist distributed, the medication log must also include the name and date of birth of the trained targeted responder, the date of distribution, lot number of each opioid antagonist dose and the expiration date of each opioid antagonist dose.

B. Any registered *overdose prevention and education program*, may make an opioid antagonist available for use in response to a possible overdose incident. The opioid antagonist designated for use at an *overdose prevention and education program* for a possible overdose response shall be stored in a secure but accessible location.

[7.32.7.10 NMAC - Rp, 7.32.7.10 NMAC, 7/15/2016]

7.32.7.11 LABELING OF THE OPIOID ANTAGONIST:

A. The *overdose prevention and education program* shall label the opioid antagonist prior to it leaving the designated secure storage location which shall include:

(1) the name and address of the *overdose prevention and education program* distributing the opioid antagonist; and

(2) the text "use as directed."

B. At the time of distribution of an opioid antagonist to a trained targeted responder, the overdose response educator shall complete the following information on the label:

(1) name of the trained targeted responder;

(2) date of distribution of the opioid antagonist; and

C. At the time of distribution of an opioid antagonist to a trained targeted responder, the overdose response educator will provide directions for use of the opioid antagonist.

[7.32.7.11 NMAC - N, 7/15/2016]

7.32.7.12 MINIMUM REQUIREMENTS FOR ENROLLMENT AND RECORD OF USE FORMS:

A. The enrollment form shall include at a minimum:

(1) name of the *overdose prevention and education program*;

(2) department designated code of the trained targeted responder; and

(3) the quantity of the opioid antagonist distributed.

B. The record of use form shall contain at a minimum:

(1) the name of the *overdose prevention and education program* recording the report;

(2) the department designated code of the reporting trained targeted responder;

(3) the quantity of the opioid antagonist administered, lost, or expired;

(4) the date or approximate date of the overdose incident, if there is one being reported;

(5) the disposition of the person who was administered the opioid antagonist; and

(6) the quantity of the opioid antagonist distributed.

[7.32.7.12 NMAC-N, 7/15/2016]

7.32.7.13 APPLICABILITY OF REGULATIONS:

In the event an approved opioid antagonist is classified as an "over the counter" (OTC) medication the following portions of these regulations shall no longer be applicable: 7.32.7.9, 7.32.7.10, 7.32.7.11 NMAC. Department protocols will remain in effect.

[7.32.7.13 NMAC-N, 7/15/2016]

PART 8: OPIOID TREATMENT PROGRAMS [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.321.10 NMAC.]

PART 9-19: [RESERVED]

PART 20: DRIVING WHILE IMPAIRED (DWI) SCHOOLS

7.32.20.1 ISSUING AGENCY:

New Mexico Department of Transportation.

[7.32.20.1 NMAC - Rp, 7 NMAC 32.20.1, 1-1-03; A, 2-13-09]

7.32.20.2 SCOPE:

This rule applies to all persons seeking to operate DWI schools, or serve as DWI facilitators for DWI programs offered, in New Mexico.

[7.32.20.2 NMAC - Rp, 7 NMAC 32.20.2, 1-1-03]

7.32.20.3 STATUTORY AUTHORITY:

Sections 9-1-5, 66-7-512, and 66-8-102 NMSA 1978.

[7.32.20.3 NMAC - Rp, 7 NMAC 32.20.3, 1-1-03; A, 2-13-09]

7.32.20.4 DURATION:

Permanent.

[7.32.20.4 NMAC - Rp, 7 NMAC 32.20.4, 1-1-03]

7.32.20.5 EFFECTIVE DATE:

January 1, 2003, unless a later date is cited at the end of a section.

[7.32.20.5 NMAC - Rp, 7 NMAC 32.20.5, 1-1-03]

7.32.20.6 OBJECTIVE:

The purpose of this rule is to provide minimum and uniform standards for the issuance, renewal, and revocation of DWI school licenses and DWI facilitator certificates and to establish requirements for the operation of DWI schools.

[7.32.20.6 NMAC - Rp, 7 NMAC 32.20.6, 1-1-03]

7.32.20.7 DEFINITIONS:

For use in this part, the following definitions apply:

A. ADA means the Americans with Disabilities Act, 42 U.S.C. Section 12101 et seq.;

B. bureau means the traffic safety bureau (TSB) of the New Mexico department of transportation;

C. certificate means a document issued by the bureau authorizing a person to serve as a DWI facilitator;

D. certificate of completion means an official document obtained from the bureau and issued to the student upon successful completion of a DWI course;

E. clean driving record means a person has no more than six (6) points on that person's driver's license, and that person has not within the last ten (10) years had a driver's license suspended or revoked as a result of a DWI conviction or refusal to submit to or failure of chemical tests pursuant to the Implied Consent Act, or been convicted in any jurisdiction of an alcohol or drug-related driving offense, or has received three (3) or more failure to appear summonses or citations in the past year;

F. convicted or conviction has the meaning given in Section 66-8-102 NMSA 1978;

G. credit hour means fifty (50) minutes of instruction and 10 minutes of break time;

H. crime involving moral turpitude means a crime that is contrary to honesty, justice or good morals, such as a crime involving dishonesty, fraud, perjury, forgery, murder or serious sexual offenses;

I. curriculum means a course of instruction approved by the bureau pursuant to Section 66-8-102 NMSA 1978;

J. designee means a person authorized to perform certain specified duties on behalf of the bureau;

K. diploma means a document evidencing that a person has completed a DWI facilitator training course or recertification DWI facilitator training course conducted by the bureau;

L. DWI course or course means a driver rehabilitation curriculum taught by a certified DWI facilitator;

M. DWI school or school or licensee means a person licensed by the bureau to operate a school offering DWI courses;

N. DWI facilitator or facilitator means a person certified by the bureau as qualified and trained to conduct DWI courses pursuant to Section 66-8-102 NMSA 1978;

O. enrolled means a student has registered for a DWI program, attended the first day of the course, and the sentencing court has acknowledged the student as enrolled;

P. extension site means a location other than the main school site where a licensed DWI school offers DWI programs;

Q. Implied Consent Act means Sections 66-8-105 through 66-8-112, NMSA 1978;

R. limited driving history means a driving record from the New Mexico motor vehicle division of the taxation and revenue department or its equivalent that includes actions and citations, and drivers' license revocations pursuant to the Implied Consent Act;

S. license means the document issued by the bureau authorizing a person to operate a DWI school;

T. MVD means the New Mexico motor vehicle division of the taxation and revenue department;

U. person means an individual, firm, partnership, association, corporation, or other legal entity;

V. revocation or revoked means the involuntary permanent termination of a license or certificate by the bureau for cause;

W. student means a person who has enrolled in a DWI program; and

X. suspension or suspended means the involuntary termination of a license or certificate by the bureau for cause for a specified period of time.

[7.32.20.7 NMAC - Rp, 7 NMAC 32.20.7, 1-1-03; A, 2-13-09]

7.32.20.8 DWI SCHOOL NEEDS ASSESSMENT:

The bureau shall have ultimate responsibility for assessing the need for a DWI school in a particular community and may conduct a needs assessment on its own initiative. The bureau shall find that a need exists for a DWI school if:

A. the existing DWI school license in that community will expire on October 31 of that year and the owner has not applied to renew the license or the bureau has decided not to renew the license, the DWI school license has been revoked for cause by the bureau, or the DWI school has ceased operations;

B. community needs are not being adequately served by existing DWI schools and the number of students from the community in a given time period would be sufficient to make a DWI school economically self-sustaining; or

C. the distance to the nearest licensed DWI school would create safety problems for students.

[7.32.20.8 NMAC - Rp, 7 NMAC 32.20.8, 1-1-03; A, 2-13-09]

7.32.20.9 REQUEST FOR DWI SCHOOL APPLICATIONS:

A. Whenever the bureau determines that there is a need for a DWI school in a community, the bureau shall publish a request for applications for a license to operate a DWI school in that community. The request for applications shall be published once in a newspaper of general circulation in the community. The bureau shall accept applications for DWI school licenses for the period of time specified in the request, but for not less than thirty (30) days.

B. The bureau shall select the successful applicant and notify all applicants of its decision.

[7.32.20.9 NMAC - Rp, 7 NMAC 32.20.9, 1-1-03; A, 2-13-09]

7.32.20.10 APPLICATION FOR DWI SCHOOL LICENSE:

A. License required. No person may operate a DWI school without first having obtained a license from the bureau.

B. Application form. A person wishing to obtain a license to operate a DWI school shall file an application with the bureau. A person may obtain an application by contacting the bureau at 1-800-541-7952 or accessing the bureau's website at http://www.nmshtd.state.nm.us and clicking on "traffic safety".

C. Contents of application. An application for a DWI school license shall contain:

(1) the applicant's name, mailing address, telephone number, physical address of the main school site, and, if the applicant has one, the applicant's e-mail address;

(2) a photocopy of the certificate of maximum occupant load issued by the state or local fire marshal stating the maximum occupancy allowed by the fire code for each room at the main school site and each extension site, if applicable, that will be used as a classroom;

(3) a list of all extension sites to be used for conducting DWI courses;

(4) a list of all facilitators who will conduct DWI courses;

(5) a schedule of fees applicable to students who enroll in a DWI course, including primary and incidental costs charged for the course, school policies for passing and failing, refund and reschedule policies and attendance requirements;

(6) the proposed curriculum, handouts and videos for the DWI course;

(7) the name, address, and telephone number of three (3) character and employment references who are not family members;

(8) the applicant's resume or related work history;

(9) a copy of the applicant's limited driving history from the motor vehicle division, driver services bureau or its equivalent from any state in which the applicant has held a driver's license in the past ten (10) years dated no earlier than sixty (60) days before the date the application is filed with the bureau; and

(10) a state police background check from any state in which the applicant has resided in the past ten (10) years dated no earlier than sixty (60) days before the date the application is filed with the bureau, or verification that the applicant submitted a request for a state police background check to the department of public safety or its equivalent at least sixty (60) days before the date the application is filed with the bureau.

D. Completeness. When the bureau receives an application for a DWI school license, the bureau shall check the application for completeness.

(1) If the application is not complete, the bureau shall contact the applicant for additional information within fifteen (15) days of receipt. The applicant shall then have thirty (30) days from the date of contact to complete the application. If the applicant fails to complete the application within the thirty (30) days, the applicant's file shall be closed and the application shall be returned to the applicant.

(2) If the application is complete, the bureau shall review the application.

[7.32.20.10 NMAC - Rp, 7 NMAC 32.20.9, 1-1-03; A, 2-13-09]

7.32.20.11 ISSUANCE OF INITIAL DWI SCHOOL LICENSE:

A. Standards for issuance. In reviewing applications for DWI schools, the bureau shall consider whether:

(1) the information provided by the applicant is accurate and valid;

(2) the character and employment references provided by the applicant report that the applicant is fit to operate a DWI school;

(3) the community's needs will be adequately served;

(4) the proposed DWI school can certify that its facilities meet the accessibility requirements of the ADA;

(5) the applicant has not been convicted of a crime involving moral turpitude;

(6) the applicant has a clean driving record;

(7) the applicant's name does not appear on the human services department (HSD) listing for failure to comply with any valid child support order or agreement pursuant to the Parental Responsibility Act, Sections 40-5A-1 et seq. NMSA 1978 or any rule implementing that act; and

(8) the persons who will serve as DWI facilitators meet the requirements of this rule.

B. Issuance of initial license. If the bureau determines that an applicant meets the standards prescribed in Subsection A of this section, the bureau shall issue a license upon:

(1) payment of the $50.00 license fee (or $25.00 for applications filed on or after May 1 of the current license year);

(2) payment of the $35.00 extension site fee for each extension site, if applicable; and

(3) posting of a surety bond with the bureau in the amount of $5,000 issued by a company authorized to transact surety business in New Mexico. The surety bond shall be continuous, shall name the New Mexico department of transportation, traffic safety bureau as obligee, and shall assure the satisfactory performance of all contracts with students, including tuition refund agreements, and the maintenance of student records.

C. Interim licenses. The bureau may issue an interim license to a DWI school for a term to expire on October 31 of the year in which the interim license is issued in order to provide a replacement for a school that has ceased operations or had its license revoked.

D. Denial of license. If the bureau determines that an applicant does not meet the standards prescribed in Subsection A of this section, the bureau shall issue a letter stating the reasons for denial of the license. A person may reapply for a license at any time.

[7.32.20.11 NMAC - Rp, 7 NMAC 32.20.9, 1-1-03; A, 2-13-09]

7.32.20.12 TERM OF DWI SCHOOL LICENSE:

A. Term. An initial license shall be valid until October 31 of each year, unless suspended or revoked for cause before that date. Initial licenses shall be valid from the date of issuance to the next October 31. Renewal licenses shall be valid from November 1 of the year of renewal to October 31 of the following year.

B. License renewal.

(1) A licensee shall file an application for renewal of its license with the bureau on or before October 1 of each year to ensure license renewal by November 1. A licensee who files an application for renewal after October 1 shall pay a late fee of $25.00.

(2) A person may obtain an application for renewal by contacting the bureau at 1-800-541-7952 or accessing the bureau's website at http://www.nmshtd.state.nm.us and clicking on "traffic safety".

(3) The application for renewal shall be accompanied by the documents specified in Subsection C of 7.32.20.10 NMAC, except for the documents specified in Paragraphs (7) and (8) of Subsection C of 7.32.20.10 NMAC.

(4) The bureau shall review applications for renewal in the order in which they are received.

C. Approval/disapproval of application for license renewal.

(1) The bureau will renew a license for a period of one (1) year if:

(a) the bureau or its designee finds that the DWI school is in compliance with the requirements of this rule;

(b) the licensee has submitted all required reports to the bureau;

(c) the licensee has submitted a continuation certificate or proof of payment for the surety bond required by Paragraph 3 of Subsection B of 7.32.20.11 NMAC; and

(d) the licensee pays the $50.00 annual license fee and, if applicable, the $35.00 extension site fee for each extension site and the $25.00 late fee if the application was filed after October 1.

(2) The bureau shall not renew the license of any DWI school not in compliance with the requirements of this rule.

D. Notice of rule violation. The bureau may send any licensee a notice of rule violation if it finds that the DWI school is not in compliance with one or more

requirements of this rule. The notice of rule violation shall specify the provisions of this rule with which the licensee is not in compliance. Failure to correct the rule violation in the time requested by the bureau may result in suspension or revocation of the license.

E. Early termination.

(1) A license shall automatically terminate if a DWI school ceases operation.

(2) The bureau may suspend or revoke a license for cause as provided in this rule.

(3) If a DWI school ceases operation for any reason, the school shall comply with the requirements of Subsection L of 7.32.20.14 NMAC.

F. Restriction on sale of license. A DWI school license shall not be sold or transferred.

[7.32.20.12 NMAC - Rp, 7 NMAC 32.20.9 and 32.20.23, 1-1-03; A, 2-13-09]

7.32.20.13 CLASSROOM COURSE REQUIREMENTS FOR DWI SCHOOLS:

A licensee shall:

A. engage as DWI facilitators only those persons who have been certified by the bureau; a licensee may not serve as a facilitator unless the licensee has been certified by the bureau as a facilitator pursuant to this rule;

B. enroll no fewer than four (4) students and no more than thirty (30) students per facilitator or the maximum occupancy allowed by the fire code, whichever is less, in a DWI program, unless prior written approval is obtained from the bureau;

C. not charge a student more than $175.00, including tax, for enrolling in a DWI program;

D. display the license issued by the bureau in an appropriate and visible location;

E. display the placard issued by the fire marshal stating the maximum occupancy of each classroom in an appropriate and visible location in the classroom;

F. use classroom facilities that:

(1) have adequate space, lighting, heating, and ventilation;

(2) have seats and tables or seats with attached tables for each student in the class; and

(3) comply with all federal, state, and local laws relating to persons with disabilities, public health, safety, and sanitation, including restroom facilities;

G. ensure that the learning environment is conducive to learning and free from discrimination, intimidation, and harassment; no person shall engage in, or be permitted to engage in, conduct that is offensive to the ordinary dignity, decency, and morality of others;

H. use only the curriculum, handouts and videos, approved by the bureau;

I. if a licensee becomes aware that a student is disabled, inquire as to the need for accommodations, and provide reasonable accommodations for the student, including but not limited to auxiliary aids or services such as assisted listening devices or a sign language interpreter, unless the accommodation presents an undue burden on the licensee; the bureau shall pay for sign language interpretation if the student is under the age of eighteen (18), provided that the licensee shall contact the bureau at least fourteen (14) days before the scheduled date of the driver education course to arrange for interpretation;

J. provide at least twelve (12) program hours for each DWI program, divided into no fewer than three (3) four-hour segments scheduled at least one (1) week apart;

K. offer classes as frequently as necessary to accommodate the number of students in the community, but no less frequently than once every three (3) months;

L. if certificates of completion are issued, use certificates obtained from the bureau, issued sequentially by the licensee; and

M. not permit a student to attend any DWI classes until the student has received written information stating all fees, including primary and incidental costs, charged for the course, school policies for passing and failing, refund and reschedule policies, and attendance requirements.

[7.32.20.13 NMAC - Rp, 7 NMAC 32.20.10 and 32-20-23, 1-1-03; A, 2-13-09]

7.32.20.14 OPERATING REQUIREMENTS FOR DWI SCHOOLS:

A licensee:

A. shall adhere strictly to the requirements of this rule;

B. shall notify the bureau at least thirty (30) days in advance if the DWI school intends to cease operations;

C. shall make all DWI school records available for inspection and copying by the bureau or its designee at any time; a licensee shall maintain all hard copies and

electronic versions of its records for a minimum of three (3) years for each student receiving instruction, including students who passed, failed, withdrew, cancelled, or transferred to another school; the records shall be updated for each course;

D. shall:

(1) at the time of enrollment and on a quarterly basis thereafter, provide the bureau with a student report, on a form prepared or approved by the bureau; if no course is held during the quarter, the licensee shall submit a student report indicating the same; and

(2) submit a $50.00 per student fee to the bureau, unless other arrangements have been made with the bureau in advance;

E. shall have a written refund policy and a written reschedule policy which must be issued to each student upon enrollment;

F. shall, upon request, provide each student with a form prepared by the bureau that allows the student or the student's parent to notify the bureau regarding a comment or concern about the school or a facilitator;

G. shall notify the bureau of:

(1) any changes in address ten (10) days before opening for business at the new location;

(2) the addition or closing of extension sites within ten (10) days of their opening or closing; and

(3) the addition or deletion of facilitators within ten (10) days of their hiring or leaving;

H. shall conduct all school operations in a professional and courteous manner;

I. shall operate all extension sites under the name used for the main school site and be accountable for all extension site operations;

J. shall notify the sentencing court or other appropriate agency in writing within five (5) working days if a student fails to attend any session of the program or fails to complete the program within three (3) months of enrollment;

K. may use the phrases "licensed by the traffic safety bureau" or "curriculum approved by the traffic safety bureau" but may not otherwise use the word "approved" or any of its synonyms in its advertising or promotional materials;

L. upon ceasing operations for any reason, shall make all DWI school records available for inspection or copying by the bureau or its designee at any time, and shall return all unused completion certificates to the bureau within ten (10) days of the school ceasing operation; for any certificates not returned within ten (10) days of the school ceasing operation, the bureau shall notify the appropriate authority that the certificates are no longer valid.

[7.32.20.14 NMAC - Rp, 7 NMAC 32.20.10, 1-1-03; A, 2-13-09]

7.32.20.15 EVALUATION OF DWI SCHOOLS:

A. Responsibility. The bureau or its designee:

(1) shall conduct periodic evaluations of DWI schools using criteria developed by the bureau; the bureau shall prepare a written evaluation and shall provide a copy of the evaluation to the licensee upon request; the bureau may in its discretion conduct evaluations of a DWI school on its own initiative at any time and for any reason or in response to complaints from any person; the bureau shall document, investigate, and discuss all complaints with the DWI school;

(2) may conduct on-site quality assurance visits; on-site visits may address the adequacy of classroom facilities, facilitators' traffic safety knowledge and teaching techniques, learning environment, quality of the curriculum, class materials and customer service.

B. Relevant factors. In conducting its evaluations, the bureau shall consider:

(1) the number and nature of any comments or complaints received from students, facilitators, judges, law enforcement officers, and others;

(2) whether the DWI school consistently meets the requirements of this rule; and

(3) the results from on-site quality assurance visits.

[7.32.20.15 NMAC - Rp, 7 NMAC 32.20.11, 1-1-03; A, 2-13-09]

7.32.20.16 INITIAL CERTIFICATION OF DWI FACILITATORS:

A. Certification required. No person or licensee may serve as a DWI facilitator without first having obtained a certificate from the bureau.

B. Application requirements. A person wishing to obtain a certificate as a DWI facilitator shall file an application with the bureau. A person may obtain an application by contacting the bureau at 1-800-541-7952 or accessing the bureau's website at http://www.nmshtd.state.nm.us and clicking on "traffic safety".

C. Contents of application. The application shall be accompanied by:

(1) a copy of the applicant's limited history driving record from the motor vehicle division, driver services bureau or its equivalent from any state in which the applicant has held a driver's license in the past ten (10) years dated no earlier than sixty (60) days before the date the application is filed with the bureau;

(2) a state police background check from any state in which the applicant has resided in the past ten (10) years dated no earlier than sixty (60) days before the date the application is filed with the bureau, or verification that the applicant submitted a request for a state police background check to the department of public safety or its equivalent at least sixty (60) days before the date the application is filed with the bureau;

(3) a copy of the applicant's health certificate signed by a physician and dated no earlier than sixty (60) days before the date the application is filed with the bureau stating that the applicant is free from all communicable diseases;

(4) the name, address, and telephone number of three (3) character and employment references who are not family members;

(5) the applicant's resume or related work history;

(6) transcripts from any post secondary educational or training institutions the applicant has attended; and

(7) the name of the school at which the facilitator will be providing DWI facilitation.

D. Completeness. When the bureau receives an application for certification as a DWI facilitator, the bureau shall check the application for completeness.

(1) If the application is incomplete, the bureau shall contact the applicant for additional information within fifteen (15) days of receipt. The applicant shall then have thirty (30) days from the date of contact to complete the application. If the applicant fails to complete the application within the thirty (30) days, the applicant's file shall be closed and the application shall be returned to the applicant.

(2) If the application is complete, the bureau shall review the application.

E. Standards for issuance of DWI facilitator certificate. In reviewing applications for DWI facilitators, the bureau shall consider whether:

(1) the information provided is accurate and valid;

(2) the character and employment references provided by the applicant report that the applicant is fit to be a DWI facilitator;

(3) the applicant is at least twenty-one (21) years of age;

(4) the applicant has at least a high school diploma or equivalent;

(5) the applicant holds a valid driver's license;

(6) the applicant has not been convicted of a crime involving moral turpitude;

(7) the applicant has a clean driving record; and

(8) the applicant's name does not appear on the human services department (HSD) listing for failure to comply with any valid child support order or agreement pursuant to the Parental Responsibility Act, Sections 40-5A-1 et seq. NMSA 1978 or any rule implementing that act.

F. Approval for training.

(1) If the bureau determines that the applicant meets the standards in Subsection E of this section, the bureau shall grant approval to proceed with facilitator training. Each applicant for a certificate as a DWI facilitator shall, within six (6) months of approval to proceed with training:

(a) satisfactorily complete the New Mexico DWI facilitator training course, as verified by the bureau;

(b) attend one (1) DWI trial or three (3) DWI hearings in a court in the community, as verified by the clerk of the court;

(c) observe a minimum of one (1) complete twelve-hour DWI program, as verified by the certified DWI facilitator conducting the program; and

(d) co-facilitate at least six (6) hours of a DWI program under the direct supervision of a certified DWI school facilitator, as verified by that facilitator.

(2) If the bureau determines that the applicant does not meet the standards in Subsection E of this section, the bureau shall issue a letter stating the reasons it is not granting approval to proceed with facilitator training.

G. Final review.

(1) If the bureau determines that an applicant has successfully completed the requirements in Subsection F of this section and is otherwise fit, the bureau shall issue a certificate upon payment of the $50.00 facilitator certification fee.

(2) If the bureau determines that an applicant has not successfully completed the facilitator training program or is otherwise not fit, the bureau shall issue a letter stating its reasons for denial of certification.

H. Term. A DWI facilitator certificate shall be valid until October 31 of each year, unless suspended or revoked for cause before that date. Initial certificates shall be valid from the date of issuance to the next October 31. Renewal certificates shall be valid from November 1 of the year of renewal to October 31 of the following year. If the DWI school at which the facilitator is teaching changes during the term of the certificate, the facilitator shall notify the bureau within ten (10) days of such change.

[7.32.20.16 NMAC - Rp, 7 NMAC 32.20.12, 32.20.13, 32.20.14, and 32-20.23, 1-1-03; A, 2-13-09]

7.32.20.17 RECERTIFICATION OF DWI FACILITATORS:

A. Certificate renewal.

(1) A DWI facilitator shall file an application for renewal of his or her certificate with the bureau on or before October 1 each year to ensure certificate renewal by November 1. A DWI facilitator who files an application for renewal after October 1 shall pay a late fee of $25.00.

(2) A person may obtain an application for renewal by contacting the bureau at 1-800-541-7952 or accessing the bureau's website at http://www.nmshtd.state.nm.us and clicking on "traffic safety".

(3) The application for renewal shall be accompanied by the documents specified in Subsection C of 7.32.20.16 NMAC, except for the documents specified in Paragraphs (4), (5) and (6) of Subsection C of 7.32.20.16 NMAC.

(4) The bureau shall review applications for renewal in the order in which they are received.

B. Continuing education requirements.

(1) DWI facilitators shall complete a minimum of eight (8) credit hours of continuing education each license year to qualify for annual recertification.

(2) A DWI facilitator may satisfy this requirement in whole or in part by attending bureau sponsored:

(a) DWI school workshops;

(b) traffic safety issues forums;

(c) community DWI prevention program workshops; or

(d) any traffic safety related courses or workshops.

(3) The bureau may, in its discretion, approve continuing education credit on the basis of one (1) continuing education credit hour for every hour of attendance at the following types of programs if a copy of the workshop agenda or course curriculum is submitted to the bureau:

(a) drug or alcohol workshops;

(b) counseling or treatment workshops; or

(c) education courses or workshops.

(4) The bureau shall grant one (1) continuing education credit hour for each hour spent observing a DWI school facilitator from the bureau's approved list but not from the same school, up to a maximum of four (4) credit hours in one year.

C. Approval/disapproval of application for certificate renewal.

(1) The bureau shall renew the certificate of a DWI facilitator for a period of one (1) year if the DWI facilitator:

(a) pays the $50.00 annual certification fee;

(b) meets the standards specified in Subsection E of 7.32.20.16 NMAC;

(c) has received an overall rating of satisfactory or better in the periodic evaluations conducted by the bureau or its designee in the preceding license year; and

(d) has completed eight (8) credit hours of continuing education in the license year preceding the application for renewal.

(2) The bureau shall not renew the license of any DWI facilitator who:

(a) fails to complete eight (8) hours of continuing education in the license year preceding the application for renewal; or

(b) fails to meet the standards specified in Subsection E of 7.32.20.16 NMAC.

[7.32.20.17 NMAC - Rp, 7 NMAC 32.20.15, 32.20.16 and 32.20.17, 1-1-03; A, 2-13-09]

7.32.20.18 SUSPENSION OR REVOCATION OF A LICENSE OR CERTIFICATE:

A. Grounds. The bureau may suspend or revoke the license or certificate of a licensee or DWI facilitator:

(1) who makes a false statement on an application;

(2) who fails to follow the approved curriculum;

(3) who poses an immediate danger to the physical or mental safety or health of a student;

(4) who is convicted of any alcohol or drug-related driving offense;

(5) who has refused to submit to or failed chemical tests pursuant to the Implied Consent Act;

(6) whose New Mexico driver's license is suspended or revoked;

(7) who fails to notify the bureau in writing within ten (10) days that the licensee's or DWI facilitator's driver's license has been suspended or revoked as a result of a DWI conviction or refusal to submit to or failure of chemical tests pursuant to the Implied Consent Act, or that the licensee or DWI facilitator has been convicted in any jurisdiction of an alcohol or drug-related driving offense or an offense involving moral turpitude;

(8) whose conduct in the performance of official duties is unethical, including but not limited to, verbal abuse or sexual harassment of students;

(9) who fails to comply with any requirement of this rule or any lawful order of the bureau;

(10) who becomes employed or remains employed by a DWI school whose license has been revoked pursuant to this rule;

(11) who employs or continues to employ a DWI facilitator whose certificate has been revoked pursuant to this rule;

(12) whose name appears on the human services department (HSD) listing for failure to comply with any valid child support order or agreement pursuant to the Parental Responsibility Act, Sections 40-5A-1 et seq. NMSA 1978, or any rule implementing that act; or

(13) who fails to forward the $50.00 per-student fee to the bureau within thirty (30) days after the end of the program unless other arrangements have been made with the bureau.

B. Procedure. The bureau shall use the procedures prescribed in the Uniform Licensing Act, Sections 61-1-1 et seq. NMSA 1978, in all suspension and revocations proceedings held pursuant to this rule.

C. Consequences of suspension or revocation.

(1) A DWI school shall not offer or conduct any DWI programs if its license is suspended or revoked.

(2) A DWI facilitator shall not conduct any DWI programs if his or her certificate is suspended or revoked.

D. Notice of suspension or revocation. Upon completion of any proceedings held pursuant to the Uniform Licensing Act:

(1) The bureau shall immediately notify by certified mail, return receipt requested, each DWI facilitator employed by a DWI school whose license has been suspended or revoked that the DWI school's license has been suspended or revoked and that the DWI facilitator may not conduct any DWI programs for that DWI school unless and until the license is reinstated by the bureau.

(2) The bureau shall immediately notify by certified mail, return receipt requested, each DWI school that employs a DWI facilitator whose certificate is suspended or revoked that the DWI facilitator's certificate has been suspended or revoked and that the DWI school may not employ that DWI facilitator unless and until the certificate is reinstated by the bureau.

(3) The bureau shall notify all motor vehicle division field offices that the DWI school's license or the DWI facilitator's certificate has been revoked or suspended.

(4) The bureau shall notify all state courts that the DWI school's license has been revoked or suspended and that the DWI school is no longer an approved school.

[7.32.20.18 NMAC - Rp, 7 NMAC 32.20.24, 32.20.25, and 32.20.29, 1-1-03; A, 2-13-09]

7.32.20.19 EXEMPTION OR VARIANCE:

A. Any school may petition in writing for an exemption or variance from any of the requirements of this rule. Such petition shall:

(1) identify the section of this rule for which the exemption or variance is requested;

(2) describe the situation which necessitates the exemption or variance;

(3) describe the effect of complying with this rule on the school and its customers, and on its competitors and their customers, if the exemption or variance is not granted;

(4) state how the exemption or variance will achieve the purposes of this rule and the Traffic Safety Act; and

(5) state why the proposed alternative is in the public interest or is better than the requirement in the rule.

B. Such petition may include a motion that the bureau stay the affected portion of this rule for the transaction specified in the motion.

C. Petitions for an exemption or a variance and motions for a stay must be supported by an affidavit signed by the licensee or other person with authority to bind the licensee.

D. The bureau may, at its discretion, require an informal conference or formal evidentiary hearing prior to making its determination.

E. Each exemption or variance shall be valid for no longer than the end of the current license year.

[7.32.20.19 NMAC - Rp, 7 NMAC 32.20.26, 32.20.27, and 32.20.28, 1-1-03; Repealed, 2-13-09; 7.32.20.19 NMAC - Rn, 7.32.20.20 NMAC & A, 2-13-09]

CHAPTER 33: SCIENTIFIC, CHEMICAL AND BIOLOGIC LABORATORIES AND TESTING

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: BLOOD AND BREATH TESTING UNDER THE NEW MEXICO IMPLIED CONSENT ACT

7.33.2.1 ISSUING AGENCY:

New Mexico Department of Health - Scientific Laboratory Division (SLD).

[7.33.2.1 NMAC - Rp, 7.33.2.1 NMAC, 04-30-2010]

7.33.2.2 SCOPE:

This rule governs the certification of laboratories, breath alcohol instruments, operators, key operators, and operator instructors of the breath alcohol instruments as well as establishes the methods of taking and analyzing samples of blood and breath testing for

alcohol or other chemical substances under the New Mexico Implied Consent Act, Section 66-8-107 et. seq. NMSA 1978.

[7.33.2.2 NMAC - Rp, 7.33.2.2 NMAC, 04-30-2010]

7.33.2.3 STATUTORY AUTHORITY:

This rule is promulgated by the secretary of the department of health under the authority of Section 9-7-6(E), Section 24-1-22 and Section 66-8-107 et seq, NMSA 1978. Administration and enforcement of this rule is the responsibility of SLD of the department of health.

[7.33.2.3 NMAC - Rp, 7.33.2.3 NMAC, 04-30-2010]

7.33.2.4 DURATION:

Permanent.

[7.33.2.4 NMAC - Rp, 7.33.2.4 NMAC, 04-30-2010]

7.33.2.5 EFFECTIVE DATE:

04-30-2010, unless a later date is cited at the end of a section.

[7.33.2.5 NMAC - Rp, 7.33.2.5 NMAC, 04-30-2010]

7.33.2.6 OBJECTIVE:

The objective is to establish standards and procedures for the certification of laboratories, breath alcohol instruments, operators, key operators, and operator instructors as well as the methods of taking and analyzing samples for blood and breath testing for alcohol and other chemical substances under the New Mexico Implied Consent Act. The scientific laboratory division shall conduct blood/breath tests for alcohol and other chemical substances collected pursuant to the New Mexico Implied Consent Act and this administrative rule.

[7.33.2.6 NMAC - Rp, 7.33.2.6 NMAC, 04-30-2010]

7.33.2.7 DEFINITIONS:

A. "Adequate operational environment" - An area that has limited exposure to volatile organic compounds, has access restricted to authorized personnel and has been evaluated for radio frequency interference.

B. "Alcohol" - A hydrocarbon molecule that contains a hydroxyl group (oxygen, hydrogen) as its primary functional group.

C. "Blood" - Whole blood which contains the cellular components and the serum or plasma of blood or hemolyzed blood.

D. "Blood alcohol concentration (BAC)" - The concentration of alcohol in blood; the unit of measurement of alcohol in blood is the number of grams of alcohol per 100 milliliters of blood.

E. "Breath" - That portion of exhaled lung air that is collected for alcohol analysis.

F. "Breath alcohol concentration (BrAC)" - The concentration of alcohol in breath; the unit of measurement is the number of grams of alcohol per 210 liters of breath.

G. "Breath alcohol instrument" - Any evidential breath testing device that is capable of analyzing breath to establish the concentration of alcohol contained in a breath sample. Such instruments must be approved and individually certified by SLD for use in testing pursuant to the Implied Consent Act and this rule.

H. "Breath alcohol instrument modification" - Any alteration, variation or redesign of any part, device or electronic circuit that directly affects, alters, varies or changes the analytical or operational section of the equipment.

I. "Calibration check" - The analysis of an externally delivered, controlled, ethanol vapor specimen of known alcohol concentration. SLD shall determine the breath alcohol simulator solutions or gases to be used.

J. "Director" - The director of SLD.

K. "Drug" - Any chemical agent that affects living processes and has the potential to impair those processes.

L. "Equipment" - Devices which are not a component of the breath alcohol instrument but assist in meeting the requirements of an evidentiary breath test, including but not limited to simulators, gas tanks, gas brackets, and reference standards.

M. "Fixed location" - A location inside a building or breath testing mobile command center which is the primary or sole site for a breath alcohol instrument.

N. "Foreign substance" - Material not commonly found in the human mouth; it does not include dental appliances, dental adhesives, orthodontics or orthotics.

O. "Certified key operator" - An individual who has successfully completed the course for a certified operator and who has successfully completed a key operator class conducted by SLD.

P. "Certified operator" - A person who has successfully completed a breath alcohol operator class conducted by a representative of SLD or a SLD certified instructor and who qualifies to conduct implied consent breath alcohol tests.

Q. "Inspection" - A thorough examination and testing of a breath alcohol instrument by trained personnel to evaluate its accuracy and compliance with this SLD rule.

R. "Operator instructor" - Operator instructors train, test, and grade breath operators in the use of breath alcohol instruments.

S. "Portable instrument" - A breath alcohol instrument intended for use inside or outside buildings, including mobile applications (e.g. in vehicles).

T. "Preservative" - Any chemical that inhibits the development of microbial growth in a collected blood sample.

U. "Proficiency" - A solution of unknown alcohol concentration in blood or water used to evaluate the competency of an analyst or key operator conducting a chemical test and to assure the accuracy and precision of the instrument in reference to the target value(s).

V. "Sample" - A quantity of a subject's blood or exhaled breath to be analyzed for the presence of alcohol or other drugs or both pursuant to the New Mexico Implied Consent Act.

W. "Supplies" - Items that are used in the process of administering a breath or blood test but do not impact the test results, including but not limited to mouthpieces, and printer paper.

X. "Scientific laboratory division (SLD)" - A division of the department of health.

Y. "System blank" - A reference sample such as ambient air or distilled water containing no analyte of interest used to verify a negative test result for the purpose of testing blood or breath instruments.

Z. "Test" - In the case of blood, "test" means the analysis of a blood sample for alcohol or other chemical substances or both. In the case of breath, "test" means the analysis of breath samples for alcohol or other chemical substances or both.

[7.33.2.7 NMAC - Rp, 7.33.2.7 NMAC, 04-30-2010]

7.33.2.8 LABORATORIES:

A. Initial certification. Any laboratory seeking certified status for alcohol or drug testing in blood shall submit a request in writing to the director of SLD. Applicants shall furnish the materials listed below to the director of SLD for review and approval. SLD

shall review the materials and inspect the location of the applicant laboratory within 60 days of receipt. SLD shall issue a certificate to any laboratory that meets the standards and successfully completes the required proficiency testing requirements.

(1) Laboratories seeking SLD certification for blood alcohol analysis shall submit:

(a) written documentation of the scientific training and experience in toxicology or clinical/analytical chemistry of its director and all personnel who will perform tests;

(b) written copies of the analytical methods, techniques and equipment it proposes to use;

(c) a proposed set of quality control/ assurance measures;

(d) results of all required proficiency tests;

(e) evidence that the lab has adequate space, equipment and materials to perform blood alcohol analysis.

(2) Laboratories seeking SLD certification for drug analysis in blood shall submit:

(a) written documentation of the scientific training and experience in toxicology or clinical/analytical chemistry of its director and all personnel who will perform tests;

(b) written copies of the analytical methods, techniques and equipment it proposes to use;

(c) a proposed set of quality control/ assurance measures;

(d) results of all required proficiency tests;

(e) evidence that the lab has adequate space, equipment and materials to perform drug testing on blood.

(f) proof of accreditation by the American board of forensic toxicology (ABFT) in forensic toxicology or by the American society of crime lab directors /laboratory accreditation board (ASCLD/LAB) in the field of forensic science testing in the discipline of toxicology in the category of testing of blood/urine drug testing, or the current accrediting body.

B. Continuing responsibilities of laboratories.

(1) Each SLD-certified laboratory shall adhere to an SLD-approved written standard operating procedure and shall maintain evidence of its compliance.

(2) Each SLD-certified laboratory shall be subject to inspection by authorized personnel of SLD prior to certification and may be re-inspected at any time during the period for which certification was granted.

(3) SLD-certified laboratories are required to submit to the director of SLD any changes in their analytical personnel, analytical methodology or analytical equipment for approval a minimum of 20 days prior to commencing analysis with the new personnel, methodology or equipment.

(4) SLD-certified laboratories shall maintain records containing all pertinent facts relating to analyses performed for a minimum period of five years. All records shall be sufficiently complete as to allow verification by an independent chemist, unaffiliated with the SLD-certified laboratory. Such records shall be open to inspection by authorized personnel of SLD.

(5) SLD certified laboratories shall submit to SLD copies of all results of tests for alcohol or other drugs within 30 days of the completion of the blood analysis. The name of the scientist responsible for reviewing the test data and determining the final result shall be provided on the report.

(6) All SLD-certified laboratories shall establish and maintain adequate SLD-approved quality control measures and shall maintain complete records of their quality control programs. These records shall be available for inspection by SLD personnel upon demand and shall be maintained for a minimum period of five years.

(7) Those laboratories certified in drug testing shall maintain their ABFT or ASCLD/LAB accreditation or accreditation from the current accrediting body with required proficiencies.

(8) Proficiency testing.

(a) SLD shall require that each laboratory certified for blood alcohol testing complete the analysis of a minimum of eight samples each year. These tests include proficiencies issued by SLD as well as proficiencies issued by other certifying agencies. In the case of proficiency samples provided by SLD, certified laboratories must return test results within ten days of their receipt. Performance is considered satisfactory if the results of all analyses in a single year fall within acceptable limits based on considerations that include, but are not limited to, the subject analytes and the sample matrix. Acceptable limits for alcohol proficiencies for blood samples are:

(i) ± 10 percent of the alcohol content of the specimen if the known alcohol content is 0.10 grams per 100 milliliters or more;

(ii) ± 0.01 grams per 100 milliliters if the known alcohol content is less than 0.10 grams per 100 milliliters.

(b) Drug proficiency testing shall be in accordance with accrediting agency standards.

C. Recertification. SLD certified laboratories may be certified for a period not to exceed one year to conduct blood tests subject to the following standards, procedures, conditions and on-site inspections:

(1) all laboratory certifications shall expire annually on June 30;

(2) SLD certified laboratories must apply for renewal of certification annually; all applications must be received at least 60 days prior to the expiration date of the laboratory's certification;

(3) applications for renewal of certification shall include the following:

(a) the same information regarding personnel, techniques and equipment as described in Subsection A of this section;

(b) results of all proficiency tests performed in the previous year including SLD proficiencies as well as proficiencies issued by other certifying agencies;

(4) continued certification of a laboratory shall depend on compliance with approved methods, qualified staff and facilities, and satisfactory performance in the proficiency testing.

D. Denial, suspension, and revocation.

(1) SLD may refuse to certify or may suspend or revoke the certification of any SLD-certified laboratory for any one or more of the following causes:

(a) failure to comply with any of the previously stated requirements for certification in Subsection A of this section;

(b) fraud or deceit in applying for or obtaining the certification or renewal thereof;

(c) loss of professional certification or affiliation of staff;

(d) loss of required accreditation of lab;

(e) any serious or repeated violation of any rule of SLD;

(f) any major violation of the standards for laboratories, facilities, personnel or equipment relevant to the testing procedures that are the subject of this rule;

(g) for good cause, including but not limited to perjury, fraud or incompetence;

(h) failure to perform analyses and proficiency testing in a satisfactory manner as specified by SLD.

(2) SLD shall provide notice to the laboratory of any proposed adverse action.

(3) Any laboratory seeking review of unsatisfactory proficiency test results may request a stay of suspension or revocation for good cause. The request must be in writing to the director of SLD.

(4) Any laboratory that has had their SLD certification denied, revoked or suspended may request a hearing pursuant to Subsection F of 7.33.2.18 NMAC.

(5) Any laboratory that has had their SLD certification revoked may not re-apply for a minimum of one year after the notice of final action or after the completion of any requested hearing whichever is later.

(6) Any laboratory denied certification or renewal of certification may not re-apply for certification until 90 days after the completion of any requested hearing or 90 days after the notice of final action, whichever is later. Subsequent denials will require that six months, not 90 days, elapse prior to re-application.

[7.33.2.8 NMAC - Rp, 7.33.2.9 NMAC & 7.33.2.16 NMAC, 04-30-2010]

7.33.2.9 SELECTION AND EVALUATION OF BREATH ALCOHOL INSTRUMENTS AND ASSOCIATED EQUIPMENT:

SLD shall select the primary breath alcohol instrument for use by law enforcement agencies in New Mexico. Selection shall be based on, but not be limited to, performance of the instrumentation in each section of SLD's evaluation process, the field history of the instrumentation, the manufacturer’s support capability, and evaluations by other users of the instruments, including approval by the national highway traffic safety administration (NHTSA).

A. All manufacturers of breath alcohol instruments, wet-bath simulators, and reference standards for breath alcohol instruments seeking to introduce their instruments and equipment to law enforcement agencies in New Mexico for the purpose of implied consent evidential testing shall first submit their instrumentation and equipment to SLD for approval.

B. SLD will evaluate these instruments per SLD policy.

C. Manufacturers must also designate at least one representative knowledgeable in the technology and electronic configurations of the breath alcohol instrument to provide training to SLD personnel.

D. Manufacturers must provide all information concerning any modifications, changes or upgrades to SLD-approved breath alcohol instruments within two months of the modifications, changes or upgrades. SLD will evaluate the modifications, changes or upgrades and determine if they substantially affect the operation of the instruments and whether the instrument alterations require that the instruments be reevaluated.

E. All analytical results shall be reported as grams of alcohol per 210 liters of breath (g per 210L). These results shall be reported to two decimal places except in the case of standards and proficiency samples, which shall be reported to three decimal places.

F. Failure to comply with these or any subsequent manufacturer related rules may result in the withdrawal of approval for the manufacturers breath alcohol instruments to be utilized in testing under the New Mexico Implied Consent Act.

G. SLD reserves the right to withdraw the approval of any breath alcohol instrument and equipment if the manufacturer fails to comply with the provisions of the approval criteria or the terms of any contracts with SLD.

H. SLD reserves the right to make recommendations for equipment and supplies for breath alcohol instruments for use by law enforcement agencies in New Mexico based on, but not limited to, performance , manufacturer recommendations of the breath alcohol instrument, the field history, and evaluations by SLD and other users of the instruments.

[7.33.2.9 NMAC - Rp, 7.33.2.18 NMAC, 04-30-2010]

7.33.2.10 BREATH ALCOHOL INSTRUMENTS USED BY LAW ENFORCEMENT AGENCIES:

A. Initial certification. Any breath alcohol instrument to be used for implied consent evidential testing must be approved and certified by SLD. Certification for breath alcohol instruments shall be for a period of up to one year, expiring September 30. A certificate shall be issued for each instrument and shall be maintained by the responsible agency. Instruments requiring initial certification must meet all of the following criteria and such criteria must be met before placement and use of the instrument in the field.

(1) SLD shall inspect and perform a calibration check. This check may take place at SLD.

(2) At least one certified key operator shall be responsible for the maintenance of each breath alcohol instrument. The key operator is not required to be a member of the agency in which the instrument is placed.

B. Continuing responsibilities.

(1) Instruments.

(a) Copies of the logbook forms should be submitted to SLD no later than the 10th day of the following month. Electronic records pertaining to all tests administered on the instrument(s) will be transmitted as scheduled by SLD.

(b) Four proficiency samples should be analyzed yearly on each such certified instrument.

(c) A calibration check on the instrument(s) shall be conducted at least once every seven calendar days or a 0.08 calibration check shall be conducted with each subject test or both.

(d) All breath alcohol instruments shall be returned to SLD twice annually for inspection. Such inspection shall consist of, but not be limited to:

(i) establishing the current status of the breath alcohol instrument;

(ii) evaluating the breath alcohol instrument's electronic functions and settings;

(iii) analyzing a series of controlled ethyl alcohol solutions with an accuracy requirement of ± 5 percent or .005, whichever is greater, on all target values;

(iv) installing all updates, modifications, or changes that have been approved by SLD;

(v) reviewing the breath alcohol instrument's sensitivity for the detection of any interfering substances.

(2) Instrument location.

(a) All agencies maintaining a breath alcohol instrument in a fixed location shall furnish each instrument with an adequate operational environment.

(b) An adequate operational environment for the breath alcohol instrument shall:

(i) have adequate ventilation to minimize volatile organic compounds;

(ii) restrict access to the instrument to only authorized personnel;

(iii) be evaluated for radio frequency interference.

(c) A breath alcohol instrument assigned to a fixed location may be used as a portable breath alcohol instrument if the option is available. Transitions for instruments between portable and fixed shall be recorded in the logbook.

(d) Any portable, certified breath alcohol instrument is approved for use anywhere in the state of New Mexico.

C. Recertification of instruments.

(1) Certification is renewed annually based on compliance with this rule.

(2) A certificate shall be issued for each instrument and shall be maintained by the responsible agency.

D. Denial, suspension, and revocation.

(1) SLD may refuse to certify or may suspend or revoke the certification of any breath alcohol instrument for implied consent testing for any one or more of the following causes:

(a) the instrument in use is not on the list of SLD approved testing instruments;

(b) calibration results do not meet SLD established criteria;

(c) if an agency fails to identify and maintain a certified key operator for each breath alcohol instrument, certification of the instrument shall be suspended or revoked;

(d) other failures to abide by this rule may also result in suspension or revocation.

(2) SLD shall provide notice to an agency before taking an adverse action with regard to the certification of the agency's instrument.

(3) Agencies seeking review of a denial, suspension or revocation of the instrument's certification may request a stay of suspension or revocation for good cause. The request must be in writing and in accordance with Subsection B of 7.33.2.18 NMAC.

(4) Agencies seeking review of any denial, suspension or revocation of an instrument's certification may request a review in writing pursuant to Subsection B of 7.33.2.18 NMAC.

E. Repair of instruments. SLD is not required to support or service any breath alcohol instruments that are not owned by SLD. Law enforcement agencies shall be required to pay for any repairs or adjustments of an SLD owned instrument caused as a

result of any negligence, incompetence or misconduct in the operation or handling of the instrument as determined by SLD review.

[7.33.2.10 NMAC - Rp, 7.33.2.8 NMAC, 7.33.2.11 NMAC, 7.33.2.16 NMAC and 7.33.2.17 NMAC, 04-30-2010]

7.33.2.11 OPERATORS OF BREATH ALCOHOL TESTING EQUIPMENT:

A. Initial certification. Certification shall be granted for up to two years and shall expire on the last day of the month issued. SLD shall provide training for operator applicants at SLD or other facilities in Albuquerque. SLD may authorize training classes in other areas of the state.

(1) Qualified applicants for implied consent testing must:

(a) be a salaried peace officer commissioned in New Mexico or an employee of a detention facility in New Mexico; or

(b) be a reserve peace officer commissioned in New Mexico.

(2) Accepted applicants who are not commissioned peace officers or detention employees will be given a certificate of completion and are not authorized to conduct implied consent testing.

(3) SLD approved training shall meet the following requirements:

(a) the training shall be provided by representatives of SLD or SLD-certified operator instructors; the training formulated or approved by SLD must include:

(i) the value and purpose of blood and breath alcohol testing;

(ii) the effects of alcohol on the human body and its performance;

(iii) the methods of alcohol analysis and the theory of breath testing;

(iv) breath alcohol instruments and the procedures for breath testing;

(v) practical experience and demonstration of competency;

(vi) New Mexico Implied Consent Act, this rule and any amendments or revisions and court testimony;

(b) applicants must demonstrate competency by passing comprehensive practical and written examinations; these examinations will be formulated or approved by SLD and shall be graded by representatives of SLD or SLD-certified operator instructors.

(4) Certified operators of an SLD approved model of breath alcohol instrument may be certified to operate additional SLD-approved breath alcohol instruments by demonstrating competency with the successful completion of training conducted by representatives of SLD or SLD-certified operator instructors. This training shall follow a course of instruction outlined or approved by SLD as well as written and practical examinations formulated or approved by SLD.

B. Recertification.

(1) Applications for renewal shall show:

(a) the applicant has successfully completed an operator certification or recertification training formulated or approved by SLD within the previous 27 months;

(b) demonstration of competency by successful completion of recertification training formulated or approved by SLD and conducted by representatives of SLD or SLD-certified operator instructors; this training shall include a written as well as a practical, examinations formulated or approved by SLD.

(2) Candidates for renewal who do not satisfy the requirements must attend and successfully complete the initial certification class, as stated in Subsection A of 7.33.2.11 NMAC above.

(3) If the certification of an operator is due to expire before the certification is renewed, the operator may request an extension from SLD for good cause. This request must be received by SLD before certification is due to expire. Extension of certification shall be within the discretion of SLD based on good cause having been shown and shall be for a period of not more than 60 days. Certification shall be deemed to have expired at the end of the extension period if the renewal requirements have not been completed satisfactorily.

C. Denial, suspension, and revocation.

(1) Certification may be denied for inadequate scores or failure to complete any performance tests or examinations in the manner prescribed by SLD; or for any of the reasons set out in Paragraph (2) of this subsection below.

(2) SLD may suspend or revoke certification of any SLD-certified operator for one or more of the following causes:

(a) fraud or deceit in applying for or obtaining the certification or renewal thereof;

(b) loss of professional certification or affiliation;

(c) any serious or repeated violation of any rule or rules of SLD;

(d) any major violation of the standards for personnel or equipment relevant to the testing procedures that are the subject of this rule;

(e) for good cause, including but not limited to perjury, fraud or incompetence;

(f) as required by New Mexico Parental Responsibility Act (Section 40-5A-1- et. seq. NMSA 1978).

(3) SLD shall provide notice of any proposed adverse action to the officer and the agency chief.

(4) A written request to stay suspension or revocation for good cause may be made by any operator who is unable to carry out his/her specific duties. The request must be made in accordance with Subsection B of 7.33.2.18 NMAC.

(5) If any operator is denied certification or renewal of certification, they may re-apply for certification 90 days after the denial or final decision of the record review. Subsequent denials will require that six months elapse prior to re-application.

(6) If any operator has had their SLD certification revoked, they may not re-apply for a minimum of one year after the denial or final decision of the record review.

[7.33.2.11 NMAC - Rp, 7.33.2.13 NMAC and 7.33.2.16 NMAC, 04-30-2010]

7.33.2.12 KEY OPERATORS OF BREATH ALCOHOL TESTING EQUIPMENT:

A. Initial certification. Certification shall be up to one year.

(1) Qualified applicants must have:

(a) status as a certified operator, or hold an operator certificate of completion for the instrument(s) on which they seek to be certified as a key operator; AND

(b) status as a salaried employee of a law enforcement agency or detention facility in New Mexico; OR

(c) SLD may certify as key operators, SLD-selected individuals of law enforcement agencies or corrections departments in New Mexico who successfully complete written and practical examinations formulated and administered by SLD.

(2) Required training.

(a) Training by SLD representatives shall consist of the following:

(i) the theory of breath testing;

(ii) the operational and theoretical principles of the selected breath testing instruments;

(iii) the preparation and use of a simulator;

(iv) calibration checks of selected breath alcohol instrument(s);

(v) quality control measures and proficiency testing;

(vi) minor maintenance and repair of breath alcohol testing equipment;

(vii) the New Mexico Implied Consent Act, this rule and any amendments or revisions and their application to court testimony on the operation and certification of the selected breath alcohol instruments;

(viii) laboratory practice and the demonstration of competency on the applicable equipment;

(ix) introduction to radio frequency interference (RFI) and how to prepare a RFI report.

(b) Demonstration of competency by successful completion of comprehensive practical and written examinations administered by SLD.

(3) Key operator certification shall be limited to the model of instruments upon which the key operator has been trained and examined or models considered equivalent by SLD.

(4) Certified key operators of a SLD approved model of breath alcohol instrument may be certified to operate additional SLD-approved breath alcohol instrument(s) by demonstrating competency with the successful completion of training conducted by representatives of SLD. This training shall include written as well as and practical examinations formulated by SLD.

B. Continuing responsibilities. Certified key operators shall be responsible for:

(1) the calibration checks of the instruments they oversee, maintenance of those instruments and their supplies;

(2) successful completion of the proficiency testing specified in this rule:

(a) solutions for proficiency testing of each certified key operator shall be issued at least four times every year by SLD;

(b) a minimum of one solution must be analyzed by each certified key operator within 30 days of receipt of the solutions; results on the proficiency report form provided by SLD must be received by SLD within 10 working days thereafter;

(c) the average of the proficiency test results must be within ± 10% of target value; if the target value is less than 0.100 g/210L, then the results must be within ± 0.010 g/210L;

(3) insuring that the records and notifications specified in training are submitted as required by SLD rules;

(4) at least monthly submission to SLD of all logbook copies no later than the 10th day of the following month; electronic records pertaining to all tests administered on the instrument(s) will be transmitted as scheduled by SLD.

C. Recertification. Key operators shall be certified for a period of up to one year. All key operator certifications shall expire annually on March 31.

(1) Certifications may be renewed based on a demonstration of competency which may include successful completion of a refresher class as specified by SLD.

(2) If the certification of a key operator is due to expire before the certification is renewed, the key operator may request an extension of certification. This request must be received by SLD before certification is due to expire. Extension of certification shall be within the discretion of SLD based on good cause having been shown and shall be for a period of not more than 60 days. Extensions shall not be granted for more than a total of 60 consecutive days. Certification shall be deemed to have expired at the end of the extension period if the renewal requirements have not been completed satisfactorily. New certification may be obtained by successfully completing the initial certification process as set out in Subsection A of 7.33.2.12 NMAC above.

D. Denial, suspension, or revocation.

(1) Certification may be denied for inadequate scores; or failure to complete any performance tests; or examinations in the manner prescribed by SLD; or for any of the reasons set out in Paragraph (2) of this subsection.

(2) SLD may refuse to certify or may suspend or revoke certification of any SLD-certified key operator for one or more of the following causes:

(a) fraud or deceit in applying for or obtaining the certification or renewal thereof;

(b) loss of professional certification or affiliation;

(c) any serious or repeated violation of this rule;

(d) any major violation of the standards for personnel or equipment relevant to the testing procedures that are the subject of this rule;

(e) for good cause, including but not limited to perjury, fraud or incompetence;

(f) failure to perform analyses and proficiency testing in a satisfactory manner as specified by SLD;

(g) as required by New Mexico Parental Responsibility Act (Section 40-5A-1- et. seq. NMSA 1978).

(3) SLD shall provide notice of a proposed adverse action to the key operator and the head of the agency maintaining the instrument for which the key operator is responsible.

(4) A written request to stay suspension or revocation for good cause may be made by any key operator who is unable to carry out his/her specific duties. The request must be made in accordance with Subsection B of 7.33.2.18 NMAC.

(5) If any key operator is denied certification or renewal of certification, they may re-apply for certification 90 days after the denial or final decision of the record review. Subsequent denials will require that six months elapse prior to re-application.

(6) If any key operator has had their SLD certification revoked, they may not re-apply for a minimum of one year after the denial or final decision of the record review.

[7.33.2.12 NMAC - Rp, 7.33.2.14 NMAC and 7.33.2.16 NMAC, 04-30-2010]

7.33.2.13 OPERATOR INSTRUCTORS OF BREATH ALCOHOL TESTING EQUIPMENT:

A. Designation as operator instructors. Qualified employees of SLD shall be designated as operator instructors, as determined by the director.

B. Initial certification. Persons not employed by SLD shall be certified for up to one year and certification shall expire on December 31.

(1) Applicants shall demonstrate the following qualifications:

(a) current certification as an operator and key operator of the applicable breath testing equipment;

(b) at least 12 semester hours in which the applicant received a grade of C (or satisfactory) or higher in any combination of the following disciplines: chemistry, biology, physics, or mathematics from an accredited university or college; at least four of those 12 semester hours must be in chemistry;

(c) a minimum of 32 hours of instruction in areas relating to blood/breath collection and analysis, to include the following:

(i) the value and purpose of blood and breath alcohol analysis;

(ii) the effects of alcohol on the human body;

(iii) the instruments and procedures for alcohol analysis;

(iv) the interpretation of the results of alcohol analysis;

(v) the New Mexico Implied Consent Act, this rule and any amendments or revisions and court testimony;

(vi) the methods of alcohol analysis;

(vii) the operational principles of the selected breath alcohol instruments;

(viii) practical experience and demonstration of competency in use of blood/breath collection and analyses;

(d) as an alternative to completing the above course of instruction as listed in Subparagraph (c) of Paragraph (1) of Subsection B of this section, an operator instructor may be certified if he/she has earned a bachelor's degree in chemistry, biology or a related science from an accredited university or college and he/she demonstrates equivalent knowledge by successfully completing written and practical examinations formulated or approved by SLD.

(2) Comprehensive practical and written examinations shall be successfully completed by all applicants prior to certification. These examinations shall be administered by SLD.

C. Continuing responsibilities.

(1) Operator instructors not employed by SLD must maintain their certification as operators and key operators.

(2) Requirements for conducting an operator class:

(a) a certified operator instructor should notify SLD in writing at least 10 working days in advance of the date, time and location of all training and examinations to be conducted; in case of emergency or unforeseen circumstances, the date, time, or location of such training or examinations may be changed if SLD is notified at least 24 hours before such a change is made;

(b) all operator training classes conducted by a certified operator instructor shall follow a course of instruction outlined or approved by SLD;

(c) tests must be outlined or approved by SLD for each type of breath alcohol instrument covered in the training;

(d) all students of the operator instructor must take and pass examinations designed or approved by SLD prior to certification;

(e) maintain records of the classes he or she has conducted for at least the previous three years; these records shall include but not be limited to the dates, times, locations and attendees of such classes; SLD may inspect the operator instructor's records concerning the courses taught by the instructor;

(f) allow representatives of SLD to observe any training sessions and examinations;

(g) forward all copies of the graded examinations to SLD within one month of class date with a written statement by the instructor that he or she has conducted the class in compliance with the requirements of this rule;

(h) notify an applicant’s supervisor in writing if the candidate did not successfully complete the course; a copy of the letter shall be submitted to SLD.

(3) SLD instructors shall not release copies of any examinations to anyone other than applicants and approved certified instructors in order to protect the integrity of the training process and to insure that applicants for certification are tested on their knowledge of the materials presented. Applicants shall be required to return all copies of the tests they may have received at the end of the testing session.

(4) Operator instructors must conduct at least one operator class per certification year.

D. Recertification: operator instructors are certified for a period of up to one year.

(1) Certifications may be renewed based upon adequate performance of continuing responsibility requirements, a demonstration of competency, or successful completion of a refresher class as specified by SLD.

(2) If the certification of an operator instructor is due to expire before the certification is renewed, the operator instructor may request an extension of certification from SLD. This request must be received by SLD no later than five working days before certification is due to expire. Extension of certification shall be within the discretion of SLD based on good cause having been shown and shall be for a period of not more than 60 days. Certification shall be deemed to have expired at the end of the extension period if the renewal requirements have not been completed satisfactorily.

E. Suspension, revocation or denial.

(1) Certification may be denied for inadequate scores or failure to complete any performance tests or examinations in the manner prescribed by SLD or for any of the reasons set out in Paragraph (2) of Subsection E of 7.33.2.13 NMAC below.

(2) SLD may refuse to certify or may suspend or revoke the certification of any operator instructor for any one or more of the following causes:

(a) fraud or deceit in applying for or obtaining the certification or renewal thereof;

(b) loss of professional certification or affiliation;

(c) any serious or repeated violation of any rule or rule of SLD;

(d) failure to conduct classes in accordance with the rules and standards of SLD;

(e) for good cause, including but not limited to perjury, fraud or incompetence;

(f) as required by New Mexico Parental Responsibility Act (Section 40-5A-1- et. seq. NMSA 1978);

(g) failure to maintain certification as an operator and key operator;

(h) failure to demonstrate knowledge as established by SLD to be an operator instructor.

(3) SLD shall provide notice of any proposed adverse action to the instructor and the agency chief.

(4) An operator instructor may request a stay of suspension or revocation for good cause. The request must be in writing and in accordance with Subsection of B of 7.33.2.18 NMAC.

(5) If any operator instructor is denied certification or renewal of certification, they may re-apply for certification 90 days after the denial or final decision of the record review. Subsequent denials will require that six months elapse prior to re-application.

(6) If any operator instructor has had their SLD certification revoked, they may not re-apply for a minimum of one year after the denial or final decision of the record review.

[7.33.2.13 NMAC - Rp, 7.33.2.15 NMAC and 7.33.2.16 NMAC, 04-30-2010]

7.33.2.14 METHODS OF ANALYSIS:

A. Alcohol in blood.

(1) All analytical methods and any modifications of approved analytical methods must be approved in advance by SLD.

(2) The method used shall be capable of analyzing reference samples of known alcohol concentration with accuracy limits of ± 10% of the actual blood alcohol concentration if the known alcohol concentration is 0.10 grams per 100 milliliters or more and ± 0.01 grams per 100 milliliters if the known concentration is less than 0.10 grams per 100 milliliters. The method shall also be capable of analyzing reference samples of known alcohol concentration within specificity and precision limits that will be established and reviewed by SLD.

(3) All analytical results shall be expressed in terms of the alcohol concentration in blood, based on the number of grams of alcohol per 100 milliliters of blood. These results shall be reported to two decimal places except for analyses of standards, controls and proficiency samples, which shall be reported to three decimal places.

B. Drugs in blood.

(1) All analytical methods and any modifications of approved analytical methods must be approved in advance by SLD.

(2) The results of positive tests for drugs other than alcohol shall not be reported until they are confirmed. Confirmation tests must employ an approved method that is different than the one utilized to achieve the initial result unless the confirmation test method has been approved for that use by SLD.

(3) Accuracy limits for the reference samples and proficiencies shall be in accordance with the approved methods for the particular analysis as determined by the accrediting agency.

C. Alcohol in breath samples.

(1) Breath samples shall be collected by certified operators or certified key operators on instruments certified by SLD.

(2) The minimum requirements for an evidential breath sample for implied consent testing are:

(a) a system blank analysis shall be used preceding each breath sample;

(b) a calibration check using SLD approved solutions and/or gases shall be performed in accordance with the following:

(i) the instrument shall be maintained and calibration checked by the key operator; calibration checks shall be made a minimum of once every seven days; these calibration checks shall consist of checking the instrument with two breath alcohol solutions or gases, one of which shall simulate 0.08 grams per 210 liters BrAC and the other shall simulate a BrAC of greater than 0.15 grams per 210 liters BrAC; satisfactory calibration results must be within ± 10 percent of the listed values for a BrAC of 0.10 grams per 210 liters and above or ±0.01 for a BrAC below 0.10 grams per 210 liters; or

(ii) a single calibration check using solutions or gases which simulate 0.08 grams per 210 liters shall be performed with each subject test; satisfactory calibration check results must be within ± 0.01; these test results shall be valid for the purpose of determining if the subject test is 0.08 grams per 210 liters or more; or

(iii) both Items (i) and (ii) of this subparagraph.

(3) The minimum requirements for a non-implied consent test are:

(a) a system blank preceding each breath sample;

(b) a system blank after each breath sample.

(4) All analytical results shall be reported as grams of alcohol per 210 liters of breath (g /210L). These results shall be reported to two decimal places except in the case of standards and proficiency samples, which shall be reported to three decimal places.

(5) A chronological log book shall be kept for each instrument to show calibration checks, maintenance, analyses performed, results and identities of the subjects tested, as well as the identities of the persons performing analyses. These records shall be kept on forms provided by SLD. Copies of these records shall be submitted to SLD each month as per Paragraph (4) of Subsection B of 7.33.2.12 NMAC above.

[7.33.2.14 NMAC - Rp, 7.33.2.10 NMAC, 04-30-2010]

7.33.2.15 APPROVED METHODS FOR SAMPLE COLLECTION, ANALYSIS, AND RETENTION:

A. Blood sample collection.

(1) Blood samples shall be collected in the presence of the arresting officer or other responsible person who can authenticate the samples. Blood samples shall be collected by veni-puncture as authorized by the New Mexico Implied Consent Act

NMSA 1978, Sections 66-8-105 et. seq. The term laboratory technician shall include phlebotomists.

(2) The initial blood samples should be collected within three hours of arrest. Any blood samples collected subsequent to the initial blood or breath sample collection should be collected within 60 minutes of the initial sample collection.

(3) Ethyl alcohol shall not be used as a skin antiseptic in the course of collecting blood samples. The samples shall be dispensed or collected using an SLD-approved blood collection kit. SLD-approved blood collection kit will contain two or more sterile tubes with sufficient sodium fluoride so that the final concentration shall contain not less than 1.0 percent sodium fluoride. In the case of an insufficient sample, it shall be permissible to collect the sample in one tube only.

(4) The blood samples shall be delivered to SLD or a laboratory certified by SLD to conduct tests for alcohol or other drug content. At the laboratory, the seal shall be broken on one tube and the blood shall be analyzed. If necessary it shall be permissible to open more than one sample tube.

(5) The samples of blood shall be retained by the laboratory which performed the initial alcohol or drug testing for a period of not less than six months. Any interested party may request the laboratory retain the samples longer than 6 months. The request must be made in writing and include: the name of the donor of the sample; the date of arrest; the arresting agency; the county of arrest and; if available, any laboratory identification numbers.

(6) Retained samples shall be made available upon receipt of a court order directing the laboratory to release a portion of the remaining sample to a testing facility specified by the requesting party. The laboratory which performed the initial alcohol or drug testing is not responsible for the transport of the retained samples.

B. Breath sample collection.

(1) Samples of the subject's breath shall be collected and analyzed pursuant to the procedures prescribed by SLD and employing only SLD approved equipment and certified instruments.

(2) Breath samples shall be collected and analyzed by certified operators or certified key operators and shall be end expiratory in composition. The breath test operator should make a good faith attempt to collect and analyze at least two samples of breath. Breath shall be collected only after the certified operator or certified key operator has ascertained that the subject has not had anything to eat, drink or smoke for at least 20 minutes prior to collection of the first breath sample. If during this time the subject eats, drinks or smokes anything, another 20 minute deprivation period must be initiated. The two breath samples shall be taken not more than 15 minutes apart. If the difference in the results of the two samples exceeds 0.02 grams per 210 liters (BrAC), a

third sample of breath or blood shall be collected and analyzed. If the subject declines or is physically incapable of consent for the second or third samples, it shall be permissible to analyze fewer samples.

[7.33.2.15 NMAC - Rp, 7.33.2.12 NMAC, 04-30-2010]

7.33.2.16 SLD LISTS:

SLD will maintain lists of the following:

A. all certified laboratories;

B. breath alcohol instruments and equipment that have been approved by SLD for use under the New Mexico Implied Consent Act;

C. approved evidential blood collection devices to ensure the quality of test results.

[7.33.2.16 NMAC - Rp, 7.33.2.19 NMAC and 7.33.2.11 NMAC, 04-30-2010]

7.33.2.17 FEES:

For the most current fee list visit the SLD website. SLD reserves the right to charge reasonable fees for the following:

A. replacement or duplicate operator certification credentials;

B. replacement or duplicate key operator certification credentials;

C. replacement or duplicate operator instructor certification credentials.

[7.33.2.17 NMAC - Rp, 7.33.2.13 NMAC and 7.33.2.14 NMAC, 04-30-2010]

7.33.2.18 DENIAL OF CERTIFICATION FOR LABORATORIES, OPERATORS, KEY OPERATORS, OPERATOR INSTRUCTORS AND BREATH ALCOHOL TESTING EQUIPMENT:

A. Record review. All applicants whose certification has been denied, revoked or suspended may request a record review from SLD.

B. Procedure for requesting informal administrative review.

(1) An applicant or certified operator, key operator or operator instructor given notice of a denial, suspension or revocation of their certification or that of their instrument may submit a written request for a record review. To be effective, the written request shall:

(a) be made within 30 calendar days, as determined by the postmark, from the date of the notice of action issued by SLD;

(b) be properly addressed to SLD;

(c) state the applicant's name, address, and telephone numbers;

(d) state the status of the certification as denied, suspended, or revoked;

(e) identify the instrument in question and the agency holding the instrument, if applicable; and

(f) provide a brief narrative rebutting the circumstances of the denial, revocation or suspension.

(2) If the applicant or operator, key operator or operator instructor wishes to submit additional documentation for consideration, such additional documentation must be included with the request for a record review.

C. Record review proceeding. The review proceeding is intended to be an informal non-adversarial administrative review of written documentation. It shall be conducted by an administrative review committee designated for that purpose by SLD. In cases where the administrative review committee finds the need for additional or clarifying information, the review committee shall request that the applicant supply such additional information within the time set forth in the committees' request.

D. Final determination.

(1) Content: the administrative review committee shall render, sign and enter a written decision setting forth the reasons for the decision and the evidence upon which the decision is based.

(2) Effect: the decision of the administrative review committee is the final decision of the informal administrative review proceeding.

(3) Notice: a copy of the decision shall be mailed by registered or certified mail to the applicant/ agency.

E. Judicial review. Judicial review of the administrative review committee's final decision is permitted to the extent provided by law. The party requesting the appeal shall bear the cost of such appeal.

F. Request for hearing and hearing processes and procedure for laboratories.

(1) Any laboratory seeking to contest the denial of certification, denial of recertification, revocation or suspension of certification must request a hearing in writing. The request must be:

(a) addressed to the director of SLD;

(b) signed by the laboratory director;

(c) delivered by hand or mail, return receipt requested; and

(d) received within ten business days after being served with a notice of proposed action by SLD.

(2) SLD will follow the hearing processes and other provisions of 7.1.2.16 NMAC through 7.1.2.43 NMAC as applicable. All references to the "licensing authority" or the "department" in that rule shall be understood and interpreted as references to the department of health and the SLD for purposes of this rule and any hearing relating to the certification of a laboratory by SLD.

[7.33.2.18 NMAC - N, 04-30-2010]

CHAPTER 34: MEDICAL USE OF CANNABIS

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: ADVISORY BOARD RESPONSIBILITIES AND DUTIES

7.34.2.1 ISSUING AGENCY:

New Mexico Department of Health, Medical Cannabis Program.

[7.34.2.1 NMAC - Rp, 7.34.2.1 NMAC, 2/27/2015]

7.34.2.2 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the department of health pursuant to the authority granted under Section 9-7-6 (E) NMSA 1978, and the Lynn and Erin Compassionate Use Act, 26-2B-1 et seq. NMSA 1978.

[7.34.2.2 NMAC - Rp, 7.34.2.2 NMAC, 2/27/2015]

7.34.2.3 SCOPE:

This part governs the membership, duties, responsibilities and public hearing proceedings of the medical cannabis advisory board.

[7.34.2.3 NMAC - Rp, 7.34.2.3 NMAC, 2/27/2015]

7.34.2.4 DURATION:

Permanent.

[7.34.2.4 NMAC - Rp, 7.34.2.4 NMAC, 2/27/2015]

7.34.2.5 EFFECTIVE DATE:

February 27, 2015, unless a later date is cited at the end of a section.

[7.34.2.5 NMAC - Rp, 7.34.2.5 NMAC, 2/27/2015]

7.34.2.6 OBJECTIVE:

The objective of this part is to establish membership, duties, responsibilities, and public hearing procedures that govern the medical cannabis advisory board proceedings.

[7.34.2.6 NMAC - Rp, 7.34.2.6 NMAC, 2/27/2015]

7.34.2.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) "Act" means the Lynn and Erin Compassionate Use Act, Sections 26-2B-1 through 26-2B-10, NMSA 1978.

(2) "Adequate supply" means an amount of cannabis, in a form approved by the department possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver, that is determined by rule of the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months and that is derived solely from an intrastate source.

(3) "Administrative review committee" means an intra-department committee that reviews qualified patient or primary caregiver application denials in accordance with department rules. The administrative review committee shall consist of the chief medical officer of the department (or that's person's designee); a deputy secretary of the department (or that person's designee), and the chief nursing officer of the department (or that person's designee).

(4) "Administrative withdrawal" means the procedure for the voluntary withdrawal of a qualified patient or primary caregiver from the medical cannabis program.

(5) **"Advisory board"** means the medical cannabis advisory board consisting of nine practitioners knowledgeable about the medical use of cannabis, who are appointed by the secretary.

(6) **"Applicant"** means any person applying for enrollment or re-enrollment in the medical cannabis program as a qualified patient or primary caregiver.

B. Definitions beginning with "B": [RESERVED]

C. Definitions beginning with "C":

(1) **"Cannabis"** means

(a) means all parts of the plant Cannabis containing a delta-9-tetrahydrocannabinol concentration of more than three-tenths percent on a dry weight basis, whether growing or not; the seeds of the plant; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin; and

(b) does not include the mature stalks of the plant; fiber produced from the stalks; oil or cake made from the seeds of the plant; any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, fiber, oil or cake; the sterilized seed of the plant that is incapable of germination; the weight of any other ingredient combined with cannabis to prepare topical or oral administrations, food, drink or another product; or hemp;

(2) **"Cannabis-derived product"** or **"cannabis product"** means

(a) means a product that contains cannabis, including edible or topical products that may also contain other ingredients; and

(b) does not include the weight of any other ingredient combined with cannabis or cannabis extract to prepare topical or oral administrations, food, drink or another product.

(3) **"CBD"** means cannabidiol, a cannabinoid and the primary non-psychoactive ingredient found in cannabis.

(4) **"CBDA"** means cannabidiolic acid, a non-psychoactive ingredient found in cannabis and an acid precursor to CBD.

D. Definitions beginning with "D":

(1) "Debilitating medical condition" means:

(a) cancer;

(b) glaucoma;

(c) multiple sclerosis;

(d) damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity;

(e) seizure disorder, including epilepsy;

(f) positive status for human immunodeficiency virus or acquired immune deficiency syndrome;

(g) admitted into hospice care in accordance with rules promulgated by the department;

(h) amyotrophic lateral sclerosis;

(i) Crohn's disease;

(j) hepatitis C infection;

(k) Huntington's disease;

(l) inclusion body myositis;

(m) inflammatory autoimmune-mediated arthritis;

(n) intractable nausea or vomiting;

(o) obstructive sleep apnea;

(p) painful peripheral neuropathy;

(q) Parkinson's disease;

(r) posttraumatic stress disorder;

(s) severe chronic pain;

(t) severe anorexia or cachexia;

(u) spasmodic torticollis;

(v) ulcerative colitis; or

(w) any other medical condition, medical treatment, or disease as approved by the department which results in pain, suffering, or debility for which there is credible evidence that medical use cannabis could be of benefit.

(2) "Department" means the department of health or its agent.

(3) "Diversion" means the unlawful transfer of a cannabis plant, plant material, or cannabis-derived product.

(4) "Dried usable cannabis" means the dried leaves, flowers, and trim of the female cannabis plant, but does not include the seeds, stalks, or roots of the cannabis plant.

(5) "Dry weight basis" means a process by which delta-9-tetrahydrocannabinol concentration is measured relative to the aggregate weight of all parts of the plant genus Cannabis, whether growing or not, including the leaves of the plant, the flowers and buds of the plant, the seeds of the plant, the resin of the plant and the stalks of the plant, at the point of harvest and with no moisture added to the harvested plant.

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F": [RESERVED]

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": "Hemp" means the plant cannabis sativa L. and any part of the plant, whether growing or not, containing a delta-9-tetrahydrocannabinol concentration of no more than three-tenths percent on a dry weight basis;

I. Definitions beginning with "I":

(1) "Intrastate" means existing or occurring within the state boundaries of New Mexico.

(2) "Inversion" means the unlawful acquisition of a cannabis plant, plant material, or cannabis-derived product.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": "Licensee" means any person licensed by the New Mexico cannabis control division pursuant to the Cannabis Regulation Act,

Sections 26-2C-1 through 26-2C-42 NMSA 1978 who is authorized by that license to sell cannabis to qualified patients, primary caregivers, and reciprocal participants.

M. Definitions beginning with "M":

(1) "Medical cannabis program" means the program established pursuant to the Lynn and Erin Compassionate Use Act for authorization and regulation of the medical use of cannabis in the state.

(2) "Medical cannabis program director" means the administrator of the medical cannabis program who holds that title.

(3) "Medical director" means a medical practitioner designated by the department to determine whether the medical condition of an applicant qualifies as a debilitating medical condition eligible for enrollment in the program, and to perform other duties.

(4) "Medical provider certification for patient eligibility form" means a written certification form provided by the medical cannabis program signed by a patient's practitioner that, in the practitioner's professional opinion, the patient has a debilitating medical condition as defined by the act or this part and would be anticipated to benefit from the use of cannabis.

(5) "Minor" means an individual who is less than 18 years of age.

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P":

(1) "Paraphernalia" means any equipment, product, or material of any kind that is primarily intended or designed for use in compounding, converting, processing, preparing, inhaling, or otherwise introducing cannabis or its derivatives into the human body.

(2) "Patient enrollment/re-enrollment form" means the registry identification card application form for patient applicants provided by the medical cannabis program.

(3) "Petitioner" means any New Mexico resident or association of New Mexico residents petitioning the advisory board for the inclusion of a new medical condition, medical treatment, or disease to be added to the list of debilitating medical conditions that qualify for the use of cannabis.

(4) "Practitioner" means a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act, Sections 30-31-1 *et seq.*, NMSA 1978.

(5) "Primary caregiver" means a resident of New Mexico who is at least 18 years of age and who has been designated by the qualified patient or their representative and the patient's practitioner as being necessary to take responsibility for managing the well-being of a qualified patient with respect to the medical use of cannabis pursuant to the provisions of the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq*., NMSA 1978.

(6) "Primary caregiver application form" means the registry identification card application form provided by the medical cannabis program.

Q. Definitions beginning with "Q": "Qualified patient" means a resident of New Mexico who has been diagnosed by a practitioner as having a debilitating medical condition and has received written certification and a registry identification card pursuant to the Lynn and Erin Compassionate Use Act on the basis of having been diagnosed, in person or via telemedicine, by a practitioner as having a debilitating medical condition.

R. Definitions beginning with "R":

(1) "Recall" means to request the return of a product after the discovery of a safety issue or product defect.

(2) "Reciprocal limit" means the quantity of cannabis and cannabis products that a reciprocal participant can use and possess in a given year pursuant to department rule.

(3) "Reciprocal participant" means a person who is not a resident of New Mexico and who holds proof of enrollment by a governmental regulatory authority to participate in the medical cannabis program of another state of the United States, the District of Columbia or a territory or commonwealth of the United States in which the person resides or a person who holds proof of enrollment by a governmental regulatory authority of a New Mexico Indian nation, tribe or pueblo to participate in its medical cannabis program;

(4) "Registry identification card" means a document in printed or electronic form that the department issues:

(a) to a qualified patient that identifies the bearer as a qualified patient and authorizes the qualified patient to use cannabis for a debilitating medical condition; or

(b) to a primary caregiver that identifies the bearer as a primary caregiver authorized to engage in the intrastate possession and administration of cannabis for the sole use of a qualified patient who is identified on the document.

(5) "Representative" means an individual designated as the applicant's or petitioner's agent, guardian, surrogate, or other legally appointed or authorized health care decision maker.

S. Definitions beginning with "S": "Secretary" means the secretary of the New Mexico department of health.

T. Definitions beginning with "T":

(1) "THC" means tetrahydrocannabinol, a substance that is the primary psychoactive ingredient in cannabis.

(2) "Technical evidence" means scientific, clinical, medical, or other specialized testimony, or evidence, but does not include legal argument, general comments, or statements of policy or position concerning matters at issue in the hearing.

(3) "Telemedicine" means the use of telecommunications and information technology to provide clinical health care from a site apart from the site where the patient is located, in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or off-site patient monitoring and telecommunications in order to deliver health care services.

U. Definitions beginning with "U":

(1) "Unit" means a quantity of usable cannabis, concentrate, or cannabis-derived product that is used in identifying the maximum supply that a qualified patient may possess for purposes of department rules.

(2) "Usable cannabis" means the dried leaves and flowers of the female cannabis plant and cannabis-derived products, including concentrates, but does not include the seeds, stalks, or roots of the plant.

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W":

(1) "Wastage" means the destruction of usable cannabis or cannabis plants;

(2) "Written certification" means a statement made on a department-approved form and signed by a patient's practitioner that indicates, in the practitioner's professional opinion, that the patient has a debilitating medical condition and the

practitioner believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the patient.

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z" [RESERVED]

[7.34.2.7 NMAC - Rp, 7.34.2.7 NMAC, 2/27/2015; A, 2/29/2016; A, 8/27/2019; A, 6/23/2020; A, 2/22/2022]

7.34.2.8 ADVISORY BOARD MEMBERSHIP REQUIREMENTS AND RESPONSIBILITIES:

A. Advisory board membership: The advisory board shall consist of nine practitioners knowledgeable about the medical use of cannabis. The members shall be chosen for appointment by the secretary from a list proposed by the New Mexico medical society, the New Mexico nurses association, the New Mexico academy of family physicians, the New Mexico academy of physician assistants, the New Mexico pharmacists association, or the New Mexico Hispanic medical association.

B. Duties and responsibilities: The advisory board shall convene at least twice per year to:

(1) review and recommend to the department for approval additional debilitating medical conditions that would benefit from the medical use of cannabis;

(2) recommend quantities of cannabis that are necessary to constitute an adequate supply for qualified patients and primary caregivers;

(3) accept and review petitions to add medical conditions, medical treatments or diseases to the list of debilitating medical conditions that qualify for the medical use of cannabis and all lawful privileges under the act and implementing rules;

(4) issue recommendations concerning rules to be promulgated for the issuance of registry identification cards; and

(5) review conditions previously reviewed by the board and approved by the secretary for the purpose of determining whether to recommend the revision of eligibility criteria for persons applying under those conditions or to review new medical and scientific evidence pertaining to currently approved conditions.

C. Advisory board membership term: Each member of the advisory board shall serve a term of two years from the date of appointment by the secretary. No member

may be removed prior to the expiration of his or her term without a showing of good cause by the secretary.

D. Chairperson elect: The advisory board shall elect by majority vote cast of the nine member board a chairperson and an alternate. The chairperson or alternate shall exercise all powers and duties prescribed or delegated under the act or this rule.

(1) Public hearing responsibilities: The chairperson shall conduct a fair and impartial proceeding, assure that the facts are fully elicited and avoid delay. The chairperson shall have authority to take all measures necessary for the maintenance of order and for the efficient, fair and impartial resolution of issues arising during the public hearing proceedings or in any public meeting in which a quorum of the advisory board are present.

(2) Delegation of chair: The chairperson may delegate their responsibility to an alternate. The alternate shall exercise all powers and duties prescribed or delegated under the act or this part.

E. Per diem and mileage: All advisory board members appointed under the authority of the act or this part will receive as their sole remuneration for services as a member those amounts authorized under the Per Diem and Mileage Act, Sections 10-8-1 *et seq.*, NMSA 1978.

[7.34.2.8 NMAC - Rp, 7.34.2.8 NMAC, 2/27/2015; A, 8/27/2019]

7.34.2.9 PETITION REQUIREMENTS:

A. Petition requirements. The advisory board may accept and review petitions from any individual or association of individuals requesting the addition of a new medical condition, medical treatment or disease for the purpose of participating in the medical cannabis program and all lawful privileges under the act. Except as otherwise provided, a petitioner filing a petition shall file the petition and a copy with the medical cannabis program staff by either personal delivery or certified mail. In order for a petition to be processed and forwarded to the advisory board the following information shall be submitted to the medical cannabis program staff.

(1) Petition format: Unless otherwise provided by this part or by order of the hearing officer, all documents, except exhibits, shall be prepared on 8 1/2 x 11-inch white paper, printed double-sided, if possible, and where appropriate, the first page of every document shall contain a heading and caption. The petitioner shall include in the petition documents a narrative address to the advisory board, which includes:

(a) petition caption stating the name, address and telephone number of the petitioner and the medical condition, medical treatment or disease sought to be added to the existing debilitating medical conditions;

(b) an index of the contents of the petition, an introductory narrative of the individual or association of individuals requesting the inclusion of a new medical condition, medical treatment or disease to include the individual or association of individuals' relationship or interest for the request whether that interest is professional or as a concerned citizen;

(c) the proposed benefits from the medical use of cannabis specific to the medical condition, medical treatment or disease sought to be added to the existing debilitating medical conditions listed under the act; and

(d) any additional supporting medical, testimonial, or scientific documentation.

(2) Statement of intent to present technical evidence: If the petitioner wishes to present technical evidence at the hearing, the petition shall include a statement of intent. The statement of intent to present technical evidence shall include:

(a) the name of the person filing the statement;

(b) the name of each witness;

(c) an estimate of the length of the direct testimony of each witness;

(d) a list of exhibits, if any, to be offered into evidence at the hearing; and

(e) a summary or outline of the anticipated direct testimony of each witness.

B. Qualified patient applicant petitioner: If the petitioner is submitting their requests as a potential qualified patient applicant the petitioner shall attach an original medical practitioner's certification for patient eligibility form provided by the medical cannabis program manager or designee which includes the following information:

(1) the name, address, telephone number and clinical licensure of the petitioner's practitioner;

(2) the medical justification for practitioner's certification of the petitioner's debilitating medical condition;

(3) the practitioner's signature and date of signature;

(4) the name, address and date of birth of the petitioner;

(5) the name, address and telephone number of the petitioner's practitioner;

(6) a reasonable xerographic copy of the petitioner's New Mexico driver's license or comparable New Mexico state or federal issued photo identification card verifying New Mexico residence;

(7) documented parental consent if applicable to the petitioner;

(8) if applicable, the petitioner's potential debilitating medical condition;

(9) the length of time the petitioner has been under the care of the practitioner providing the medical provider certification for patient eligibility;

(10) the petitioner's signature and date; and

(11) a signed consent for release of medical information form provided by the medical cannabis program.

C. Petitioner confidentiality: The department shall maintain a confidential file containing the names and addresses of the persons who have either applied for or received a public hearing petition request. Individual names on the list shall be confidential and not subject to disclosure, except:

(1) to authorized employees or agents of the department as necessary to perform the duties of the department pursuant to the provisions of the act or this part;

(2) as provided in the federal Health Insurance Portability and Accountability Act of 1996.

D. Department notification: The medical cannabis program manager or designee shall review each petition request and within reasonable time after receipt issue notice of docketing upon the petitioner, each advisory board member, and the advisory board legal counsel. The notice of docketing shall contain the petition caption and docket number, the date upon which the petition was received and scheduling date of the advisory board public hearing. A copy of this rule shall be included with a notice of docketing sent to the petitioner.

E. Examination allowed: Subject to the provisions of law restricting the public disclosure of confidential information, any person may, during normal business hours, inspect and copy any document filed in any public hearing proceeding. Inspection shall be permitted in accordance with the Inspection of Public Records Act, Sections 14-2-1 *et seq.*, NMSA 1978, but may be limited by the Health Insurance Portability and Accountability Act of 1996. Documents subject to inspection shall be made available by the medical cannabis program manager, or designee as appropriate. Unless waived by the department, the cost of duplicating documents or audio filed in any public hearing proceeding shall be borne by the person seeking the copies.

F. Notice of withdrawal: A petitioner may withdraw a petition at any time prior to a decision by the advisory board by filing a notice of withdrawal with the medical cannabis program manager or designee.

[7.34.2.9 NMAC - Rp, 7.34.2.9 NMAC, 2/27/2015]

7.34.2.10 ADVISORY BOARD PUBLIC HEARING PROCEDURES:

A. Public hearing requirement: The advisory board shall convene by public hearing at least twice per year to accept and review petitions requesting the inclusion of medical conditions, medical treatments or diseases to the list of debilitating medical conditions. Any meeting consisting of a quorum of the advisory board members held for the purpose of evaluating, discussing or otherwise formulating specific opinions concerning the recommendation of a petition filed pursuant to this rule, shall be declared a public hearing open to the public at all times, unless a portion of the hearing is closed to protect information made confidential by applicable state or federal laws. A petitioner or his or her representative may request to close a portion of the hearing to protect the disclosure of confidential information by submitting their request in writing and having that request delivered to medical cannabis program staff at least 48 hours prior to the hearing.

B. Location of the public hearing: Unless otherwise ordered by the advisory board, the public hearing shall be in held in New Mexico at a location sufficient to accommodate the anticipated audience.

C. Public hearing notice: The medical cannabis program manager or designee shall, upon direction from the advisory board chairperson, prepare a notice of public hearing setting forth the date, time and location of the hearing, a brief description of the petitions received, and information on the requirements for public comment or statement of intent to present technical evidence, and no later than 30 days prior to the hearing date, send copies, with requests for publication, to at least one newspaper of general circulation. The program manager or designee may further issue notice of the hearing by any other means the department determines to be acceptable to provide notice to the public.

D. Public hearing agenda: The department shall make available an agenda containing a list of specific items to be discussed or information on how the public may obtain a copy of such agenda.

E. Postponement of hearing: Request for postponement of a public hearing will be granted, by the advisory board for good cause shown.

F. Statement of intent to present technical evidence: Any individual or association of individuals who wish to present technical evidence at the hearing shall, no later than 15 days prior to the date of the hearing, file a statement of intent. The statement of intent to present technical evidence shall include:

(1) the name of the person filing the statement;

(2) indication of whether the person filing the statement supports or opposes the petition at issue;

(3) the name of each witness;

(4) an estimate of the length of the direct testimony of each witness;

(5) a list of exhibits, if any, to be offered into evidence at the hearing; and

(6) a summary or outline of the anticipated direct testimony of each witness.

G. Ex parte discussions: At no time after the initiation and before the conclusion of the petition process under this part, shall the department, or any other party, interested participant or their representatives discuss ex parte the merits of the petitions with any advisory board member.

H. Public hearing process: The advisory board chairperson shall conduct the public hearing so as to provide a reasonable opportunity for all interested persons to be heard without making the hearing unreasonably lengthy or cumbersome or burdening the record with unnecessary repetition.

(1) A quorum of the advisory board shall consist of five voting members.

(2) The advisory board chairperson or alternate shall convene each public hearing by:

(a) introduction of the advisory board members;

(b) statutory authority of the board;

(c) statement of the public hearing agenda; and

(d) recognition of the petitioner.

(3) Petitioner comment period. The petitioner or by representative may present evidence to the advisory board. The advisory board shall only consider findings of fact or scientific conclusions of medical evidence presented by the petitioner or by representative to the advisory board prior to or contemporaneously with the public hearing.

(4) Public comment period: The advisory board may provide for a public comment period. Public comment may be by written comment, verbal or both.

(a) Written comment: Any individual or association of individuals may submit written comment to the advisory board either in opposition or support of the inclusion of a medical conditions, medical treatments or diseases to the existing list of debilitating medical conditions contained under the act. All written comment shall adhere to the requirements of Subsection F of this section.

(b) Public comment: Any member of the general public may testify at the public hearing. No prior notification is required to present general non-technical statements in support of or in opposition to the petition. Any such member may also offer exhibits in connection with his testimony, so long as the exhibit is non-technical in nature and not unduly repetitious of the testimony.

I. Recording the hearing: Unless the advisory board orders otherwise, the hearing will be audio recorded. Any person, other than the advisory board, desiring a copy of the audio tapes must arrange copying with the medical cannabis program or designee at their own expense.

[7.34.2.10 NMAC - Rp, 7.34.2.10 NMAC, 2/27/2015; A, 8/27/2019]

7.34.2.11 ADVISORY BOARD RECOMMENDATION TO THE DEPARTMENT:

A. Advisory board recommendation: Upon final determination the advisory board shall provide to the secretary a written report of finding, which recommends either the approval or denial of the petitioner's request. The written report of findings shall include a medical justification for the recommendation based upon the individual or collective expertise of the advisory board membership. The medical justification shall delineate between the findings of fact made by the advisory board and scientific conclusions of credible medical evidence.

B. Department final determination: The department shall notify the petitioner within 10 days of the secretary's determination. A denial by the secretary regarding the inclusion of a medical conditions, medical treatments or diseases to the existing list of debilitating medical conditions contained under the act shall not represent a permanent denial by the department. Any individual or association of individuals may upon good cause re-petition the advisory board. All requests shall present new supporting findings of fact, or scientific conclusions of credible medical evidence not previously examined by the advisory board.

[7.34.2.11 NMAC - Rp, 7.34.2.11 NMAC, 2/27/2015]

7.34.2.12 SEVERABILITY:

If any part or application of these rules is held to be invalid, the remainder or its application to other situations or persons shall not be affected. Failure to promulgate rules or implement any provision of these rules shall not interfere with the remaining protections provided by these rules and the act.

[7.34.2.12 NMAC - Rp, 7.34.2.12 NMAC, 2/27/2015]

PART 3: REGISTRY IDENTIFICATION CARDS

7.34.3.1 ISSUING AGENCY:

New Mexico Department of Health, Medical Cannabis Program.

[7.34.3.1 NMAC - Rp, 7.34.3.1 NMAC, 2/27/2015]

7.34.3.2 SCOPE:

This rule governs the issuance of registry identification cards to qualified patients and primary caregivers as defined by the Lynn and Erin Compassionate Use Act, 26-2B-3(F) and (G) NMSA 1978. All requirements contained herein are necessary prerequisites to the state's ability to distinguish between authorized use under the act and unauthorized use under the state's criminal laws.

[7.34.3.2 NMAC - Rp, 7.34.3.2 NMAC, 2/27/2015]

7.34.3.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the department of health pursuant to the authority granted under Section 9-7-6 (E) NMSA 1978, and the Lynn and Erin Compassionate Use Act, 26-2B-1 *et seq*. NMSA 1978. Although federal law currently prohibits any use of cannabis, the laws of several states permit the medical use and cultivation of cannabis. New Mexico adopts these regulations to accomplish the purpose of the Lynn and Erin Compassionate Use Act as stated in Section 26-2B-2 NMSA 1978, "to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments," while at the same time ensuring proper enforcement of any criminal laws for behavior that has been deemed illicit by the state.

[7.34.3.3 NMAC - Rp, 7.34.3.3 NMAC, 2/27/2015]

7.34.3.4 DURATION:

Permanent.

[7.34.3.4 NMAC - Rp, 7.34.3.4 NMAC, 2/27/2015]

7.34.3.5 EFFECTIVE DATE:

February 27, 2015, unless a later date is cited at the end of a section.

[7.34.3.5 NMAC - Rp, 7.34.3.5 NMAC, 2/27/2015]

7.34.3.6 OBJECTIVE:

Ensuring the safe use and possession of cannabis for individuals living with debilitating medical conditions, and the safe possession and administration of cannabis for medical

use to those individuals by primary caregivers, as mandated under the Lynn & Erin Compassionate Use Act Sections 26-2B-1 *et seq*., NMSA 2007.

[7.34.3.6 NMAC - Rp, 7.34.3.6 NMAC, 2/27/2015]

7.34.3.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) "Act" means the Lynn and Erin Compassionate Use Act, Sections 26-2B-1 through 26-2B-10, NMSA 1978.

(2) "Adequate supply" means an amount of cannabis, in a form approved by the department possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver, that is determined by rule of the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months and that is derived solely from an intrastate source.

(3) "Administrative review committee" means an intra-department committee that reviews qualified patient or primary caregiver application denials in accordance with department rules. The administrative review committee shall consist of the chief medical officer of the department (or that's person's designee); a deputy secretary of the department (or that person's designee), and the chief nursing officer of the department (or that person's designee).

(4) "Administrative withdrawal" means the procedure for the voluntary withdrawal of a qualified patient or primary caregiver from the medical cannabis program.

(5) "Advisory board" means the medical cannabis advisory board consisting of nine practitioners knowledgeable about the medical use of cannabis, who are appointed by the secretary.

(6) "Applicant" means any person applying for enrollment or re-enrollment in the medical cannabis program as a qualified patient or primary caregiver.

B. Definitions beginning with "B": [RESERVED]

C. Definitions beginning with "C":

(1) "Cannabis" means:

(a) means all parts of the plant Cannabis containing a delta-9-tetrahydrocannabinol concentration of more than three-tenths percent on a dry weight basis, whether growing or not; the seeds of the plant; the resin extracted from any part

of the plant; and every compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin; and

(b) does not include the mature stalks of the plant; fiber produced from the stalks; oil or cake made from the seeds of the plant; any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, fiber, oil or cake; the sterilized seed of the plant that is incapable of germination; the weight of any other ingredient combined with cannabis to prepare topical or oral administrations, food, drink or another product; or hemp;

(2) "Cannabis-derived product" or **"cannabis product"** means

(a) means a product that contains cannabis, including edible or topical products that may also contain other ingredients; and

(b) does not include the weight of any other ingredient combined with cannabis or cannabis extract to prepare topical or oral administrations, food, drink or another product.

(3) "CBD" means cannabidiol, a cannabinoid and the primary non-psychoactive ingredient found in cannabis.

(4) "CBDA" means cannabidiolic acid, a non-psychoactive ingredient found in cannabis and an acid precursor to CBD.

D. Definitions beginning with "D":

(1) "Debilitating medical condition" means:

(a) cancer;

(b) glaucoma;

(c) multiple sclerosis;

(d) damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity;

(e) seizure disorder, including epilepsy;

(f) positive status for human immunodeficiency virus or acquired immune deficiency syndrome;

(g) admitted into hospice care in accordance with rules promulgated by the department;

(h) amyotrophic lateral sclerosis;

(i) Crohn's disease;

(j) hepatitis C infection;

(k) Huntington's disease;

(l) inclusion body myositis;

(m) inflammatory autoimmune-mediated arthritis;

(n) intractable nausea or vomiting;

(o) obstructive sleep apnea;

(p) painful peripheral neuropathy;

(q) Parkinson's disease;

(r) posttraumatic stress disorder;

(s) severe chronic pain;

(t) severe anorexia or cachexia;

(u) spasmodic torticollis;

(v) ulcerative colitis; or

(w) any other medical condition, medical treatment, or disease as approved by the department which results in pain, suffering, or debility for which there is credible evidence that medical use cannabis could be of benefit.

(2) "Department" means the department of health or its agent.

(3) "Diversion" means the unlawful transfer of a cannabis plant, plant material, or cannabis-derived product.

(4) "Dried usable cannabis" means the dried leaves, flowers, and trim of the female cannabis plant, but does not include the seeds, stalks, or roots of the cannabis plant.

(5) "Dry weight basis" means a process by which delta-9-tetrahydrocannabinol concentration is measured relative to the aggregate weight of all parts of the plant genus Cannabis, whether growing or not, including the leaves of the

plant, the flowers and buds of the plant, the seeds of the plant, the resin of the plant and the stalks of the plant, at the point of harvest and with no moisture added to the harvested plant;

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F": [RESERVED]

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": "Hemp" means the plant cannabis sativa L. and any part of the plant, whether growing or not, containing a delta-9-tetrahydrocannabinol concentration of no more than three-tenths percent on a dry weight basis;

I. Definitions beginning with "I":

(1) "Intrastate" means existing or occurring within the state boundaries of New Mexico.

(2) "Inversion" means the unlawful acquisition of a cannabis plant, plant material, or cannabis-derived product.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L": "Licensee" means any person licensed by the New Mexico Cannabis Control Division pursuant to the Cannabis Regulation Act, Sections 26-2C-1 through 26-2C-42 NMSA 1978, who is authorized by that license to sell cannabis to qualified patients, primary caregivers, and reciprocal participants.

M. Definitions beginning with "M":

(1) "Medical cannabis program" means the program established pursuant to the Lynn and Erin Compassionate Use Act for authorization and regulation of the medical use of cannabis in the state.

(2) "Medical cannabis program director" means the administrator of the medical cannabis program who holds that title.

(3) "Medical director" means a medical practitioner designated by the department to determine whether the medical condition of an applicant qualifies as a debilitating medical condition eligible for enrollment in the program, and to perform other duties.

(4) "Medical provider certification for patient eligibility form" means a written certification form provided by the medical cannabis program signed by a patient's practitioner that, in the practitioner's professional opinion, the patient has a debilitating medical condition as defined by the act or this part and would be anticipated to benefit from the use of cannabis.

(5) "Minor" means an individual who is less than 18 years of age.

N. Definitions beginning with "N": [RESERVED]

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P":

(1) "Paraphernalia" means any equipment, product, or material of any kind that is primarily intended or designed for use in compounding, converting, processing, preparing, inhaling, or otherwise introducing cannabis or its derivatives into the human body.

(2) "Patient enrollment/re-enrollment form" means the registry identification card application form for patient applicants provided by the medical cannabis program.

(3) "Petitioner" means any New Mexico resident or association of New Mexico residents petitioning the advisory board for the inclusion of a new medical condition, medical treatment, or disease to be added to the list of debilitating medical conditions that qualify for the use of cannabis.

(4) "Practitioner" means a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act, Sections 30-31-1 *et seq.*, NMSA 1978.

(5) "Primary caregiver" means a resident of New Mexico who is at least 18 years of age and who has been designated by the qualified patient or their representative and the patient's practitioner as being necessary to take responsibility for managing the well-being of a qualified patient with respect to the medical use of cannabis pursuant to the provisions of the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq*., NMSA 1978.

(6) "Primary caregiver application form" means the registry identification card application form provided by the medical cannabis program.

Q. Definitions beginning with "Q": "Qualified patient" means a resident of New Mexico who has been diagnosed by a practitioner as having a debilitating medical condition and has received written certification and a registry identification card pursuant to the Lynn and Erin Compassionate Use Act on the basis of having been

diagnosed, in person or via telemedicine, by a practitioner as having a debilitating medical condition.

R. Definitions beginning with "R":

(1) "Recall" means to request the return of a product after the discovery of a safety issue or product defect.

(2) "Reciprocal limit" means the quantity of cannabis and cannabis products that a reciprocal participant can use and possess in a given year pursuant to department rule.

(3) "Reciprocal participant" means a person who is not a resident of New Mexico and who holds proof of enrollment by a governmental regulatory authority to participate in the medical cannabis program of another state of the United States, the District of Columbia or a territory or commonwealth of the United States in which the person resides or a person who holds proof of enrollment by a governmental regulatory authority of a New Mexico Indian nation, tribe or pueblo to participate in its medical cannabis program;

(4) "Registry identification card" means a document in printed or electronic form that the department issues:

(a) to a qualified patient that identifies the bearer as a qualified patient and authorizes the qualified patient to use cannabis for a debilitating medical condition; or

(b) to a primary caregiver that identifies the bearer as a primary caregiver authorized to engage in the intrastate possession and administration of cannabis for the sole use of a qualified patient who is identified on the document.

(5) "Representative" means an individual designated as the applicant's or petitioner's agent, guardian, surrogate, or other legally appointed or authorized health care decision maker.

S. Definitions beginning with "S": "Secretary" means the secretary of the New Mexico department of health.

T. Definitions beginning with "T":

(1) "THC" means tetrahydrocannabinol, a substance that is the primary psychoactive ingredient in cannabis.

(2) "Technical evidence" means scientific, clinical, medical, or other specialized testimony, or evidence, but does not include legal argument, general comments, or statements of policy or position concerning matters at issue in the hearing.

(3) "Telemedicine" means the use of telecommunications and information technology to provide clinical health care from a site apart from the site where the patient is located, in real time or asynchronously, including the use of interactive simultaneous audio and video or store-and-forward technology, or off-site patient monitoring and telecommunications in order to deliver health care services.

U. Definitions beginning with "U":

(1) "Unit" means a quantity of usable cannabis, concentrate, or cannabis-derived product that is used in identifying the maximum supply that a qualified patient may possess for purposes of department rules.

(2) "Usable cannabis" means the dried leaves and flowers of the female cannabis plant and cannabis-derived products, including concentrates, but does not include the seeds, stalks, or roots of the plant.

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W":

(1) "Wastage" means the destruction of usable cannabis or cannabis plants;

(2) "Written certification" means a statement made on a department-approved form and signed by a patient's practitioner that indicates, in the practitioner's professional opinion, that the patient has a debilitating medical condition and the practitioner believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the patient.

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z" [RESERVED]

[7.34.3.7 NMAC - Rp, 7.34.3.7 NMAC, 2/27/2015; A, 2/29/2016; A, 8/27/2019; A, 6/23/2020; A, 2/22/2022]

7.34.3.8 QUALIFYING DEBILITATING MEDICAL CONDITIONS:

A. Statutorily-approved conditions: As of the date of promulgation of this rule, specific qualifying debilitating medical conditions, diseases, and treatments ("qualifying conditions") identified in the Lynn and Erin Compassionate Use Act, Subsection B of Section 26-2B-3 NMSA 1978, include:

(1) cancer;

(2) glaucoma;

(3) multiple sclerosis;

(4) damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity;

(5) seizure disorder, including epilepsy;

(6) positive status for human immunodeficiency virus or acquired immune deficiency syndrome;

(7) admission into hospice care in accordance with rules promulgated by the department.

(8) amyotrophic lateral sclerosis (Lou Gehrig's disease);

(9) Crohn's disease;

(10) hepatitis C infection;

(11) Huntington's disease;

(12) inclusion body myositis;

(13) inflammatory autoimmune-mediated arthritis: each individual applying to the program for enrollment shall submit medical records that confirm the diagnosis of inflammatory autoimmune-mediated arthritis;

(14) intractable nausea/vomiting;

(15) obstructive sleep apnea;

(16) painful peripheral neuropathy: application to the medical cannabis program shall be accompanied by medical records that confirm the objective presence of painful peripheral neuropathy;

(17) Parkinson's disease;

(18) post-traumatic stress disorder (PTSD): each individual applying to the program for enrollment shall submit medical records that confirm a diagnosis of PTSD meeting the diagnostic criteria of the current *diagnostic and statistical manual of mental disorders*;

(19) severe chronic pain:

(a) objective proof of the etiology of the severe chronic pain shall be included in the application; and

(b) a practitioner familiar with the patient's chronic pain shall provide written certification that the patient has an unremitting severe chronic pain condition;

(20) severe anorexia/cachexia;

(21) spasmodic torticollis (cervical dystonia); and

(22) ulcerative colitis.

B. Department-approved conditions: The department finds that the following additional qualifying conditions result in pain, suffering, or debility for which there is credible evidence that the medical use of cannabis could be of benefit, through the alleviation of symptoms, and the department accordingly approves these conditions as qualifying debilitating medical conditions for the participation of a qualified patient or primary caregiver in the medical cannabis program. The department-approved conditions include:

(1) autism spectrum disorder;

(2) Friedreich's ataxia;

(3) Lewy body disease;

(4) spinal muscular atrophy;

(5) Alzheimer's disease;

(6) opioid use disorder;

(7) such other conditions as the secretary may approve.

C. Additional application requirements: A patient shall submit with the patient's application a written certification from the patient's practitioner which shall attest:

(1) to the diagnosis of the medical condition;

(2) that the condition is debilitating; and

(3) that potential risks and benefits of the use of medical cannabis for the condition have been discussed with the patient, in accordance with this rule; a patient who applies on the basis of having a department-approved condition may also be required to satisfy additional eligibility criteria, as specified in this rule.

D. Annual written certification requirement: Pursuant to the Lynn and Erin Compassionate Use Act, Section 26-2B-7.1 NMSA 1978, in order to remain eligible for participation in the medical cannabis program, a qualified patient shall submit annually to the department, and at least 30 calendar days prior to the annual certification date printed on their card, a statement from a practitioner on a department approved form. The annual written certification shall be attested by the certifying practitioner no more than 90 days prior to submission of the certification to the department. The certification shall indicate the following:

(1) the practitioner has examined the qualified patient during the preceding 12 months;

(2) the qualified patient continues to have a debilitating medical condition; and

(3) the practitioner believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the qualified patient.

E. Modification or removal of department-approved conditions: The secretary may remove or modify a department-approved condition only if the secretary determines, on the basis of substantial credible medical and scientific evidence, and after an opportunity for review of the proposed removal or modification by the medical advisory board, that the use of cannabis by patients who have the approved condition would more likely than not result in substantial harm to the patients' health.

[7.34.3.8 NMAC - N, 2/27/2015; A, 2/29/2016; A, 8/27/2019; A, 2/22/2022]

7.34.3.9 QUANTITY OF USABLE CANNABIS THAT MAY BE POSSESSED BY A QUALIFIED PATIENT OR PRIMARY CAREGIVER:

A. Maximum quantity: A qualified patient and a qualified patient's primary caregiver may collectively purchase within any three-month period a quantity of usable cannabis no greater than 425 total units. For purposes of department rules, this quantity is deemed an adequate supply. (For ease of reference: 425 units is equivalent to 425 grams, or approximately 15 ounces, of dried usable cannabis plant material.) A qualified patient and a primary caregiver may possess the amounts of cannabis permitted in accordance with the Cannabis Regulation Act, Sections 26-2C-1 through 26-2C-42 NMSA 1978. Once commercial cannabis sales are authorized by the cannabis control division to begin in accordance with Subsection K of Section 26-2C-6 NMSA 1978, qualified patients and primary caregivers will be able to make commercial purchases above the adequate supply limit, in accordance with the Cannabis Regulation Act.

B. Calculation of units: For purposes of department rules, one unit of usable cannabis shall consist of one gram of the dried leaves and flowers of the female cannabis plant, or 0.2 grams (200 milligrams) of THC for cannabis-derived products.

[7.34.3.9 NMAC - N, 2/27/2015; A, 8/27/2019; A, 2/22/2022]

7.34.3.10 QUALIFIED PATIENT AND PRIMARY CAREGIVER REGISTRY IDENTIFICATION CARD APPLICATION REQUIREMENTS:

A. The department shall issue a registry identification card to an applicant for the purpose of participating in the medical cannabis program upon the written certification of the applicant's practitioner and supporting application documents. Certifications from certifying providers must be obtained within 90 calendar days prior to the expiration of the patient's registry identification card.

B. The department may require the submittal of a recent photograph from a patient applicant and primary caregiver applicant.

C. The following information shall be provided in (or as an attachment to) the participant enrollment form submitted to the department in order for a registry identification card to be obtained and processed. An attached original medical provider certification for patient eligibility form shall contain:

(1) the name, address, and telephone number of the practitioner;

(2) the practitioner's clinical licensure;

(3) the patient applicant's name and date of birth;

(4) the medical justification for the practitioner's certification of the patient's debilitating medical condition, which shall include but not be limited to a statement that, in the practitioner's professional opinion, the practitioner believes that the potential health benefits of the medical use of cannabis would likely outweigh health risks for the patient;

(5) an attestation that the practitioner's primary place of practice is located within the state of New Mexico;

(6) the practitioner's signature and the date;

(7) the name, address, and date of birth of the applicant;

(8) the name, address, and telephone number of the applicant's practitioner;

(9) a legible photocopy of the applicant's New Mexico driver's license or comparable state of New Mexico issued photo identification card verifying New Mexico residence;

(10) documented parental consent, if applicable, to the applicant;

(11) the applicant's debilitating medical condition;

(12) the length of time the applicant has been under the care of the practitioner providing the medical provider certification for patient eligibility;

(13) the applicant's signature and date; and

(14) a signed consent for release of medical information related to the patient's debilitating medical condition, on a form provided by the medical cannabis program.

D. Qualified minor: The department shall issue a registry identification card to an applicant under the age of 18 for the purpose of participating in the medical cannabis program upon the medical provider certification for patient eligibility from the applicant's practitioner and supporting application documents required under this rule. The qualified minor parental consent form shall require the following information to be provided:

(1) written documentation that the applicant's practitioner has explained the potential risks and benefits of the use of cannabis to both the applicant and parent or representative of the applicant; and

(2) written consent of the applicant's parent or legal representative to:

(a) allow the applicant's use of cannabis and cannabis-derived products;

(b) serve as the applicant's primary caregiver; and

(c) control the acquisition of the cannabis, dosage, and the frequency of the use of cannabis and cannabis-derived products by the applicant.

E. Primary caregiver: The department shall issue a registry identification card to a primary caregiver applicant for the purpose of managing the well-being of up to four qualified patients pursuant to the requirements of this rule upon the completion and approval of the primary caregiver application form available from the medical cannabis program. In order for a registry identification card to be obtained and processed, the following information shall be submitted to the medical cannabis program:

(1) New Mexico driver's license or comparable state of New Mexico issued photo identification card verifying that the applicant is at least 18 years of age and is a resident of New Mexico;

(2) written approval by each qualified patient, and written approval by at least one certifying practitioner for each qualified patient, authorizing the primary caregiver's responsibility for managing the well-being of the patient(s) with respect to the medical use of cannabis;

(3) the name(s), address(es), telephone number(s), and date of birth(s) of the qualified patient(s);

(4) the name, address, and telephone number of each qualified patient's practitioner;

(5) the name, address, and telephone number of the applicant primary caregiver;

(6) an attestation from the primary caregiver applicant that he or she is a resident of the state of New Mexico; and

(7) the applicant primary caregiver's signature and the date.

F. Primary caregiver requirements:

(1) A primary caregiver applicant shall be a resident of New Mexico.

(2) A qualified patient's primary caregiver shall be permitted to obtain and transport medical cannabis from a licensed nonprofit to the qualified patient.

(3) The primary caregiver of a qualified patient who holds a personal production license may assist the qualified patient to produce medical cannabis at the designated licensed location, identified on the personal production license.

(4) A qualified patient shall only reimburse their primary caregiver for the cost of travel, supplies, or utilities associated with the possession of medical cannabis, or cannabis-derived products by the primary caregiver for the qualified patient. No other cost associated with the possession of medical cannabis, or cannabis-derived products by the primary caregiver for the qualified patient, including the cost of labor, shall be reimbursed or paid. All medical cannabis or cannabis-derived products possessed by a primary caregiver for a qualified patient are the property of the qualified patient.

(5) A qualified patient shall notify the medical cannabis program in the event that the qualified patient ceases to retain the services of a primary caregiver. A primary caregiver shall promptly dis-enroll from the medical cannabis program at the time that the primary caregiver's services are no longer used by a qualified patient in their care.

G. Certifying practitioner requirements:

(1) A patient may not be certified by a practitioner who is related to the patient within the second degree of consanguinity or the first degree of affinity, including a spouse, child, stepchild, parent, step-parent, sibling, grandparent, mother-in-law, father-in-law, son-in law, or daughter-in-law of the patient.

(**2)** A practitioner's primary place of practice must be located within the state of New Mexico in order for the practitioner to certify a patient's eligibility.

(3) In order to certify a patient's application, a practitioner must have an actual physician-client relationship with the applicant or qualified patient. A practitioner shall conduct an in-person physical or mental evaluation of the applicant or qualified patient prior to issuing a certification. A practitioner may only issue a written certification on the basis of an evaluation conducted via telemedicine if the practitioner has previously examined the patient in person.

(4) A practitioner may be prohibited from certifying patient applications for:

(a) failure to comply with any provision of this rule;

(b) falsification of any material or information submitted to the department;

(c) threatening or harming an employee of a producer, a medical practitioner, a patient, or an employee of the department; or

(d) any determination by the practitioner's licensing body that practitioner has engaged in unprofessional or dishonorable conduct.

H. Continuing education of certifying practitioners: The department encourages certifying practitioners to obtain at least two continuing medical education credit hours annually related to the medicinal use of cannabis.

[7.34.3.10 NMAC - Rp, 7.34.3.9 NMAC, 2/27/2015; A, 8/27/2019; A, 2/22/2022]

7.34.3.11 REGISTRY IDENTIFICATION CARDS:

A. Department inquiry:

(1) The department may verify information on each application and accompanying documentation by the following methods:

(a) contacting each applicant by telephone or mail, or if proof of identity is uncertain, by requiring a face-to-face meeting, and the production of additional identification materials;

(b) when applicable, contacting a minor's parent or legal representative;

(c) contacting the New Mexico medical board, the New Mexico board of nursing, board of pharmacy, or other licensing agencies to verify that the practitioner is licensed to practice and prescribe controlled substances in New Mexico and is in good standing; and

(d) contacting the practitioner to obtain further documentation to verify that the applicant's medical diagnosis and medical condition qualify the applicant for enrollment in the medical cannabis program.

(2) The department shall approve or deny an application within 30 calendar days of receipt of the completed application. A request by the department for additional information shall toll this period until such time as the requested information is received.

B. Department registry identification card: The department shall issue a registry identification card within five business days of approving an application. A registry identification card shall include the name, address, and date of birth of the qualified patient and primary caregiver (if any), the date of issuance and expiration date of the registry identification card, and a code maintained by the program which identifies the qualified patient or primary caregiver. Unless renewed at an earlier date, suspended, or revoked, a registry identification card shall be valid for a period of three years from the date of issuance and shall expire at midnight on the day indicated on the registry identification card as the expiration date. A registry identification card is the property of the department, and shall be returned to the department upon the disenrollment, suspension, or revocation of a qualified patient or primary caregiver, and upon a change of address, or change of a qualified patient's primary caregiver.

C. Supplemental information requirement: A qualified patient or primary caregiver who possesses a registry identification card shall notify the department of any change in the person's name, address, qualified patient's primary caregiver, or change in status of the qualified patient's debilitating medical condition, within 10 calendar days of the change. Failure to provide notification of any change may result in the immediate revocation of the registry identification card and all lawful privileges provided under the act.

D. Registry identification card application denial: The medical director or designee shall deny an initial application if the application fails to satisfy any requirement of this rule, if the applicant fails to provide the information required, if the department determines that the information provided is false, if the patient does not have a debilitating medical condition eligible for enrollment in the program as determined by the medical director, or if the applicant's certifying provider(s) determine(s) that the use of cannabis by the patient would more likely than not be detrimental to the patient's health. The medical director or designee may also deny an application if the applicant has threatened or harmed an employee of a licensee, a medical practitioner, a patient, or an employee of the department. A person whose application has been denied shall not reapply for six months from the date of the denial, unless otherwise authorized by the department, and is prohibited from all lawful privileges provided by this rule and act. A person whose application as a qualified patient or primary caregiver has been denied for failure to complete an application or failure to meet a submittal requirement of this rule may request a record review to be conducted by the medical cannabis program.

E. Registry identification card renewal application: Each registry identification card issued by the department shall expire three years after the date of issuance. A qualified patient or primary caregiver shall apply for a registry identification card renewal no less than 30 calendar days prior to the expiration date of the existing registry identification card in order to prevent interruption of possession of a valid (unexpired) registry identification card. Certifications from certifying providers must be obtained within 90 calendar days prior to the submission of the application.

F. Non-transferable registration of registry identification card: A registry identification card shall not be transferred by assignment or otherwise to other persons. Any attempt shall result in the immediate revocation of the registry identification card and all lawful privileges provided by this rule and act.

G. Automatic expiration of registry identification card by administrative withdrawal: Upon request of the qualified patient or primary caregiver, the qualified patient or primary caregiver may discontinue the medical cannabis program by an administrative withdrawal. A qualified patient or primary caregiver that intends to seek an administrative withdrawal shall notify the licensing authority no later than 30 calendar days prior to withdrawal and return the proof of registry identification to the program.

H. Lost or stolen registry identification card: The qualified patient or primary caregiver shall report a lost or stolen registry identification card to the medical cannabis program within five business days after discovery. Upon notification and receipt of the *information change or replacement card* form provided by the medical cannabis program, the medical cannabis program manager or designee shall issue a new registry identification card. The patient or primary caregiver shall verify the accuracy of all documentation in the most recent application. Unless documentation in the most recent application has changed, the qualified patient or primary caregiver shall not be required to submit a new application.

[7.34.3.11 NMAC - Rp, 7.34.3.10 NMAC, 2/27/2015; A, 8/27/2019; A, 2/22/2022]

7.34.3.12 DENIAL OF AN INITIAL PATIENT OR PRIMARY CAREGIVER APPLICATION:

A. Administrative review: All patient applicants or primary caregivers whose initial application for a registry identification card has been denied may request a record review from the department.

B. Procedure for requesting informal administrative review:

(1) An applicant given notice of an application denial may submit a written request for an administrative review. To be effective, the written request shall:

(a) be made within 30 calendar days, as determined by the postmark, from the date of the denial notice issued by the department;

(b) be properly addressed to the medical cannabis program;

(c) state the applicant's name, address, and telephone numbers;

(d) state the applicant's proposed status as a qualified patient or primary caregiver;

(e) if the applicant is a potential primary caregiver, state the anticipated date of which service shall commence;

(f) provide a brief narrative rebutting the circumstances of the application denial, and

(g) if applicable, provide supplemental documentation from the applicant's practitioner supporting the debilitating medical condition as eligible for the program.

(2) If the applicant wishes to submit additional documentation for consideration, such additional documentation must be included with the request for an administrative review.

C. Administrative review proceeding: The administrative review proceeding shall be a closed proceeding that is limited to an administrative review of written application materials and documents offered to verify eligibility. The administrative review proceeding is not an adjudicatory hearing, and an individual whose initial application for a registry identification card has been denied shall not be entitled to an adjudicatory hearing to contest the denial. The administrative review shall be conducted by the administrative review committee. In cases where the administrative review committee finds the need for additional or clarifying information, the review committee shall request that the applicant supply such additional information within the time set forth in the committees' request.

D. Final determination:

(1) Content: The administrative review committee shall render a written decision setting forth the reasons for the decision and the evidence upon which the decision is based.

(2) Effect: The decision of the administrative review committee is the final decision of the informal administrative review proceeding.

(3) Notice: A copy of the decision shall be mailed to the applicant.

E. Judicial review: Except as otherwise provided by law, there shall be no right to judicial review of a decision by the administrative review committee.

[7.34.3.12 NMAC - Rp, 7.34.3.11 NMAC, 2/27/2015]

7.34.3.13 POSSESSION OF USABLE CANNABIS:

A. A qualified patient or primary caregiver shall ensure that that all cannabis, cannabis-derived products, and paraphernalia are kept secure and out of reach of children.

B. A qualified patient and primary caregiver shall ensure that all cannabis and cannabis-derived products that are purchased from a licensed non-profit producer remain in the package or container provided by the non-profit entity when not in use. If the package or container is damaged, the product label and any other identifying information from the package or container shall be kept and remain with the cannabis or cannabis-derived product upon transfer to another package or container.

[7.34.3.13 NMAC - N, 2/27/2015; A, 02/22/2022]

7.34.3.14 MONITORING AND CORRECTIVE ACTIONS:

A. Monitoring:

(1) The department or its designee may perform on-site assessments of a qualified patient or primary caregiver to determine compliance with these rules. The department may enter the premises of a qualified patient or primary caregiver during business hours for purposes of monitoring and compliance. 24 hours notice will be provided to the qualified patient or primary caregiver prior to an on-site assessment except when the department has a reasonable suspicion to believe that providing notice will result in the destruction of evidence or that providing such notice will impede the department's ability to enforce these regulations.

(2) All qualified patients or primary caregivers shall provide the department or the department's designee immediate access to any material and information necessary for determining compliance with these requirements.

(3) Failure by the qualified patient or primary caregiver to provide the department access to the premises or information may result in the revocation of the qualified patient or primary caregiver enrollment and referral to state law enforcement.

(4) Any failure by a qualified patient or primary caregiver to adhere to these rules may result in sanction(s), including suspension, revocation, non-renewal, or denial of registration and referral to state or local law enforcement.

(5) The department may refer complaints involving alleged criminal activity made against a qualified patient or primary caregiver to the appropriate New Mexico state or local authorities.

B. Corrective action:

(1) If violations of these requirements are cited as a result of a monitoring visit, the qualified patient or primary caregiver shall be provided with an official written report of the findings within seven business days following the monitoring visit.

(2) Unless otherwise specified by the department, the qualified patient or primary caregiver shall correct the violation within five calendar days of receipt of the official written report citing the violation(s).

(3) The violation shall not be deemed corrected until the department verifies in writing within seven calendar days of receiving notice of the corrective action that the corrective action is satisfactory.

(4) If the violation has not been corrected, the program manager or designee may issue a notice of contemplated action to revoke the enrollment of the qualified patient.

C. Suspension of enrollment without prior hearing: If immediate action is required to protect the health and safety of the general public, the qualified patient or primary caregivers, the medical cannabis program manager or designee may suspend the qualified patient or primary caregiver's enrollment in the medical cannabis program without notice.

(1) A qualified patient or primary caregiver whose enrollment has been summarily suspended is entitled to an administrative review not later than 30 calendar days after the enrollment is summarily suspended.

(2) An administrative review requested subsequent to a summary suspension shall be conducted by the administrative review committee.

(3) The administrative review committee shall conduct the administrative review on the summary suspension by reviewing all documents submitted by both the participant and the department.

(4) The administrative review is not an adjudicatory hearing; rather, the sole issue in an administrative review of a summary suspension is whether the individual's enrollment shall remain suspended pending a final administrative adjudicatory hearing and decision.

(5) An enrollee given notice of summary suspension by the medical cannabis program may submit a written request for an administrative review. To be effective, the written request shall:

(a) be made within 30 calendar days, as determined by the postmark, from the date of the notice issued by the department;

(b) be properly addressed to the medical cannabis program;

(c) state the requestor's name, address, and telephone numbers;

(d) provide a brief narrative rebutting the circumstances of the suspension; and

(e) be accompanied by any additional documentation offered in support of the request.

[7.34.3.14 NMAC - Rp, 7.34.3.12 NMAC, 2/27/2015]

7.34.3.15 PROHIBITIONS, RESTRICTIONS AND LIMITATIONS ON THE USE OF CANNABIS BY QUALIFIED PATIENTS:

Participation in the medical cannabis program by a qualified patient or primary caregiver does not relieve the qualified patient or primary caregiver from:

A. criminal prosecution or civil penalties for activities not authorized in this rule and act;

B. criminal prosecution or civil penalties for fraudulent representation to a law enforcement officer about the person's participation in the program to avoid arrest or prosecution;

C. liability for damages or criminal prosecution arising out of the operation of a vehicle while under the influence of cannabis or cannabis-derived products; or

D. criminal prosecution or civil penalty for possession, distribution, transfer, or use of cannabis or a cannabis-derived product:

(1) in the workplace of the qualified patient's or primary caregiver's employment;

(2) at a public park, recreation center, youth center, or other public place;

(3) to a person not approved by the department pursuant to this rule;

(4) outside New Mexico or attempts to obtain or transport cannabis, or cannabis-derived products from outside New Mexico; or

(5) that exceeds the allotted amount of usable medical cannabis, or cannabis-derived products.

[7.34.3.15 NMAC - Rp, 7.34.3.13 NMAC, 2/27/2015; A, 8/27/2019]

7.34.3.16 DISCIPLINARY ACTIONS AND APPEAL PROCESS:

A. Grounds for disciplinary action: Disciplinary action may be taken against a qualified patient, patient-applicant, primary caregiver, or primary caregiver-applicant. Disciplinary action may include revocation, suspension, or denial, summary suspension, summary revocation, and other action. Disciplinary action may be imposed for:

(1) failure to comply with or satisfy any provision of this rule;

(2) falsification or misrepresentation of any material or information submitted to the department;

(3) failing to allow or impeding a monitoring visit by authorized representatives of the department;

(4) failure to adhere to any acknowledgement, verification, or other representation made to the department;

(5) failure to submit or disclose information required by this rule or otherwise requested by the department;

(6) failure to correct any violation of this rule cited as a result of a monitoring visit;

(7) diversion of cannabis or a cannabis-derived product, as determined by the department;

(8) threatening or harming a patient, a medical practitioner, or an employee of the department;

(9) for primary caregivers: conviction of the primary caregiver of any of the disqualifying convictions identified by department rule;

(10) for patients: failure of the patient to satisfy any criterion identified as a prerequisite to eligibility for a condition approved by the department;

(11) for patients: if a certifying provider of the patient determines that the use of cannabis by the patient would more likely than not be detrimental to the patient's health; and

(12) any other basis identified in this rule.

B. Request for hearing: A qualified patient or primary caregiver who is the subject of disciplinary action, or an applicant who has received a notice of contemplated action to deny their application for any reason other than failure to submit a completed application or failure to meet a submittal requirement of this rule, may request a hearing in writing. The appellant shall file the request for hearing within 30 calendar days of the

date the action is taken or the notice of contemplated action is received. The request shall:

(1) be properly addressed to the medical cannabis program;

(2) state the requestor's name, address, and telephone numbers; and

(3) include a statement of the issues that the appellant considers relevant to the review of the action.

C. Hearing process:

(1) All formal adjudicatory hearings held pursuant to this regulation shall be conducted by a hearing examiner appointed by the secretary.

(2) Hearings shall be conducted in Santa Fe, New Mexico, or, with the consent of the parties, at another location.

(3) Due to federal and state laws regarding the confidentiality of protected health information, all hearings held pursuant to this section shall be closed to the public.

(4) The hearing shall be recorded on audiotape or other means of sound reproduction.

(5) Any hearing provided for in this rule may be held telephonically, with the consent of the parties.

D. Scheduling: The department shall schedule and hold the hearing no later than 60 calendar days from the date the department receives the appellant's request for hearing. The hearing examiner may extend the 60 day time period for good cause shown, or the parties may extend that period by mutual agreement. The department shall issue notice of the hearing, which shall include:

(1) a statement of the time, place, and nature of the hearing;

(2) a statement of the legal authority and jurisdiction under which the hearing is to be held; and

(3) a short and plain statement of the subject of the hearing.

E. Presentation of evidence: All parties shall be given the opportunity to respond and present evidence and argument on relevant issues.

F. Record of proceeding: The record of the proceeding shall include the following:

(1) all pleadings, motions, and rulings;

(2) evidence and briefs received or considered;

(3) a statement of any matters officially noticed;

(4) offers of proof, objections, and rulings thereon;

(5) proposed findings and conclusions; and

(6) any action recommended by the hearing examiner.

G. Audio recording: A party may request a copy of the audio recording of the proceedings.

H. Procedures and evidence:

(1) a party may be represented by a person licensed to practice law in New Mexico or a non-lawyer representative, or may represent himself or herself;

(2) the rules of evidence as applied in the courts do not apply in these proceedings; any relevant evidence shall be admitted; irrelevant, immaterial, or unduly repetitious evidence may be excluded;

(3) the experience, technical competence, and specialized knowledge of the hearing examiner, the department or the department's staff may be used in the evaluation of evidence;

(4) an appellant's failure to appear at the hearing at the date and time noticed for the hearing shall constitute a default.

I. Conduct of proceeding: Unless the hearing examiner determines a different procedure to be appropriate, the hearing shall be conducted as follows:

(1) the appellant may present an opening statement and the department may present an opening statement or reserve the statement until presentation of its case;

(2) upon conclusion of any opening statements, the appellant shall present his or her case;

(3) upon the conclusion of the appellant's case, the department shall present its case;

(4) upon conclusion of either party's case, the opposing party may present rebuttal evidence; and

(5) after presentation of the evidence by the parties, the parties may present closing arguments.

J. Burden of proof: The appellant bears the burden of establishing by a preponderance of the evidence that the decision made or proposed by the department should be reversed or modified.

K. Continuances: The hearing examiner may grant a continuance for good cause shown. A motion to continue a hearing shall be made at least 10 calendar days before the hearing date.

L. Telephonic hearings:

(1) any party requesting a telephonic hearing shall do so no less than 10 business days prior to the date of the hearing; notice of the telephonic hearing shall be given to all parties and shall include all necessary telephone numbers;

(2) failure of an appellant to provide their correct telephone number or failure to be available at the commencement of the hearing shall be treated as a failure to appear and shall constitute a default;

(3) the in-person presence of some parties or witnesses at the hearing shall not prevent the participation of other parties or witnesses by telephone with prior approval of the hearing examiner.

M. Recommended action and final decision:

(1) the parties may submit briefs including findings of fact and conclusions of law for consideration by the hearing examiner;

(2) no later than 30 calendar days after the last submission by a party, the hearing examiner shall prepare and submit to the secretary a written recommendation of action to be taken by the secretary; the recommendation shall propose sustaining, reversing, or modifying the proposed action of the department;

(3) the secretary shall issue a final written decision accepting or rejecting the hearing examiner's recommendation in whole or in part no later than 30 calendar days after receipt of the hearing examiner's recommendation; the final decision shall identify the final action taken; service of the secretary's final decision shall be made upon the appellant by registered or certified mail;

(4) the final decision or order shall be made a part of the patient or primary caregiver's file with the medical cannabis program.

[7.34.3.16 NMAC - Rp, 7.34.3.14 NMAC, 2/27/2015; A, 2/29/2016]

7.34.3.17 EXEMPTION FROM STATE CRIMINAL AND CIVIL PENALTIES FOR THE MEDICAL USE OF CANNABIS:

A. Possession of, or application for, a registry identification card shall not constitute probable cause or give rise to reasonable suspicion for any governmental agency to search the person or property of the person possessing or applying for the card.

B. A qualified patient shall not be subject to arrest, prosecution, or penalty in any manner by the state of New Mexico or a political subdivision thereof for the possession of or the use of medical cannabis if the quantity of cannabis, concentrates, or cannabis-derived products does not exceed an adequate supply as defined by rule; provided that a qualified patient or the qualified patient's primary caregiver may collectively possess that qualified patient's harvest of cannabis.

C. A primary caregiver shall not be subject to arrest, prosecution, or penalty in any manner for the possession of cannabis by the state of New Mexico, or a political subdivision thereof, for the medical use by the qualified patient if the quantity of cannabis, concentrates, or cannabis-derived products does not exceed an adequate supply as defined by rule.

D. A qualified patient or a primary caregiver shall be granted the full legal protections provided under the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq.*, NMSA 1978, by the state of New Mexico if the qualified patient or primary caregiver is in possession of a valid registry identification card. If the qualified patient or primary caregiver is not in possession of a valid registry identification card, the qualified patient or primary caregiver shall be given an opportunity to produce the registry identification card before any arrest, or criminal charges, or other penalties are initiated.

E. A practitioner shall not be subject to arrest or prosecution, penalized in any manner, or denied any right or privilege by the state of New Mexico, or political subdivision thereof, for recommending the medical use of cannabis, or providing written certification for the medical use of cannabis pursuant to this rule and the act.

F. Any property interest that is possessed, owned, or used in connection with the medical use of cannabis, or acts incidental to such use, shall not be harmed, neglected, injured, or destroyed while in the possession of New Mexico state or local law enforcement officials. Any such property interest shall not be forfeited under any New Mexico state or local law providing for the forfeiture of property except as provided in the Forfeiture Act. Cannabis, cannabis-derived products, paraphernalia, or other property seized from a qualified patient or primary caregiver in connection with the claimed medical use of cannabis shall be returned immediately upon the determination by a court or prosecutor that the qualified patient or primary caregiver is entitled to the protections of the provisions of this rule and the act, as may be evidenced by a failure to actively investigate the case, a decision not to prosecute, the dismissal of charges, or acquittal.

G. A person shall not be subject to arrest or prosecution by the state of New Mexico, or political subdivision thereof, for a cannabis-related offense for being in the presence of the medical use of cannabis as permitted under the provisions of this rule and the act.

[7.34.3.17 NMAC - Rp, 7.34.3.15 NMAC, 2/27/2015; A, 8/27/2019]

7.34.3.18 QUALIFIED PATIENT, PRIMARY CAREGIVER, AND MEDICAL PROVIDER CONFIDENTIALITY:

The department shall maintain a confidential file containing the names and contact information of the persons who have either applied for or received a registry identification card, as well as the names and contact information of certifying and diagnosing providers.

A. Patient applicants and qualified patients: Names and contact information regarding a qualified patient or patient-applicant shall be confidential and shall not be subject to disclosure, except:

(1) to employees or agents of the department as necessary to perform the duties of the department pursuant to the provisions of this rule and the act;

(2) to employees of New Mexico state or local law enforcement agencies, for the purpose of verifying that a person is lawfully enrolled in the medical cannabis program, or in the event that the medical cannabis program manager or designee has reason to believe that a qualified patient or patient-applicant may have violated an applicable law; and

(3) as provided in the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and applicable state and federal regulations.

B. Primary caregivers and certifying providers: Names and contact information regarding a primary caregiver or medical provider shall be confidential and shall not be subject to disclosure, except:

(1) to applicable licensing bodies, for the purpose of verifying the practitioner’s licensure status, or in the event that the medical cannabis program manager or designee has reason to believe that a practitioner may have violated licensing requirements or an applicable law;

(2) to employees of New Mexico state or local law enforcement agencies, in the event that the medical cannabis program manager or designee has reason to believe that a primary caregiver or medical provider may have violated an applicable law; and

(3) as provided in the federal HIPAA of 1996 and applicable state and federal regulations.

[7.34.3.18 NMAC - Rp, 7.34.3.16 NMAC, 2/27/2015]

7.34.3.19 DISPOSAL OF UNUSED CANNABIS:

Unused cannabis, concentrate, or cannabis-derived product in the possession of a qualified patient, primary caregiver, or reciprocal participant that is no longer needed for the needs of the patient or reciprocal participant may be disposed of by transporting the unused portion to a state or local law enforcement office, by destroying the unused cannabis, or by transferring, without financial consideration, to a person who is 21 years of age or older not more than the amount of cannabis lawfully purchased and obtained pursuant to the Medical Cannabis Program or the Cannabis Regulation Act.

[7.34.3.19 NMAC - Rp, 7.34.3.17 NMAC, 2/27/2015; A, 8/27/2019; A, 2/22/2022]

7.34.3.20 PROGRAM COOPERATION WITH LAW ENFORCEMENT:

A. The medical cannabis program shall be accessible via telephone 24-hours per day for state and local law enforcement to contact the program to determine the enrollment status of a patient, consistent with this rule, and shall make available a telephone number for this purpose. State and local law enforcement may obtain this telephone number by contacting the medical cannabis program's main number, or by visiting the medical cannabis program website.

B. The medical cannabis program shall cooperate with state and local law enforcement to provide education and training regarding the Lynn and Erin Compassionate Use Act and department rules.

[7.34.3.20 NMAC - N, 2/27/2015]

7.34.3.21 SEVERABILITY:

If any part or application of these rules is held to be invalid, the remainder or its application to other situations or persons shall not be affected. Failure to promulgate rules or implement any provision of these rules shall not interfere with the remaining protections provided by these rules and the act.

[7.34.3.21 NMAC - Rp, 7.34.3.19 NMAC, 2/27/2015]

7.34.3.22 RECIPROCITY:

Beginning July 1, 2020, an individual who holds proof of authorization to participate in the medical cannabis program of another state of the United States, the District of Columbia, a territory or commonwealth of the United States or a New Mexico Indian nation, tribe or pueblo may lawfully purchase a quantity of cannabis that does not exceed the reciprocal limit identified in this section. A reciprocal participant may possess the amounts of cannabis permitted in accordance with the Cannabis

Regulation Act, Sections 26-2C-1 through 26-2C-42 NMSA 1978. Once commercial cannabis sales are authorized by the cannabis control division to begin in accordance with Subsection K of Section 26-2C-6 NMSA 1978, a reciprocal participant will be able to make commercial purchases above the reciprocal limit, in accordance with the Cannabis Regulation Act. A qualified patient may not be registered or participate as a reciprocal participant in the New Mexico medical cannabis program.

A. Reciprocal participation:

(1) General requirements: A reciprocal participant:

(a) may participate in the medical cannabis program in accordance with department rules;

(b) shall not be required to comply with the registry identification card application and renewal requirements established pursuant to this section and department rules;

(c) shall at all times possess proof of authorization to participate in the medical cannabis program of another state, the District of Columbia, a territory or commonwealth of the United States or a New Mexico Indian nation, tribe or pueblo and shall present proof of that authorization when purchasing cannabis from a licensee; and

(d) shall register with a licensee for the purpose of tracking sales to the reciprocal participant in an electronic system specified by the cannabis control division of the regulation and licensing department that is accessible to the department of health.

(2) Minors: In the event that a reciprocal participant is a minor, the reciprocal participant may not purchase cannabis, but may have cannabis purchased on their behalf by the minor's parent or legal guardian who holds proof of authorization to purchase cannabis on the minor's behalf that was issued by another state of the United States, the District of Columbia, a territory or commonwealth of the United States or a New Mexico Indian nation, tribe or pueblo.

(3) Residency requirements:

(a) Non-residents: A person who is not a resident of New Mexico may participate in the medical cannabis program as a reciprocal participant, provided that the reciprocal participant's place of residence is consistent with their place of enrollment. (For example: a Colorado resident shall not be registered or otherwise participate as a reciprocal participant on the basis that he or she is enrolled in the medical cannabis program of a state or other jurisdiction other than Colorado.)

(b) New Mexico residents: A New Mexico resident who is not a member of a New Mexico Indian nation, tribe, or pueblo shall not participate in the medical

cannabis program as a reciprocal participant, but may pursue enrollment as a qualified patient in accordance with rule 7.34.3 NMAC. A member of a New Mexico Indian nation, tribe or pueblo medical cannabis program may participate as a reciprocal participant, provided that the individual has proof of authorization to participate in the New Mexico Indian nation, tribe or pueblo's medical cannabis program.

B. Reciprocal limit: A reciprocal participant may collectively possess within any three-month period a quantity of usable cannabis no greater than 425 total units. For purposes of department rules, this quantity is deemed the reciprocal limit. (For ease of reference: 425 units is equivalent to 425 grams, or approximately 15 ounces, of dried usable cannabis plant material.)

C. Registration: At the time of registration, a reciprocal participant shall sign a registration form acknowledging that they understand the requirements of participation in the program, including but not limited to acknowledging the time and quantity limits for reciprocal participation under this rule, as well as the state and federal prohibitions against the transport of cannabis across state and international boundaries.

D. Proof of authorization: Proof of authorization to participate in the medical cannabis program of another jurisdiction (an "originating jurisdiction") shall consist of a card or other physical document issued by a governmental entity authorized by law to enroll the applicant in the medical cannabis program in the originating jurisdiction. For purposes of reciprocal participation in the New Mexico medical cannabis program, permission from a medical practitioner shall not in itself be deemed proof of authorization to participate in the medical cannabis program of another jurisdiction, but shall be accompanied by a card or other proof of enrollment issued by an authorized governmental entity of the originating jurisdiction. (For example, a written letter from a physician authorizing the individual to participate in the California medical cannabis program shall not be deemed proof of authorization for the purpose of participating in the New Mexico medical cannabis program.)

E. Compliance with rule requirements: Noncompliance with the requirements of this rule may result in the suspension or revocation by the department of a reciprocal participant's registration and ability to participate reciprocally in the New Mexico medical cannabis program.

[7.34.3.22 NMAC - N, 2/22/2022]

PART 4: LICENSING REQUIREMENTS FOR PRODUCERS, PRODUCTION FACILITIES AND DISTRIBUTION

7.34.4.1 ISSUING AGENCY:

New Mexico Department of Health, Medical Cannabis Program.

[7.34.4.1 NMAC - Rp, 7.34.4.1 NMAC, 6/23/2020]

7.34.4.2 SCOPE:

This rule applies to all licensed producers of medical use cannabis, defined in Subsection D of Section 26-2B-3 NMSA 1978 as "any person or association of persons within New Mexico that the department determines to be qualified to produce, possess, distribute, and dispense cannabis pursuant to the Lynn and Erin Compassionate Use Act and that is licensed by the department."

[7.34.4.2 NMAC - Rp, 7.34.4.2 NMAC, 6/23/2020]

7.34.4.3 STATUTORY AUTHORITY:

The requirements set forth herein are promulgated by the secretary of the department of health (DOH) pursuant to the authority granted under Subsection E of Section 9-7-6 NMSA 1978, and the Lynn and Erin Compassionate Use Act, 26-2B-1 *et seq*., NMSA 1978. Although federal law currently prohibits any use of cannabis, the laws of several states permit the medical use and cultivation of cannabis. New Mexico joins this effort to provide for the health and welfare of its citizens. New Mexico adopts these regulations to accomplish the purpose of the Lynn and Erin Compassionate Use Act as stated in Section 26-2B-2 NMSA 1978, "to allow for the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments," while at the same time ensuring proper enforcement of any criminal laws for behavior that has been deemed illicit by the state.

[7.34.4.3 NMAC - Rp, 7.34.4.3 NMAC, 6/23/2020]

7.34.4.4 DURATION:

Permanent.

[7.34.4.4 NMAC - Rp, 7.34.4.4 NMAC, 6/23/2020]

7.34.4.5 EFFECTIVE DATE:

June 23, 2020 unless a later date is cited at the end of a section.

[7.34.4.5 NMAC - Rp, 7.34.4.5 NMAC, 6/23/2020]

7.34.4.6 OBJECTIVE:

Ensuring the safe production, distribution, and dispensation of cannabis for the sole purpose of medical use for alleviating symptoms caused by debilitating medical conditions in a regulated system.

[7.34.4.6 NMAC - Rp, 7.34.4.6 NMAC, 6/23/2020]

7.34.4.7 DEFINITIONS:

A. Definitions beginning with "A":

(1) "Act" means the Lynn and Erin Compassionate Use Act, Sections 26-2B-1 through 26-2B-7 NMSA 1978.

(2) "Adequate supply" means an amount of cannabis, in any form approved by the department, possessed by a qualified patient or collectively possessed by a qualified patient and the qualified patient's primary caregiver that is determined by rule of the department to be no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months and that is derived solely from an intrastate source.

(3) "Administrative review committee" means an intra-department committee that reviews qualified patient or primary caregiver application denials, licensed producer denials made by the program director, or the summary suspension of a producer's license, in accordance with department rules. The administrative review committee shall consist of the chief medical officer of the department (or that's person's designee); a deputy secretary of the department (or that person's designee), and the chief nursing officer of the department (or that person's designee).

(4) "Administrative withdrawal" means the procedure for the voluntary withdrawal of a qualified patient or primary caregiver from the medical cannabis program.

(5) "Advisory board" means the medical cannabis advisory board consisting of nine practitioners knowledgeable about the medical use of cannabis, who are appointed by the secretary.

(6) "Applicant" means any person applying for enrollment or re-enrollment in the medical cannabis program as a qualified patient, primary caregiver, or licensed producer.

(7) "Approved entity" means a manufacturer, laboratory, or courier.

B. Definitions beginning with "B": "Batch" means, with regard to usable cannabis, an identified quantity of cannabis no greater than five pounds that is of the same strain of cannabis, that is harvested during the same specified time period from the same specified cultivation area, , and with respect to which the same agricultural practices were utilized, including the use of any pesticides; and with regard to concentrated and cannabis-derived product, means an identified quantity that is uniform, that is intended to meet specifications for identity, strength, and composition, and that is manufactured, packaged, and labeled during a specified time period according to a single manufacturing, packaging, and labeling protocol.

C. Definitions beginning with "C":

(1) "Cannabis" means all parts of the plant Cannabis sativa L. containing a delta-9-tetrahydrocannabinol concentration of more than three-tenths percent on a dry weight basis, whether growing or not; the seeds of the plant; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin; and does not include the mature stalks of the plant; fiber produced from the stalks; oil or cake made from the seeds of the plant; any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, fiber, oil or cake; the sterilized seed of the plant that is incapable of germination; the weight of any other ingredient combined with cannabis to prepare topical or oral administrations, food, drink or another product; or hemp.

(2) "Cannabis consumption area" means an area within a licensed nonprofit producer's premises that is approved by the department, where cannabis may be consumed by qualified patients, in accordance with department rules.

(3) "Cannabis-derived product" means a product, other than cannabis itself, which contains or is derived from cannabis, not including hemp.

(4) "Cannabis establishment" means:

(a) a licensed cannabis courier;

(b) a licensed cannabis testing facility;

(c) a licensed cannabis manufacturer;

(d) a licensed non-profit producer; or

(e) such other person that the department may by rule approve for participation in the medical cannabis program.

(5) "CBD means cannabidiol, a cannabinoid and the primary non-psychoactive ingredient found in cannabis.

(6) "CBDA" means cannabidiolic acid, a non-psychoactive ingredient found in cannabis and an acid precursor to CBD.

(7) "Concentrated cannabis-derived product ("concentrate")" means a cannabis-derived product that is manufactured by a mechanical or chemical process that separates any cannabinoid from the cannabis plant, and that contains (or that is intended to contain at the time of sale or distribution) no less than thirty-percent THC by weight.

(8) "Courier" means a cannabis courier as defined by the Lynn and Erin Compassionate Use Act, Subsection D of Section 26-2B-3 NMSA 1978, that has been approved by the department specifically to transport usable cannabis and cannabis products within the state of New Mexico, from a cannabis establishment to a qualified patient, a primary caregiver, or another cannabis establishment.

D. Definitions beginning with "D":

(1) "Debilitating medical condition" means:

(a) cancer;

(b) glaucoma;

(c) multiple sclerosis;

(d) damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity;

(e) epilepsy;

(f) positive status for human immunodeficiency virus or acquired immune deficiency syndrome;

(g) admission into hospice care in accordance with rules promulgated by the department;

(h) amyotrophic lateral sclerosis;

(i) Crohn’s disease;

(j) hepatitis C infection;

(k) Huntington’s disease;

(l) inclusion body myositis;

(m) inflammatory autoimmune-mediated arthritis;

(n) intractable nausea or vomiting;

(o) obstructive sleep apnea;

(p) painful peripheral neuropathy;

(q) Parkinson’s disease;

(r) posttraumatic stress disorder;

(s) severe chronic pain;

(t) severe anorexia or cachexia;

(u) spasmodic torticollis;

(v) ulcerative colitis; or

(w) any other medical condition, medical treatment, or disease as approved by the department which results in pain, suffering, or debility for which there is credible evidence that medical use cannabis could be of benefit.

(2) "Department" means the department of health or its agent.

(3) "Diversion" means the unlawful transfer of a cannabis plant, plant material, or cannabis-derived product.

(4) "Dried usable cannabis" means the dried leaves, flowers, and trim of the female cannabis plant, but does not include the seeds, stalks, or roots of the cannabis plant.

E. Definitions beginning with "E": [RESERVED]

F. Definitions beginning with "F": "Facility" means any building, space, or grounds licensed for the production, possession, testing, manufacturing, or distribution of cannabis, concentrates, or cannabis-derived products.

G. Definitions beginning with "G": [RESERVED]

H. Definitions beginning with "H": "Hemp" means the plant cannabis sativa L. and any part of the plant, whether growing or not, containing a delta-9-tetrahydrocannabinol concentration of no more than three-tenths percent on a dry weight basis.

I. Definitions beginning with "I":

(1) "Intrastate" means existing or occurring within the state boundaries of New Mexico.

(2) "Inversion" means the unlawful acquisition of a cannabis plant, plant material, or cannabis-derived product.

J. Definitions beginning with "J": [RESERVED]

K. Definitions beginning with "K": [RESERVED]

L. Definitions beginning with "L":

(1) "Laboratory" means a licensed cannabis testing facility as defined in the Lynn and Erin Compassionate Use Act, Subsection I of Section 26-2B-3 NMSA 1978, that has been approved by the department specifically for the testing of cannabis, concentrates, and cannabis derived products.

(2) "Laboratory applicant" means a laboratory that seeks to become an approved laboratory, or that seeks renewal of approval as an approved laboratory, in accordance with this rule.

(3) "Licensed producer" means a person or entity licensed to produce medical cannabis.

(4) "Lot" means an identified portion of a batch, that is uniform and that is intended to meet specifications for identity, strength, and composition; or, in the case of a cannabis-derived product or concentrate, an identified quantity produced in a specified period of time in a manner that is uniform and that is intended to meet specifications for identity, strength, and composition.

M. Definitions beginning with "M":

(1) "Male plant" means a male cannabis plant.

(2) "Manufacture" means to prepare a cannabis product.

(3) "Manufacturer" means a cannabis manufacturer as defined in the Lynn and Erin Compassionate Use Act, Subsection F of Section 26-2B-3 NMSA 1978, that has been approved by the department specifically to manufacture cannabis products; package, transport or courier cannabis products; have cannabis products tested by a cannabis testing facility; purchase, obtain, sell and transport cannabis products to other cannabis establishments; and prepare products for personal production license holders.

(4) "Mature female plant" means a harvestable female cannabis plant that is flowering.

(5) "Medical cannabis program" means the administrative body of the department charged with the management of the medical cannabis program and enforcement of program regulations, to include issuance of registry identification cards, licensing of producers, and regulation of manufacturing and distribution.

(6) "Medical cannabis program director" means the administrator of the medical cannabis program who holds that title.

(7) "Medical director" means a medical practitioner designated by the department to determine whether the medical condition of an applicant qualifies as a debilitating medical condition eligible for enrollment in the program, and to perform other duties.

(8) "Medical provider certification for patient eligibility form" means a written certification form provided by the medical cannabis program signed by a patient's practitioner that, in the practitioner's professional opinion, the patient has a debilitating medical condition as defined by the act or this part and would be anticipated to benefit from the use of cannabis.

(9) "Minor" means an individual who is less than 18 years of age.

N. Definitions beginning with "N": "Non-profit producer" means a New Mexico corporation that has been designated as a non-profit corporation by the New Mexico secretary of state, that has been licensed by the department to possess, produce, dispense, distribute and manufacture cannabis and cannabis products and sell wholesale or by direct sale to qualified patients and primary caregivers.

O. Definitions beginning with "O": [RESERVED]

P. Definitions beginning with "P":

(1) "Paraphernalia" means any equipment, product, or material of any kind that is primarily intended or designed for use in compounding, converting, processing, preparing, inhaling, or otherwise introducing cannabis or its derivatives into the human body.

(2) "Patient enrollment/re-enrollment form" means the registry identification card application form for patient applicants provided by the medical cannabis program.

(3) "Permanent structure" means a building or structure that is placed on the land for the foreseeable future that is anchored to a permanent foundation, that is roofed and walled, and which requires a building permit from a local and or state governing authority.

(4) "Personal production license" means a license issued to a qualified patient or to a qualified patient’s primary caregiver participating in the medical cannabis program to permit the qualified patient or the qualified patient's primary caregiver to produce cannabis for the qualified patient's use at an address approved by the department.

(5) "Pesticide" means a pesticide as defined by the New Mexico Pesticide Control Act, Section 76-4-3, NMSA 1978.

(6) "Petitioner" means any New Mexico resident or association of New Mexico residents petitioning the advisory board for the inclusion of a new medical condition, medical treatment, or disease to be added to the list of debilitating medical conditions that qualify for the use of cannabis.

(7) "Plant" means any cannabis plant, cutting, or clone that has roots or that is cultivated with the intention of growing roots.

(8) "Policy" means a written statement of principles that guides and determines present and future decisions and actions of the licensed producer.

(9) "Practitioner" means a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act, Sections 30-31-1 *et seq.*, NMSA 1978.

(10) "Primary caregiver" means a resident of New Mexico who is at least 18 years of age and who has been designated by the qualified patient or their representative and the patient's practitioner as being necessary to take responsibility for managing the well-being of a qualified patient with respect to the medical use of cannabis pursuant to the provisions of the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq*., NMSA 1978.

(11) "Primary caregiver application form" means the registry identification card application form provided by the medical cannabis program.

(12) "Private entity" means a private, non-profit organization that applies to become or is licensed as a producer and distributor of cannabis, concentrates, or cannabis-derived products.

(13) "Produce" means to engage in any activity related to the planting or cultivation of cannabis.

(14) "Proficiency testing" means testing conducted by the department or its agent to determine the ability of a laboratory applicant or approved laboratory to accurately identify presence, quantity, or other factors pertaining to a given analyte.

Q. Definitions beginning with "Q": "Qualified patient" means a resident of New Mexico who has been diagnosed by a practitioner as having a debilitating medical condition and has received a registry identification card issued pursuant to the requirements of the act or department rules.

R. Definitions beginning with "R":

(1) "Recall" means to request the return of a product after the discovery of a safety issue or product defect.

(2) "Reciprocal limit" means the quantity of cannabis and cannabis products that a reciprocal participant can use and possess in a given year pursuant to department rule.

(3) "Reciprocal participant" means an individual who holds proof of authorization to participate in the medical cannabis program of another state of the United States, the District of Columbia, a territory or commonwealth of the United States or a New Mexico Indian nation, tribe or pueblo.

(4) "Registry identification card" means a document issued and owned by the department which identifies a qualified patient authorized to engage in the use of cannabis for a debilitating medical condition or a document issued by the department which identifies a primary caregiver authorized to engage in the intrastate possession and administration of cannabis for the sole use of the qualified patient.

(5) "Representative" means an individual designated as the applicant's or petitioner's agent, guardian, surrogate, or other legally appointed or authorized health care decision maker.

S. Definitions beginning with "S":

(1) "Secretary" means the secretary of the New Mexico department of health.

(2) "Secure grounds" means a facility that provides a safe environment to avoid loss or theft.

(3) "Security alarm system" means any device or series of devices capable of alerting law enforcement , including, but not limited to, a signal system interconnected with a radio frequency method such as cellular, private radio signals, or other mechanical or electronic device used to detect or report an emergency or unauthorized intrusion.

(4) "Security policy" means the instruction manual or pamphlet adopted or developed by the licensed producer containing security policies, safety and security procedures, and personal safety and crime prevention techniques.

(5) "Seedling" means a cannabis plant that has no flowers and that is less than 12 inches in height, as measured vertically in the plant's natural position from the uppermost part of the root system (or from the soil line, if the plant is planted in soil) to the tallest point of the plant.

(6) "Segregate" means to separate and withhold from use or sale batches, lots, cannabis, usable cannabis, or cannabis-derived products in order to first determine its suitability for use through testing by an approved laboratory.

T. Definitions beginning with "T":

(1) "THC" means tetrahydrocannabinol, a cannabinoid that is the primary psychoactive ingredient in cannabis.

(2) "THCA" means tetrahydrocannabinolic acid, a non-psychoactive ingredient in cannabis and an acid precursor to THC.

(3) "Technical evidence" means scientific, clinical, medical, or other specialized testimony, or evidence, but does not include legal argument, general comments, or statements of policy or position concerning matters at issue in the hearing.

(4) "Telemedicine" means the use of telecommunications and information technology to provide clinical health care from a site apart from the site where the patient is located, in real time or asynchronously

including the use of interactive simultaneous audio and video or store-and-forward technology, or off-site patient

monitoring and telecommunications in order to deliver health care services.

(5) "Testing" means testing of cannabis and cannabis derived products, consistent with provisions of this rule.

U. Definitions beginning with "U":

(1) "Unit" means a quantity of usable cannabis, concentrate, or cannabis-derived product that is used in identifying the maximum supply that a qualified patient may possess for purposes of department rules.

(2) "Usable cannabis" means the dried leaves and flowers of the female cannabis plant and cannabis-derived products, including concentrates, but does not include the seeds, stalks, or roots of the plant.

V. Definitions beginning with "V": [RESERVED]

W. Definitions beginning with "W": "Wastage" means the destruction of usable cannabis or cannabis plants.

X. Definitions beginning with "X": [RESERVED]

Y. Definitions beginning with "Y": [RESERVED]

Z. Definitions beginning with "Z": [RESERVED]

[7.34.4.7 NMAC - Rp, 7.34.4.7 NMAC, 6/23/2020]

7.34.4.8 PRODUCER LICENSING; GENERAL PROVISIONS:

A. The department may license two classes of producers:

(1) A qualified patient or primary caregiver who holds a valid personal production license. A qualified patient or primary caregiver who holds a valid personal production license is authorized to possess no more than four mature female plants and a combined total of 12 seedlings and male plants, and may possess no more than an adequate supply of usable cannabis, as specified in department rule; provided that a qualified patient or qualified patient's primary caregiver may possess that qualified patient's harvest of cannabis. A personal production license holder may additionally obtain usable cannabis, seeds, or plants from licensed non-profit producers. The primary caregiver of a qualified patient who holds a personal production license may assist the qualified patient to produce medical cannabis at the designated licensed location that is identified on the personal production license.

(2) A non-profit producer that operates a facility and, at any one time, is limited to a combined total of no greater than 1,750 cannabis plants, not including seedlings, and an inventory of usable cannabis and seeds that reflects current patient needs. A non-profit producer may possess any quantity of seedlings, as defined in this rule. A non-profit producer shall not possess a quantity of cannabis plants that exceeds the quantities authorized by their licensure and associated licensing fee. A licensed non-profit producer may sell and distribute usable cannabis to a person or entity authorized to possess and receive it. A licensed non-profit producer may obtain plants, seeds and usable cannabis from other licensed non-profit producers.

B. Increase to non-profit producer plant limit: The department may increase the cannabis plant limitation for a licensed non-profit producer in accordance with the following:

(1) Effective June 1, 2021, a non-profit producer may request an increase of up to 500 plants that exceeds the total plants allowed in Paragraph (2) of Subsection A of 7.34.4.8 NMAC at the time of renewal of its licensure period. In order to be considered for approval by the department, the non-profit producer shall demonstrate a need for the plant count increase to meet demand for their qualified patients. The non-profit producer shall provide the following information to the department to demonstrate the need for a plant count increase:

(a) average yield of usable cannabis flower and trim produced by the non-profit producer from the past 12 months;

(b) current reported inventory of cannabis and cannabis-derived products;

(c) percentage of usable cannabis and cannabis-derived products that was sold to qualified patients, primary caregivers, or to another licensed producer or manufacturer; and

(d) any other information requested by the department.

(2) The department shall make a determination to approve or deny the non-profit producer's request to increase plant count based on the following factors:

(a) the non-profit producer has sold at least eighty percent of its usable cannabis for the last 12 months it has operated;

(b) the non-profit producer's current inventory and average yield of usable cannabis is consistent with current averages from other licensed producers;

(c) the number and severity of complaints and enforcement actions on the non-profit licensed producer;

(d) the information provided by non-profit producer is consistent with the quarterly reports or inventory tracking information it has provided to the department within the last 12 months;

(e) supply and demand of medical cannabis throughout the state and in underserved geographical regions; and

(f) the completeness of information and data provided to the department.

(3) Effective June 1, 2021, a non-profit producer may request an emergency increase once per year outside of their license renewal period, of up to 500 plants that exceeds the total plants allowed in Paragraph (2) of Subsection A of 7.34.4.8 NMAC, at any time. The non-profit producer shall demonstrate a need for the plant count increase to meet demand for their qualified patients, and shall submit to the department the information identified in Paragraph (1) of Subsection B of 7.34.4.8 NMAC. The department shall only approve the request if the non-profit producer can demonstrate by clear and convincing evidence that it is not able to meet qualified patient demand for usable cannabis or cannabis-derived products with its current plant count or by obtaining usable cannabis or cannabis products from another licensed producer. The non-profit producer shall provide objective data about the current supply in the medical cannabis market to demonstrate these factors. The department shall also consider the same factors in Subsection B when approving or denying this request.

(4) Any increase in plant count approved under this section shall be voided in the event of a transfer of the majority of ownership for a licensed producer, at which time the plant limit for the license shall revert to the limit allowed in Paragraph (2) of Subsection A above.

(5) The department is not required to approve a request for an increase to a non-profit producer's plant limit and retains sole discretion to grant or deny the request.

C. Limitation on distribution: A non-profit producer shall not knowingly sell or otherwise distribute usable cannabis to any person or entity that is not authorized to possess and receive the usable cannabis pursuant to department rules.

D. Processing of production applications:

(1) The issuance of an application is in no way a guarantee that the completed application will be accepted or that a license will be granted. Information provided by the applicant and used by the licensing authority for the licensing process shall be accurate and truthful. Any applicant that fails to participate in good faith or that falsifies information presented in the licensing process shall have its application denied by the department.

(2) The number of licenses issued by the department to non-profit private entities, and the determination of which non-profit entities shall be licensed, shall be determined at the discretion of the secretary, which determination shall constitute the final administrative decision of the department.

(3) An applicant whose application for licensure is not approved shall not be entitled to further administrative review.

E. Factors considered: The secretary shall consider the overall health needs of qualified patients and the safety of the public in determining the number of licenses to be issued to non-profit private entities and shall further consider:

(1) the sufficiency of the overall supply available to qualified patients statewide;

(2) the service location of the applicant;

(3) the applicant's production plan, including but not limited to the applicant's plan for the growth, cultivation, and harvesting of medical cannabis;

(4) the applicant's sales and distribution plan, including but not limited to the applicant's plan for sale of medical cannabis, plan for delivery (if any) to qualified patients, and the forms of usable cannabis and cannabis-derived products to be sold or distributed;

(5) the applicant's skill and knowledge of horticulture and cannabis production technology, as well as the applicant's knowledge of current good manufacturing practice in manufacturing, packaging, labeling, or holding operations for dietary supplements; environmental protection agency agricultural worker protection standards; and New

Mexico department of agriculture (NMDA) pesticide registration, licensing and use requirements to ensure a safe product and environment;

(6) the applicant's plan for the manufacture or distribution of cannabis derived products, including but not limited to edible products;

(7) the security plan proposed, including location, security devices employed, and staffing;

(8) the applicant's quality assurance plan, including but not limited to the applicant's plan to ensure purity, consistency of dose, as well as the applicant's plan for routine testing by a department approved laboratory;

(9) the experience and expertise of the non-profit board members;

(10) the financial resources available to the applicant for licensure and operations;

(11) the facilities available to the applicant for production, distribution, storage, and other purposes, and the applicant's ownership of the property, buildings, or other facilities identified in the production and distribution plan, as applicable; and

(12) other relevant factors.

F. Production and distribution of medical cannabis by a licensed non-profit producer; use of couriers: Production and distribution of medical cannabis by a licensed non-profit producer to a qualified patient or primary caregiver shall take place at locations described in the non-profit producer's production and distribution plan approved by the department, and shall not take place at locations that are within 300 feet of any school, church, or daycare center that existed within the 300-foot area before the producer became licensed to operate at the location; provided that this distance requirement shall not apply to distribution at the home of the qualified patient or

primary caregiver. A licensed non-profit producer may, consistent with this rule, and with the consent of a purchasing qualified patient or primary caregiver, utilize an approved courier to transport usable cannabis to a qualified patient or primary caregiver, and may for this purpose share with an approved courier the contact information of the purchasing qualified patient or primary caregiver. A licensed non-profit producer may, consistent with this rule, also utilize an approved courier to transport usable cannabis to another non-profit producer, to an approved laboratory, and to an approved manufacturer. A licensed non-profit producer shall not identify any person as an intended recipient of usable cannabis who is not a qualified patient, a primary caregiver, an approved courier, an approved manufacturer, or an approved laboratory.

G. Verification of application information: The department may verify information contained in each application and accompanying documentation by:

(1) contacting the applicant by telephone, mail, or electronic mail;

(2) conducting an on-site visit;

(3) requiring a face-to-face meeting and the production of additional identification materials if proof of identity is uncertain; and

(4) requiring additional relevant information as the department deems necessary.

H. Cooperation with the department: Upon submitting an application, an applicant shall fully cooperate with the department and shall timely respond to requests for information or documentation. Failure to cooperate with a request of the department may result in the application being denied or otherwise declared incomplete.

I. Criminal history screening requirements: All persons associated with a licensed non-profit producer or non-profit producer-applicant, manufacturer or manufacturer-applicant, approved laboratory or laboratory applicant, and approved courier or courier-applicant, shall consent to and undergo a nationwide and department of public safety (DPS) statewide criminal history screening background check. This includes board members, persons having direct or indirect authority over management or policies, employees, contractors, and agents. Background check documentation shall be submitted annually for approval to the department with the applicant's renewal materials and prior to an individual assuming any duties or responsibilities for a non-profit producer, manufacturer, laboratory, or courier. Background check documentation shall be received by the medical cannabis program, and the individual shall be approved by the program, before the individual begins to provide any work or services to the producer, manufacturer, laboratory, or courier.

(1) Criminal history screening fees: All applicable fees associated with the nationwide and DPS statewide criminal history screening background checks shall be paid by the non-profit producer, manufacturer, laboratory, courier, or applicant.

(2) Disqualifying convictions: Individuals convicted of a felony violation of Section 30-31-20 (trafficking of a controlled substance); 30-31-21 (distributing a controlled substance to a minor); 30-31-22 NMSA 1978 (distributing a controlled substance); or a violation of any equivalent federal statute or equivalent statute from any other jurisdiction, shall be prohibited from participating or being associated with either a non-profit producer licensed under this rule, an approved laboratory, an approved manufacturer, or an approved courier. If an individual has been convicted of a felony violation of the NM Controlled Substances Act other than Sections 30-31-20 through 30-31-22 NMSA 1978, or has been convicted of any equivalent federal statute or equivalent statute from any other jurisdiction, and the final completion of the entirety

of the associated sentence of such conviction has been less than five years from the date of the individual's anticipated association with the production facility, then the individual shall be prohibited from serving on the board of a licensed non-profit producer, or working for the licensed producer, or approved entity. An individual who is disqualified shall be notified of his or her disqualification. If an individual has been convicted of more than one felony violation of the above-cited sections of the NM Controlled Substances Act or an equivalent federal statute or equivalent statute from any other jurisdiction, the individual shall be notified that he or she is permanently prohibited from participating or being associated with a licensed non-profit producer, approved manufacturer, approved laboratory, or approved courier. Any violation of this subsection shall result in the immediate revocation of any privilege granted under this rule and the act.

J. Board membership requirements for private entities: The board of directors for a private non-profit applicant or licensee shall include at a minimum five voting members, including one medical provider limited to a physician (MD or DO), a registered nurse, nurse practitioner, licensed practical nurse, or physician assistant, and three patients currently qualified under the Lynn and Erin Compassionate Use Act.

(1) for purposes of board membership, a single individual may not qualify as both the patient and as the medical provider;

(2) members of the board of directors for a non-profit producer shall be residents of New Mexico; and

(3) no member of a non-profit producer's board of directors may at any given time serve on more than one single board of directors for licensed non-profit producers, or be employed by another non-profit producer.

K. Limitation on number of production facilities: A licensed non-profit producer shall conduct its production operations at a single, physical location approved by the department. An additional production facility or facilities may be allowed at the department's discretion.

L. Limitation on sales within 90 consecutive calendar days: A licensed non-profit producer shall not sell or distribute usable cannabis to a qualified patient or primary caregiver in a total quantity that exceeds 230 units, as described in department rules concerning patient registry identification cards, within any 90-day period, unless the qualified patient or primary caregiver presents proof of a valid medical exception granted by the department.

M. Destruction of usable cannabis and cannabis plants: A licensed non-profit producer shall document the destruction of any usable cannabis or cannabis plants using a video recording, and shall retain the video recording of the destruction for no less than 120 days. A licensed non-profit producer shall make the video recording of the

destruction available for the department's inspection or copying upon the department's request.

N. Maximum water content in dried usable cannabis: A licensed non-profit producer shall not sell usable cannabis, other than a cannabis derived product, that contains fifteen percent or greater water content by weight. A licensed non-profit producer may be subject to testing to ensure compliance, consistent with the provisions of this rule.

O. Non-profit producer policies and procedures: The non-profit producer shall develop, implement, and maintain on the premises policies and procedures relating to the medical cannabis program, which shall at a minimum include the following:

(1) distribution criteria for qualified patients or primary caregivers appropriate for cannabis services, to include clear, legible photocopies of the registry identification card and New Mexico photo identification card of every qualified patient or primary caregiver served by the private entity;

(2) testing criteria and procedures, which shall be consistent with the testing requirements of this rule;

(3) alcohol and drug-free work place policies and procedures;

(4) an attestation that no firearms will be permitted on any premises used for production or distribution by the non-profit entity;

(5) employee policies and procedures to address the following requirements:

(a) job descriptions or employment contracts developed for every employee that identify duties, authority, responsibilities, qualifications, and supervision; and

(b) training materials concerning adherence to state and federal confidentiality laws.

(6) personnel records for each employee that include an application for employment and a record of any disciplinary action taken;

(7) on-site training curricula, or contracts with outside resources capable of meeting employee training needs, to include, at a minimum, the following topics:

(a) professional conduct, ethics, and patient confidentiality; and

(b) informational developments in the field of medical use of cannabis.

(8) employee safety and security training materials provided to each employee at the time of his or her initial appointment, to include:

(a) training in the proper use of security measures and controls that have been adopted; and

(b) specific procedural instructions regarding how to respond to an emergency, including robbery or a violent accident.

(9) a general written security policy, to address at a minimum:

(a) safety and security procedures;

(b) personal safety; and

(c) crime prevention techniques.

(10) training documentation prepared for each employee and statements signed by employees indicating the topics discussed (to include names and titles of presenters) and the date, time, and place the employee received said training;

(11) a written policy regarding the right of the private entity to refuse service;

(12) a confidentiality policy to ensure that identifying information of qualified patients is not disclosed or disseminated without authorization from the patient, except as otherwise required by the department;

(13) an attestation that the nonprofit producer will prohibit its employees and contractors from being under the influence of drugs or alcohol in the workplace; and

(14) such other policies or procedures as the department may require.

P. Retention of training documentation: A non-profit producer shall maintain documentation of an employee's training for a period of at least six months after termination of an employee's employment.

Q. Licensure periods:

(1) Licensure period for non-profit producers: The licensure period of a licensed non-profit producer shall be from August 1st (or the date of approval of the licensure application, if later) through July 31st of a given year. Exception; transition to revised 2019 rules: The licensure period for a licensed non-profit producer that would otherwise end on August 1, 2019 shall instead continue until September 30, 2019.

(2) Licensure period for qualified patient producers: A qualified patient's personal production license shall expire one year after the issuance of the personal production license, or at the end of the person's enrollment in the NM medical cannabis program, whichever occurs first.

(3) Identification cards: An employee of a licensed non-profit producer shall carry their department issued employee identification card at all times during their work, and shall present the card to law enforcement officials and to department officials upon request. An employee who is unable to produce their department issued identification card upon request shall not remain on the licensed premises, and shall produce the card for the department's inspection prior to returning to the licensed premises. Licenses and identification cards issued by the department are the property of the department and shall be returned to the department upon a producer's withdrawal from the program, upon termination of a card holder's employment with a licensed non-profit producer, or upon suspension or revocation.

R. Amended license:

(1) Submittal of application for amended license: A licensed producer shall submit to the department an application form for an amended license, and shall obtain approval from the department, at least 30 business days prior to implementing any:

(a) change of location of a qualified patient who also holds a personal production license;

(b) change of location of a non-profit producer's production or distribution facilities, change of directors, change of ownership of production or distribution facilities, producer name, capacity or any physical modification or addition to the facility; and

(c) substantial change to a producer's production plan or distribution plan, including any change to the type(s) of products produced or distributed, the producer's manufacturing plan (as applicable), the producer's method(s) of distribution, and security plan.

(2) Process for incomplete application for amended license: In the event that an application for amended licensure is determined by the program to be incomplete, the program will specify the information or materials that remain to be submitted. If the licensed producer does not submit the requested information or material, and does not otherwise contact the department regarding the application, within thirty days of receiving notice of the deficiency, the application will be closed as incomplete, and the licensed producer will be required to recommence the application in order to resume the application process.

S. Application for renewal of an annual production license:

(1) Deadline for private entities. Each licensed non-profit producer shall apply for renewal of its annual license no later than August 1st of each year by submitting a renewal application to the department. The department shall provide the renewal application requirements no later than June 1st of each year.

(2) Deadline for personal production license holders: A patient who holds personal production licensure shall apply for renewal of their annual license no later than 30 days prior to the expiration of the license by submitting a renewal application to the department.

(3) General submission requirements for qualified patients: Qualified patients applying for personal production licensure shall submit:

(a) an application for issuance or renewal of a personal production license; and

(b) a non-refundable thirty dollar ($30) application fee, except that the fee may be waived upon a showing that the income of the qualified patient is equal to or lesser than two hundred percent of the federal poverty guidelines established by the U.S. department of health and human services. A lost or stolen identification card shall be reported as soon as practicable to the medical cannabis program.

(4) General submission requirements for private entities: Private entities shall submit:

(a) an application for renewal of license; and

(b) applicable non-refundable licensure renewal fees.

T. Non-transferable registration of license:

(1) A license shall not be transferred by assignment or otherwise to other persons or locations. Unless the licensed producer applies for and receives an amended license, the license shall be void and returned to the department when any one of the following situations occurs:

(a) ownership of the facility changes;

(b) location change;

(c) change in licensed producer;

(d) the discontinuance of operation; or

(e) the removal of all medical cannabis from the facility by lawful state authority.

(2) Transactions, which do not constitute a change of ownership, include the following:

(a) when applicable, changes in the membership of a corporate board of directors or board of trustees; and

(b) two or more corporations merge and the originally licensed corporation survives.

U. Automatic expiration of license; closure of nonprofit producer operations: A license shall expire at 11:59 p.m. on the day indicated on the license as the expiration date, unless the license was renewed at an earlier date, suspended, or revoked.

V. Display of license: The licensed producer shall maintain the license safely at the production location(s) and dispensary location(s) and shall be able to produce the license immediately upon request by the department or law enforcement.

W. Fees applicable to applicants and licensees:

(1) Non-profit producer application fee: A non-profit producer shall submit with its initial application an application fee of ten thousand dollars ($10,000). If the application is denied, the department shall issue a refund of nine thousand dollars ($9,000) to the applicant.

(2) Non-profit producer license fee: A non-profit producer that is licensed shall submit to the medical cannabis program a non-refundable licensure fee before beginning operations, no earlier than July 1st of each renewal year and no later than August 1st of each renewal year, of: $40,000 for the first 500 cannabis plants to be possessed by the non-profit producer; $5,000 for each additional increment of 50 cannabis plants above 500 and up to a collective total of 1,000 cannabis plants; and $6,000 for each additional increment of 50 cannabis plants above 1,000.

(3) Exception; transition to revised LNPP fees, plant limits: A fee that is paid by a non-profit producer in the year 2019 shall be tendered to the department no earlier than September 23, 2019 and no later than October 4, 2019.

(4) Exception; newly licensed LNPPs: The license fee to be paid by a non-profit producer that obtains initial licensure after the enactment of this revised rule shall be pro-rated based on the time remaining in the licensure period.

(5) Qualified patient personal production fees: A qualified patient shall submit with each initial application and renewal application for personal production licensure a fee of thirty dollars ($30), except that the fee may be waived upon a showing that the income of the qualified patient is equal to or lesser than two hundred percent of the federal poverty guidelines established by the U.S. department of health and human services; and.

(6) Replacement license fee: A fifty dollar ($50) payment is required for replacement of an identification card for an employee of a licensed non-profit producer, and for replacement of a personal production license card.

(7) Payment: Fees shall be paid by check, money order, or any other form of payment approved by the medical cannabis program director or designee, and shall be made payable to the medical cannabis program of the department.

X. Geographic requirements for initial licenses: The department may require that a non-profit producer operate dispensaries in geographical locations of the state that are specified by the department as a precondition of initial licensure.

Y. Inventory and sales equipment: The department may require a licensed non-profit producer to utilize specified equipment, software, and services for purposes of tracking inventory, sales, and other information, and for the purpose of reporting that information to the department of health.

Z. Reporting of theft to department: A non-profit producer shall submit to the department notification of any theft, robbery, break-in, or security breach that occurs on the producer's premises, no later than 10 calendar days after the producer first becomes aware of the event. The description shall include a description of any property that was stolen or destroyed, and the quantity of any usable cannabis that was stolen.

AA. Closure of applications period: The department may close the applications period during which applications for non-profit producer licenses will be accepted and reviewed.

[7.34.4.8 NMAC - Rp, 7.34.4.8 NMAC, 6/23/2020]

7.34.4.9 NON-PROFIT PRODUCERS; MINIMUM STANDARDS FOR PRODUCTION OF CANNABIS:

A non-profit producer shall comply with the following minimum requirements for the production of cannabis:

A. General requirements: A licensed non-profit producer shall ensure the following:

(1) that all production activities are done on premises that are in compliance with state and local laws, including but not limited to zoning, occupancy, licensing, and building codes;

(2) that all equipment, implements, and fixtures that are used for the production of cannabis shall be used exclusively for the production of cannabis;

(3) that no cannabis plants other than those grown pursuant to the non-profit producer's production license from the department are grown on the licensed property of the non-profit producer, including but not limited to hemp plants;

(4) that production is conducted in a manner that does not allow cross-contamination from chemical or biological hazards;

(5) that production does not occur at a location that is within 300 feet of a school, church, or daycare center that existed within the 300-foot area before the producer became licensed to operate at the location;

(6) that any person who, by medical examination or supervisory observation, is shown to have, or appears to have, an illness, open lesion, including a boil, sore, or infected wound, or any other abnormal source of microbial contamination for whom there is a reasonable possibility of contact with preparation surfaces for cannabis, shall be excluded from any operations which may be anticipated to result in such contamination until the condition is corrected;

(7) that hand-washing facilities are provided that are adequate, accessible, and conveniently located, and that they are furnished with running water at a suitable temperature; hand-washing facilities shall be located in indoor production facilities, in restrooms, and wherever good sanitary practices require employees to wash or sanitize their hands, and shall be stocked with effective hand-cleaning and sanitizing preparations, and sanitary towel service or suitable drying devices;

(8) that all persons involved in preparing or handling medical cannabis conform to hygienic practices while on duty, including:

(a) maintaining adequate personal cleanliness;

(b) washing hands thoroughly in an adequate hand-washing area before starting work, at any other time when the hands may have become soiled or contaminated, and both before putting gloves on and after removal of gloves;

(c) refraining from preparing or handling medical cannabis or cannabis derived products if the handler has or may have an illness, open lesion, including boils, sores, or infected wounds, or any other abnormal source of microbial contamination, until such condition is corrected; and

(d) complying with the other requirements of this section;

(9) that there is sufficient space for placement of equipment and storage of materials as is necessary for the maintenance of sanitary operations for production of medical cannabis;

(10) that litter and waste are properly removed, and the operating systems for waste disposal are maintained in an adequate manner so that they do not constitute a source of contamination in areas where cannabis is exposed;

(11) that all floors (other than earthen floors), walls, and ceilings that are located within a permanent structure are constructed in such a manner that they are washable, wipeable, and non-absorbent, and can be kept clean, and kept in good repair;

(12) that walls and ceilings remain free of water damage, and that fiberglass and other insulation material not be exposed;

(13) that there is adequate safety-type lighting in all areas where cannabis is processed or stored, and where equipment or utensils are cleaned;

(14) that the non-profit producer provides adequate screening or other protection against the entry of pests; rubbish shall be disposed of so as to minimize the development of odor, minimize the potential for the waste becoming an attractant and harborage, or breeding place for pests;

(15) that building, fixtures, and other physical facilities where cannabis is produced are maintained in a sanitary condition;

(16) that all contact surfaces, including utensils and equipment used for preparation of cannabis, are cleaned and sanitized as frequently as necessary to protect against contamination;

(17) that all equipment and utensils used for preparation of cannabis are designed and of such material and workmanship as to be adequately cleanable, and are properly maintained;

(18) that only environmental protection agency (EPA) registered sanitizing agents are used in production operations and that they are used in accordance with labeled instructions;

(19) that toxic cleaning compounds, sanitizing agents, and pesticide chemicals shall be identified, held, and stored in a manner that protects against contamination of medical cannabis or cannabis derived products, and that otherwise satisfies the requirements of this rule;

(20) that the water supply is sufficient for the operations intended and is derived from a source that is a regulated water system; private water supplies shall be from a water source that is capable of providing a safe, potable, and adequate supply of water to meet the production facility’s needs;

(21) that plumbing shall be of adequate size and design, adequately installed, and maintained to carry sufficient quantities of water to required locations throughout the facility; and properly convey sewage and liquid disposable waste from the facility;

(22) that there are no cross-connections between the potable and waste water lines;

(23) that the non-profit producer provide its employees with adequate, readily accessible, on-site toilet facilities that are maintained in a sanitary condition and good repair;

(24) that all operations in the receipt, inspection, transport, segregation, preparation, manufacture, packaging, and storage of usable cannabis are conducted in accordance with adequate security and sanitation principles;

(25) that usable cannabis that can support the rapid growth of undesirable microorganisms are stored and transported in a manner that prevents the growth of these microorganisms;

(26) that storage and transportation of usable cannabis is accomplished under conditions that will maintain security and protect the usable cannabis against physical, chemical, and microbial contamination as well as against deterioration of the usable cannabis and the container;

(27) that current material safety data sheets are kept on the premises for all chemicals used, including but not limited to cleaning compounds, sanitizing agents, and pesticides;

(28) that all containers used for storage or transport of usable cannabis are washable, wipeable, and nonabsorbent;

(29) that all weighting or measuring devices that are used in the production or distribution of usable cannabis be appropriately documented as having undergone certified registration and calibration that is in accordance with applicable requirements of the New Mexico department of agriculture;

(30) that the non-profit producer will prohibit its employees and contractors from being under the influence of drugs or alcohol in the workplace; and

(31) that hemp, hemp extract, and hemp derived products, other than hemp paper and hemp seed oil, are not combined in any manner with usable cannabis intended to be sold or otherwise distributed by the non-profit producer.

[7.34.4.9 NMAC - Rp, 7.34.4.9 NMAC, 6/23/2020]

7.34.4.10 TESTING OF USABLE CANNABIS:

All dried usable cannabis produced by a non-profit producer that is not converted into a concentrated cannabis derived product, and all concentrated cannabis derived products manufactured by a non-profit producer or manufacturer, shall be sampled for testing purposes by the licensed non-profit producer or manufacturer, and those samples shall be tested by an approved laboratory consistent with the requirements of this rule and found to have passed all tests required by this rule, prior to the sale, distribution, or other use of the product. Each batch of dried usable cannabis, other than cannabis that will be converted into a concentrated cannabis derived product, shall be segregated and sampled by the non-profit producer that produced the batch, and the non-profit producer shall ensure that each sample is tested by an approved laboratory in accordance with the testing requirements of this rule and determined to have passed the following individual testing requirements, before dried usable cannabis from that batch is made available for sale or distribution, and before the dried usable cannabis or any substance derived therefrom is incorporated into a cannabis derived product. Each batch of concentrated cannabis derived product shall be segregated and sampled by the manufacturer or non-profit producer that produced the batch, and the manufacturer or non-profit producer (as applicable) shall ensure that each sample is tested by an approved laboratory in accordance with the testing requirements of this rule, and determined by the manufacturer or non-profit producer (as applicable) to have passed the following individual testing requirements, before cannabis derived product from that batch is made available for sale or distribution.

A. Exception; staggered implementation: The department may within its discretion waive testing requirements of this section, in whole or in part, based on considerations such as the ability of currently approved laboratories to process all testing samples, or in order to allow additional time for laboratories to implement revised testing standards.

B. Exception for previously tested cannabis: Except as otherwise provided in this rule, a non-profit producer or manufacturer shall not be required to sample and test dried usable cannabis or a concentrated cannabis-derived product if the batch was previously sampled and the sample was tested by another non-profit producer or manufacturer in accordance with this rule and determined to have passed the testing requirements of this rule.

C. Individual testing requirements:

(1) Microbiological test: A non-profit producer shall sample and test dried usable cannabis, and a manufacturer or non-profit producer (as applicable) shall sample and test concentrated cannabis derived products, for microbiological contaminants, using an approved laboratory prior to sale, distribution, or other use. A sample may be deemed to have passed the microbiological test if the sample contains less than each action level set forth in Table 1, Microbiological Testing Requirements, below.

Table 1. Microbiological Testing Requirements

Final Product	Test Parameter	Action Level	Test Units
Chopped or Powdered Botanicals (Dried Usable Cannabis Not Extracted)	Total Aerobic Microbial Count	>100000	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>1000	cfu/g or cfu/mL
	Bile-tolerant Gram-negative Bacteria	>1000	cfu/g or cfu/mL
	Absence of Salmonella spp. & E. coli	Absent	In 10 grams cfu/g or cfu/mL
	Total Coliforms Count	>1000	cfu/g or cfu/mL
Powdered Botanical Extracts (Extracted or Processed Cannabis Product i.e. hash, bubble hash, rosin, kief)	Total Aerobic Microbial Count	>10000	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>1000	cfu/g or cfu/mL
	Bile-tolerant Gram-negative Bacteria	>1000	cfu/g or cfu/mL
	Absence of Salmonella spp. & E. coli	Absent	In 10 grams cfu/g or cfu/mL
	Total Coliforms Count	>1000	cfu/g or cfu/mL
Tinctures (Solutions of Cannabis in Alcohol)	Total Aerobic Microbial Count	>10000	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>1000	cfu/g or cfu/mL
Infusions (solutions of cannabis in water)	Total Aerobic Microbial Count	>100	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>10	cfu/g or cfu/mL
Decoctions (Solutions of Cannabis derived by boiling in water for at	Total Aerobic Microbial Count	>100	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>10	cfu/g or cfu/mL

least 15 minutes)			
Fluid extracts (An alcoholic liquid extract made by percolation of Cannabis so that 1 mL of the fluidextract represents 1 g of the Cannabis)	Total Aerobic Microbial Count	>10000	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>1000	cfu/g or cfu/mL
Nutritional Supplements with Botanicals	Total Aerobic Microbial Count	>100000	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>1000	cfu/g or cfu/mL
	Absence of Salmonella spp. & E. coli	Absent	In 10 grams cfu/g or cfu/mL
Botanicals to be treated with boiling water before use (Dried Cannabis to which boiling water is added immediately prior to consumption)	Total Aerobic Microbial Count	>100000	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>1000	cfu/g or cfu/mL
	Absence of E. coli	Absent	In 10 grams cfu/g or cfu/mL
Nutritional products with other highly refined ingredients (Edibles)	Total Aerobic Microbial Count	>1000	cfu/g or cfu/mL
	Total Combined Yeast & Mold Count	>100	cfu/g or cfu/mL
	Absence of E. coli	Absent	In 10 grams cfu/g or cfu/mL
Quantitative analysis results shall be rounded off to the first two significant digits.			

E. coli and Salmonella results shall be reported as Present or Absent.

(2) Mycotoxin test: A non-profit producer shall sample and test dried usable cannabis, and a manufacturer or non-profit producer (as applicable) shall sample and test concentrated cannabis derived products, for mycotoxins, using an approved laboratory prior to sale, distribution, or other use. A sample may be deemed to have passed the mycotoxin test if the total quantity of aflatoxin B1, B2, G1, and G2 and ochratoxin A is collectively less than 20 µg/kg (parts per billion) of the sample. The mycotoxin test shall be conducted in accordance with the testing requirements at Table 2, Mycotoxins Testing Requirements.

Table 2. Mycotoxins Testing Requirements

Targeted Mycotoxins	**Chemical Name**	**Abbreviation**	**CAS Number**	**Method Reporting Level (µg/kg)***	**Action Level (µg/kg)***
Aflatoxins	Aflatoxin B_1	AFB1	1162-65-8	1.0	Combined concentration of five mycotoxin components: 20
	Aflatoxin B_2	AFB2	7220-81-7	1.0	
	Aflatoxin G_1	AFG1	1165-39-5	1.0	
	Aflatoxin G_2	AFG2	7241-98-7	1.0	
Ochratoxin	Ochratoxin A	OTA	303-47-9	1.0	

Mycotoxins Reporting Requirements for DOH Medical Cannabis Program

Use two significant digits when reporting a total mycotoxins result.

Non-detects are reported as less than the Method Reporting Level. Example: "Total Mycotoxins < 1 µg/kg"

*Micrograms of mycotoxin per kilogram (µg/kg) of sample is equivalent to parts per billion (ppb).

(3) Residual solvent test: A manufacturer or non-profit producer (as applicable) shall sample and test all concentrated cannabis derived products that are

manufactured using solvent extraction methods for the presence of solvent residue, using an approved laboratory prior to sale, distribution, or other use. A sample may be deemed to have passed the residual solvent test if the sample contains less than each action level set forth in Table 3, Residual Solvent Testing Requirements. The residual solvent test shall be conducted in accordance with the testing requirements at Table 3.

Table 3. Residual Solvent Testing Requirements

Targeted Compounds	**Common Chemical Name**	**IUPAC Name**	**CAS Number**	**Method Reporting Level (µg/g) or (ppm)***	**Action Level (µg/g) or (ppm)***
Propane	propane	propane	74-98-6	100	500
Butanes	*n*-butane	butane	106-97-8	100	500
	isobutane	2-methylpropane	75-28-5	100	500
Pentane	*n*-pentane	pentane	109-66-0	100	500
Hexane	*n*-hexane	hexane	110-54-3	25	50
Cyclohexane	cyclohexane	cyclohexane	110-82-7	100	500
Benzene	benzene	benzene	71-43-2	2.0	2.0
Toluene	toluene	methylbenzene	108-88-3	100	200
Heptane	*n*-heptane	heptane	142-82-5	100	500
Ethylbenzene	ethylbenzene	ethylbenzene	100-41-4	100	Combined
and Xylenes	*ortho*-xylene	1,2-dimethylbenzene	95-47-6	100	

	meta-xylene	1,3-dimethylbenzene	108-38-3	200	concentration of all four compounds: 400
	para-xylene	1,4-dimethylbenzene	106-42-3		
Methyl Alcohol	methyl alcohol	methanol	67-56-1	100	1000
Isopropyl Alcohol	isopropanol	2-propanol	67-63-0	200	1000
Methylene Chloride	methylene chloride	dichloromethane	75-09-2	50	100
Acetone	acetone	2-propanone	67-64-1	200	1000
<u>Residual Solvents Reporting Requirements for DOH Medical Cannabis Program</u> Use two significant digits when reporting residual solvent results. Non-detects are reported as less than the Method Reporting Level for each residual solvent. Example: "Benzene < 2.0 µg/g" Note: The isomers meta-xylene and para-xylene cannot be separated chromatographically, so they are reported as a pair.					
*Micrograms solvent per gram of sample (µg/g) is equivalent to parts per million (ppm).					

(4) Potency test: A non-profit producer shall sample and test all dried usable cannabis, and a non-profit producer or manufacturer (as applicable) shall sample and test all concentrated cannabis derived products, for quantity of tetrahydrocannabinol (THC, tetrahydrocannabinolic acid (THCA), cannabidiol (CBD), cannabidiolic acid (CBDA), and also for THC potency and CBD potency, using an approved laboratory prior to sale, distribution, or other use. A non-profit producer may, at the producer's option, also test for quantity of cannabinol (CBN), cannabigerolic acid (CBGA), cannabigerol (CBG), cannabichromene (CBC), tetrahydrocannabivarin (THCV), and cannabidivarin (CBDV). The potency test shall be conducted in accordance with the testing requirements at Table 4, Potency Testing Requirements.

Table 4. Potency Testing Requirements				
Cannabinoid	**Abbreviation**	**CAS Number**	**Reporting Units***	**Comments**
Tetrahydrocannabinolic Acid	THCA	23978-85-0	mg/g and % (Percent)	analysis required by rule
Tetrahydrocannabinol	THC	1972-08-3	mg/g and % (Percent)	analysis required by rule
Cannabidiolic Acid	CBDA	1244-58-2	mg/g and % (Percent)	analysis required by rule
Cannabidiol	CBD	13956-29-1	mg/g and % (Percent)	analysis required by rule
THC Potency	THC Potency = Percent THCA x 0.877 + Percent THC		mg/g and % (Percent)	reporting required by the rule and calculation listed
CBD Potency	CBD Potency = Percent CBDA x 0.877 + Percent CBD		mg/g and % (Percent)	reporting required by the rule and calculation listed
Cannabinol	CBN	521-35-7	mg/g and % (Percent)	analysis optional, recommended for strain characterization
Cannabigerolic Acid	CBGA	25555-57-1	mg/g and % (Percent)	analysis optional, recommended for strain characterization

Cannabigerol	CBG	25654-31-3	mg/g and % (Percent)	analysis optional, recommended for strain characterization
Cannabichromene	CBC	20675-51-8	mg/g and % (Percent)	analysis optional, recommended for strain characterization
Tetrahydrocannabivarin	THCV	31262-37-0	mg/g and % (Percent)	analysis optional, recommended for strain characterization
Cannabidivarin	CBDV	24274-48-4	mg/g and % (Percent)	analysis optional, recommended for strain characterization
*Milligrams per gram (mg/g) of sample; this unit can be also expressed in percent composition of the sample.				

A cannabis derived product shall be homogenous in composition with respect to THC potency. A product shall be deemed non-homogenous if ten percent of the infused portion of the product contains more than twenty percent of the total THC contained in the product. In the event that a cannabis derived product does not meet this requirement, the batch shall be wasted in accordance with the provisions of this rule.

(5) Heavy metal test: A non-profit producer shall sample and test all dried usable cannabis, and a non-profit producer or manufacturer (as applicable) shall sample and test all concentrated cannabis derived products, for heavy metals, using an approved laboratory, prior to sale, distribution, or other use. A sample may be deemed to have passed the heavy metals test if the sample contains less than each action level set forth in Table 5, Heavy Metal Testing Requirements. The heavy metals test shall be conducted in accordance with the testing requirements at Table 5.

Table 5. Heavy Metal Testing Requirements					
Heavy Metals	**Elemental Symbol**	**IUPAC Name**	**CAS Number**	**Action Level (µg/g) or (ppm)***	**Method Reporting Level (µg/g) or (ppm)***
Arsenic	As	arsenic	7440-38-2	2.0	0.2
Cadmium	Cd	cadmium	7440-43-9	0.8	0.2
Lead	Pb	lead	7439-92-1	1.2	0.2
Mercury	Hg	mercury	7439-97-6	0.4	0.1
*Micrograms per gram (µg/g) of sample is equivalent to parts per million (ppm).					

(6) Pesticide test: A non-profit producer shall sample and test all dried usable cannabis, and a non-profit producer or manufacturer (as applicable) shall sample and test all concentrated cannabis derived products, for pesticide content using an approved laboratory prior to sale, distribution, or other use. A sample may be deemed to have passed the pesticide test if the sample contains less than each action level set forth in Table 6, Pesticide Testing Requirements. The pesticide test shall be conducted in accordance with the testing requirements at Table 6.

Table 6. Pesticide Testing Requirements				
Targeted Pesticide	**Common Chemical Name**	**CAS Number**	**Action Level (µg/kg)**	**Method Reporting Level (µg/kg)**
Abamectin	avermectin B1a & avermectin B1b	71751-41-2	500	100
Azoxystrobin	azoxystrobin	131860-33-8	200	100
Bifenazate	bifenazate	149877-41-8	200	100
Etoxazole	etoxazole	153233-91-1	200	100
Imazalil	chloramizole	35554-44-0	200	100

Imidacloprid	imidacloprid	138261-41-3	400	100
Malathion	malathion	121-75-5	200	100
Myclobutanil	myclobutanil	88671-89-0	200	100
Permethrins	*cis*-permethrin & *trans*-permethrin	52645-53-1	200	100
Spinosad	spinosyn A & spinosyn D	168316-95-8	200	100
Spiromesifen	spiromesifen	283594-90-1	200	100
Spirotetramat	spirotetramat	203313-25-1	200	100
Tebuconazole	tebuconazole	80443-41-0	400	100
*Micrograms of pesticide per kilogram (**µg/kg**) of sample is equivalent to parts per billion (ppb).				

(7) Moisture content test: A non-profit producer shall sample and test all dried usable cannabis for moisture content using an approved laboratory prior to sale, distribution, or other use.

(8) Random testing of finished cannabis derived products: A non-profit producer or manufacturer that manufactures a cannabis derived product shall establish a schedule for, and shall conduct, random sampling and testing of finished, non-concentrated cannabis derived products, including but not limited to edible cannabis derived products, as follows:

(a) The non-profit producer or manufacturer shall randomly select and sample at and at least one percent of all non-concentrated cannabis derived product batches manufactured every week (and no less than one batch);

(b) The non-profit producer or manufacturer shall apply the sampling and testing standards that otherwise apply under this rule to dried cannabis and concentrated cannabis derived products; and

(c) In the event that a sample fails any of the required tests, the batch shall not be sold, distributed, or otherwise used, unless remediated in accordance with the remediation standards of this rule.

(9) Additional testing: The department may require additional testing of cannabis and cannabis derived products by non-profit producers and manufacturers, as it deems appropriate.

D. Release of batch after testing: A licensed non-profit producer or manufacturer may release an entire batch of dried cannabis or concentrated cannabis derived product for immediate manufacture, sale, or other use, provided that the sample taken from the batch passes the tests required in this section.

E. Procedures for testing: A licensed non-profit producer and a manufacturer shall ensure that the following testing procedures are followed:

(1) sampling and segregation: a licensed non-profit producer or manufacturer shall remove a sample of no less than the quantities of cannabis or cannabis derived product specified in Table 7, Minimum Test Sample Size, from every batch, and shall transfer the sample to an approved laboratory for testing; the remainder of the batch of dried, usable cannabis or concentrated cannabis-derived product shall be segregated until the licensed non-profit producer receives the results of laboratory testing report and determines whether the batch meets the testing requirements of this rule;

Table 7. Minimum Test Sample Size

Targeted Parameter	Sample Matrix	Analysis Platforms (Instrumentation Used by Lab)	Minimum Amount Required for Testing (grams)
Cannabis Potency	dried usable cannabis	HPLC, LCMS	1.0
	concentrated cannabis-derived products (CCDP)	HPLC, LCMS	1.0
	non-concentrated cannabis-derived products (NCCDP)	HPLC, LCMS	1.0
Cannabis Moisture Content	dried usable cannabis	n/a	1.0
Mycotoxins	dried usable cannabis, CCDP, or NCCDP	HPLC, LCMS, LCMSMS	1.0
Residual Solvents	CCDP	GC-FID, GC-PID/FID	1.0
	CCDP	GCMS	0.5

	NCCDP	GC-FID, GC-PID/FID	5.0
	NCCDP	GCMS	1.0
Absence of Salmonella spp. & E. coli	dried usable cannabis, NCCDP	Culture, biochemical, antibody, or nucleic acid- based assays shall be validated microbiological methodology such as FDA, USP, AOAC, or equivalent.	10.0
	CCDP		1.0
Total Aerobic Microbial Count	dried usable cannabis, CCDP, or NCCDP	Direct culture, indirect culture, or non-culture based. Must be validated microbiological methodology such as FDA, USP, AOAC, or equivalent.	10.0 (dried usable cannabis and NCCDP) 1.00 (CCDP)
Total Combined Yeast & Mold Count			
Bile-tolerant Gram-negative Bacteria			
Total Coliforms Count			
Pesticides	dried usable cannabis	HPLC, LCMS, LCMSMS	2.0
Heavy Metals	dried usable cannabis, CCDP, NCCDP	ICP-MS, FIMS	0.5
Minimum required test size for CCDP = 8 g, Minimum required test sample size for NCCDP = 27.5g, Minimum required test sample size for dried usable cannabis = 25.5 g. Minimum test sample size may change if a validated method is approved by NMDOH MCP			

(2) sample selection: a non-profit producer and manufacturer shall collect and submit samples for testing that are representative of the batch being tested; the

department may order that a non-profit producer or manufacturer modify its sampling collection practices if it has reason to believe that samples that were previously collected were not representative of an associated batch;

(3) documentation: a non-profit producer and a manufacturer shall appropriately document the sampling and testing of all dried cannabis and concentrated cannabis-derived product, and shall utilize a department approved laboratory for the purpose of testing usable cannabis;

(4) preservation and inspection of testing records: a licensed non-profit producer and a manufacturer shall maintain all results of laboratory tests conducted on cannabis or cannabis derived products produced by the licensed non-profit producer or manufacturer or their contractor for a period of at least two years, and shall make those results available to qualified patients and primary caregivers enrolled in the medical cannabis program upon request; and

(5) disciplinary action: repeated failure to pass testing may result in the imposition of disciplinary action(s) by the department, consistent with this rule.

F. Remediation; subsequent testing: If a sample fails a given test (i.e., if the sample does not measure below the action levels specified in this rule), the non-profit producer or manufacturer (as applicable) shall determine whether remediation is appropriate, and may pursue confirmatory testing at another approved laboratory. In the event that a non-profit producer or manufacturer attempts to remediate cannabis or a cannabis derived product, the batch shall again be sampled and subjected to all of the tests identified in this rule, except those required for heavy metals and pesticides. A batch of usable cannabis that fails a given test and that does not pass the required tests subsequent to remediation conducted in accordance with the terms of this rule, shall be destroyed in accordance with the wastage requirements of this rule. A non-profit producer or manufacturer may remediate cannabis or cannabis derived product in accordance with the following:

(1) Dried usable cannabis: A non-profit producer may remediate dried usable cannabis that has failed a microbiological test, by utilizing extraction or distillation methods that remove or reduce contaminants in the batch such that a subsequent sample from the batch measures within the action levels of a required test. A non-profit producer may not remediate dried usable cannabis that fails any other test required by this rule;

(2) Cannabis derived product: A non-profit producer or manufacturer (as applicable) may remediate a non-edible cannabis derived product (including concentrated product) that has failed a microbiological test or residual solvent test by utilizing extraction or distillation methods that remove or reduce contaminants in the batch such that a subsequent sample from the batch measures within the action levels of a required test. A non-profit producer or manufacturer may not remediate non-edible cannabis derived product that fails any other test required by this rule.

(3) Edible cannabis derived product: A non-profit producer or manufacturer may not remediate an edible cannabis derived product. Edible cannabis derived products include brownies, cookies, candies, and similar finished products intended for human consumption.

(4) Notice and wastage: If the batch of usable cannabis cannot be remediated such that the sample measures within the action levels of a required test, the non-profit producer or manufacturer shall notify the department within 24 hours, and shall confirm the wastage and disposal of the usable cannabis in accordance with this rule. The wasted product shall be removed from inventory, and the removal from inventory shall be tracked in an electronic system specified by the department.

(5) Testing and remediation protocols: A non-profit producer and a manufacturer shall adopt and maintain on the premises protocols regarding sampling, sample testing, remediation, and retesting, consistent with this rule.

[7.34.4.10 NMAC - Rp, 7.34.4.9 NMAC, 6/23/2020]

7.34.4.11 WASTAGE OF CANNABIS; PERMITTED METHODS:

A non-profit producer or approved entity that wastes usable cannabis or cannabis plants shall do so by rendering the cannabis unusable and unrecognizable, in accordance with the requirements of this rule, prior to removal from licensed premises. The wastage of usable cannabis and cannabis plants shall be documented by the non-profit producer or approved entity, shall be tracked by batch, and shall be recorded in an electronic tracking system specified by the department. Wastage of usable cannabis or cannabis plants shall occur only within the licensee's ordinary business hours. A non-profit producer or approved entity shall dispose of wasted cannabis and shall not attempt to incorporate wasted cannabis products into any product intended for consumption.

A. Permitted methods of wastage: Wastage of cannabis and cannabis derived products shall be accomplished by the following permitted methods:

(1) Dried usable cannabis: wastage of dried usable cannabis or cannabis plants shall be accomplished by grinding and incorporating the cannabis into other ground material, such as soil, compost material, or leaf and yard waste, so that the resulting mixture is at least fifty percent non-cannabis material by volume;

(2) Non-liquid cannabis derived product: wastage of non-liquid cannabis derived products shall be accomplished in the same manner as the wastage of dried usable cannabis; and

(3) Liquid cannabis derived product: Wastage of cannabis derived liquids shall be accomplished by mixing the liquid with absorbent material such as cat litter, sand, plastic waste, or sawdust, such that the liquid is fully absorbed into the material.

B. Disposal of wasted cannabis: Disposal of wasted cannabis and cannabis products shall be conducted in accordance with all applicable waste disposal laws, including but not limited to hazardous waste disposal laws (as applicable).

C. Holding time: Usable cannabis and cannabis plants that a licensee intends to waste shall be held in a secured designated holding area for a minimum of 72 hours prior to being wasted. A licensee shall affix to each batch that is held for wasting documents that record information concerning the batch, including batch number or code, plant number, and weight. The batch to be wasted shall not be handled, moved, or wasted during the 72 hour period, unless by specific instruction of the department. Cannabis that is intended to be wasted may be subject to inspection by the department or its designee.

D. Documentation of wastage; retention: A licensee shall record the wastage of usable cannabis and cannabis plants, including batch number, weight, plant number, the name of the receiving solid waste facility, dates of wastage and disposal, and any test results associated with a wasted batch, using an electronic system specified by the department, and shall deduct any wasted usable cannabis or cannabis plants from the licensee's inventory. The electronic record shall be retained for no less than two years following the disposal. A licensee shall additionally document the wastage of any usable cannabis or cannabis plants using a video recording, and shall retain the video recording of the destruction for no less than 120 days. A licensee shall make the video recording of the destruction available for the department's inspection and copying upon the department's request.

E. Notice to department: A non-profit producer or manufacturer shall notify the department of the wastage of usable cannabis within five business days of the wastage.

[7.34.4.11 NMAC - N, 6/23/2020]

7.34.4.12 DEPARTMENT TESTING; QUALITY ASSURANCE; RANDOMIZED TESTING; COMPLAINT PROCEDURE:

A. Quality assurance testing by the department: The department may within its discretion conduct quality assurance sampling and testing of usable cannabis, and may require a producer or a manufacturer to provide samples of usable cannabis for this purpose. The department may additionally adopt and enforce a randomized testing schedule for the sampling and testing of usable cannabis. The department may prohibit the sale or distribution of usable cannabis that is determined by the department to contain prohibited levels of contaminants, or that is found to have been improperly tested, or may require remediation of such usable cannabis that is consistent with the remediation standards of this rule.

B. Complaints: If the department or its designee receives a complaint regarding the presence of mold, bacteria, or another contaminant in usable cannabis produced by a non-profit producer, a manufacturer, or patient who holds a personal production license,

or if the department or its designee has reason to believe that the presence of bacteria physical, microbiological, chemical, or other contaminant may jeopardize the health of a patient, the department or its designee may conduct an unannounced visit to the producer or manufacturer and may require the producer or manufacturer to provide samples of medical cannabis for testing by the department. Producers and manufacturers shall bear the cost of any testing required by the department.

C. Department sampling and testing requirements: Medical cannabis program employees and their designees may possess medical cannabis samples for the sole purposes of testing or transport to a testing facility. The department or its designee shall comply with the following testing requirements:

(1) the department or its designee shall maintain chain of custody documentation for any medical cannabis samples taken;

(2) a written receipt shall be given to the producer or manufacturer for all testing samples;

(3) all testing samples shall be placed into a sealed container and clearly labeled;

(4) all testing samples shall be tested by the department or a designated testing facility; and

(5) the quantity of cannabis that is gathered by the department from a producer or manufacturer for testing purposes shall not exceed the applicable sample sizes identified in Table 7.

[7.34.4.12 NMAC - Rp, 7.34.4.10 NMAC, 6/23/2020]

7.34.4.13 USE OF PESTICIDES BY LICENSED PRODUCERS:

The use of any pesticide by a licensed producer or manufacturer in the growth or manufacture of cannabis or cannabis products shall be in accordance with the New Mexico Pesticide Control Act, Section 76-4-1 *et seq.*, NMSA 1978, and associated regulations. Pesticides shall be stored in a secured area that is accessible only to employees, and shall be segregated from usable cannabis and cannabis plants and from any product or equipment that is utilized in the manufacturing or production process.

[7.34.4.13 NMAC - Rp. 7.34.4.11 NMAC, 6/23/2020]

7.34.4.14 DEPARTMENT APPROVAL OF MANUFACTURERS OF CANNABIS DERIVED PRODUCTS; GENERAL MANUFACTURING PROVISIONS:

A. Submittal of applications: A manufacturer applicant shall submit an authorized application form to the program with each initial application and renewal application, together with a fee of five thousand dollars ($5,000) issued to the medical cannabis program. A manufacturer applicant shall comply with the application requirements of this rule, and shall submit such other information as the manufacturer applicant wishes to provide or such information as the department may request for initial approval or periodic evaluation(s) during the approval period.

B. Application requirements: A manufacturer applicant shall submit to the department:

(1) proof that the manufacturer applicant is in good standing with the New Mexico taxation and revenue department;

(2) copies of the manufacturer applicant's articles of incorporation and by-laws, as applicable;

(3) a complete written description of the means that the manufacturer applicant shall employ to safely manufacture cannabis-derived products, including but not limited to hygiene standards consistent with the requirements of this rule, and a hazard analysis critical control point plan (HACCP) for each type of product that the manufacturer wishes to manufacture;

(4) a detailed list of all cannabis derived products to be manufactured;

(5) a list of all persons or business entities having direct or indirect authority over the management or policies of the manufacturer applicant;

(6) a list of all persons or business entities having any ownership interest in any property utilized by the manufacturer applicant, whether direct or indirect, and whether the interest is in land, building(s), or other material, including owners of any business entity that owns all or part of land or building(s) utilized;

(7) a description of the facilities that shall be used in the manufacture of cannabis derived products;

(8) proof that no buildings to be used by the manufacturer are located within 300 feet of any school, church, or daycare center; or alternatively, proof that any school, church, or daycare center that is located within 300 feet of a building to be used by the applicant did not occupy that location prior to the applicant initially seeking to become licensed to operate at the location;

(9) a description of how the manufacturer applicant will obtain cannabis or cannabis concentrates from a licensed non-profit producer, and how the manufacturer applicant will transport cannabis derived products to a licensed non-profit producer, including but not limited to chain of custody documentation;

(10) testing criteria and procedures, which shall be consistent with the testing requirements of this rule;

(11) a general written security policy, to address at a minimum:

(a) safety and security procedures;

(b) personal safety;

(c) crime prevention techniques.

(12) an attestation that no firearms will be permitted on any premises used for manufacture of cannabis derived products by the manufacturer applicant;

(13) a description of the methods and device or series of devices that shall be used to provide security, as well as documentation of successful testing of alarms and law enforcement notification system;

(14) training documentation prepared for each employee of the manufacturer applicant, statements signed by employees indicating the topics discussed (to include names and titles of presenters) and the date, time, and place the employee received said training;

(15) employee policies and procedures to address the following requirements:

(a) job descriptions or employment contracts developed for every employee of the manufacturer applicant that identify duties, authority, responsibilities, qualifications, and supervision; and

(b) training materials concerning adherence to state and federal confidentiality laws.

(16) personnel records for each employee of the manufacturer applicant that include an application for employment and a record of any disciplinary action taken;

(17) employee safety and security training materials provided to each employee of the manufacturer applicant at the time of his or her initial appointment, to include:

(a) training in the proper use of security measures and controls that have been adopted; and

(b) specific procedural instructions regarding how to respond to an emergency, including robbery or a violent accident;

(18) an attestation that the manufacturer applicant will ensure that all persons who work at a facility of the manufacturer will be 18 years of age or older;

(19) a description of how the manufacturer applicant will utilize the electronic inventory tracking system required by the department;

(20) a written policy to ensure that no cross-contamination of cannabis occurs;

(21) copies of any applicable lease agreements for facilities to be used by the manufacturer applicant;

(22) an attestation that the manufacturer applicant has complied and will comply with all applicable state and local zoning, occupancy, licensing and building codes applicable to buildings to be utilized by the manufacturer;

(23) proof of prior approval by the New Mexico regulation and licensing department for the use of any compressed gas extraction equipment to be utilized by the manufacturer;

(24) an attestation that the manufacturer applicant will not use dimethylsulfoxide (DMSO) in the production of cannabis derived products, and will not possess DMSO on the premises of the manufacturer;

(25) a written statement of the days and hours that the manufacturer will operate;

(26) such other materials as the department may require.

C. Prohibited additives: A manufacturer and a non-profit producer shall not manufacture or distribute a product that is intended to be consumed by inhalation that includes polyethylene glycol, polypropylene glycol, vitamin E acetate, or medium chain triglycerides. A manufacturer and a non-profit producer shall not combine nicotine, caffeine, or any other addictive substance with a usable cannabis product. This prohibition shall not apply to the combination of cannabis with sugar, or a product in which caffeine is naturally occurring, such as coffee, tea, or chocolate.

D. Term of approval: Department approval of a manufacturer shall be for a term of one year, and shall expire after that year, or upon closure of the manufacturer. An approved manufacturer shall apply for renewal of approval annually no later than 30 days prior to expiration.

E. Identification cards: An employee of an approved manufacturer shall carry their department issued employee identification card at all times during their work, and shall present the card to law enforcement officials and to department officials upon request. An employee who is unable to produce their department issued identification card upon request shall not remain on the licensed premises, and shall produce the card for the

department's inspection prior to returning to the licensed premises. Identification cards issued by the department are the property of the department and shall be returned to the department upon termination of the holder's employment with the approved manufacturer, suspension, or revocation of approval by the department, or upon demand of the department.

F. Amended license:

(1) An approved manufacturer shall submit to the department an application form for an amended license, and shall obtain approval from the department, at least 30 business days prior to implementing any:

(a) change of location of the manufacturer's facilities, change of directors, change of ownership of the manufacturer's facilities, change of company name, and any physical modification or addition to the manufacturer's facilities; and

(b) substantial change to the manufacturer's methods for manufacturing cannabis-derived products, and any substantial change to the manufacturer's security plan.

(2) Process for incomplete application for amended license: In the event that an application for amended licensure is determined by the program to be incomplete, the program will specify the information or materials that remain to be submitted. If the manufacturer does not submit the requested information or material, and does not otherwise contact the department regarding the application, within thirty days of receiving notice of the deficiency, the application will be closed as incomplete, and the manufacturer will be required to resubmit the application in order to recommence the application process.

G. Inventory and sales equipment: The department may require a licensed manufacturer to utilize specified equipment, software, and services for purposes of tracking inventory, sales, and other information, and for the purpose of reporting that information to the department of health.

H. Reporting of theft to department: A manufacturer shall submit to the department notification of any theft, robbery, break-in, or security breach that occurs on the manufacturer's premises, no later than 10 calendar days after the manufacturer first becomes aware of the event. The description shall include a description of any property that was stolen or destroyed, and the quantity of any usable cannabis that was stolen.

I. Closure of applications period: The department may close the applications period during which applications for manufacturer licenses will be accepted and reviewed.

[7.34.4.14 NMAC - Rp. 7.34.4.12 NMAC, 6/23/2020]

7.34.4.15 STANDARDS FOR MANUFACTURE OF CANNABIS-DERIVED PRODUCTS:

The following are minimum requirements for the manufacture of cannabis-derived products which shall apply to all manufacturers and licensed non-profit producers that manufacture cannabis-derived products:

A. General requirements: A licensed non-profit producer and a manufacturer shall ensure the following:

(1) that all manufacturing shall be done in premises that are in compliance with state and local laws, including but not limited to zoning, occupancy, licensing, and building codes;

(2) that the manufacturing operation and all equipment, implements, and fixtures that are used for the manufacture of cannabis derived products shall be used exclusively for the manufacture of cannabis derived products and that food processing for personal, staff, or the general public shall be prohibited;

(3) that all manufacturing is done indoors; with the exception that compressed gas extraction may occur outdoors in accordance with applicable standards of the New Mexico regulation and licensing department;

(4) that all manufacturing is conducted in a manner that does not allow cross-contamination from chemical or biological hazards;

(5) that manufacturing does not occur at a location that is within 300 feet of a school, church, or daycare center that existed within the 300-foot area before the non-profit producer or manufacturer became licensed to operate at the location;

(6) that all non-profit producer and manufacturer staff involved in the handling, transportation, manufacture, testing, or packaging of cannabis derived products must complete general food handler safety training;

(7) that any person who, by medical examination or supervisory observation, is shown to have, or appears to have, an illness, open lesion, including a boil, sore, or infected wound, or any other abnormal source of microbial contamination for whom there is a reasonable possibility of contact with preparation surfaces for medical cannabis or cannabis derived products, shall be excluded from any operations which may be anticipated to result in such contamination until the condition is corrected;

(8) that hand-washing facilities are provided that are adequate, accessible, and conveniently located, and that they are furnished with running water at a suitable temperature; hand-washing facilities shall be located in indoor production facilities, in restrooms, and wherever good sanitary practices require employees to wash or sanitize

their hands, and shall be stocked with effective hand-cleaning and sanitizing preparations, and sanitary towel service or suitable drying devices;

(9) that all persons involved in preparing or handling medical cannabis or cannabis derived products at the manufacturing operation conform to hygienic practices while on duty, including:

(a) maintaining adequate personal cleanliness;

(b) washing hands thoroughly in an adequate hand-washing area before starting 0work, at any other time when the hands may have become soiled or contaminated, and both before putting gloves on and after removal of gloves;

(c) refraining from preparing or handling medical cannabis or cannabis derived products if the handler has or may have an illness, open lesion, including boils, sores, or infected wounds, or any other abnormal source of microbial contamination, until such condition is corrected;

(d) complying with the other requirements of this section.

(10) that there is sufficient space for placement of equipment and storage of materials as is necessary for the maintenance of sanitary operations for production of medical cannabis derived products;

(11) that litter and waste are properly removed, and the operating systems for waste disposal are maintained in an adequate manner so that they do not constitute a source of contamination in areas where medical cannabis or cannabis derived products are exposed;

(12) that floors, walls, and ceilings are constructed in such a manner that they are washable, wipeable, and non-absorbent, and can be kept clean, and kept in good repair;

(13) that walls and ceilings remain free of water damage, and that fiberglass and other insulation material not be exposed;

(14) that there is adequate safety-type lighting in all areas where medical cannabis or cannabis derived products are processed or stored, and where equipment or utensils are cleaned;

(15) that the manufacturer provides adequate screening or other protection against the entry of pests; rubbish shall be disposed of so as to minimize the development of odor, minimize the potential for the waste becoming an attractant and harborage, or breeding place for pests;

(16) that building, fixtures, and other physical facilities where cannabis derived products are manufactured are maintained in a sanitary condition;

(17) that all contact surfaces, including utensils and equipment used for preparation of cannabis derived products are cleaned and sanitized as frequently as necessary to protect against contamination;

(18) that all equipment and utensils used for preparation of cannabis derived products are designed and of such material and workmanship as to be adequately cleanable, and are properly maintained;

(19) that only environmental protection agency (EPA) registered sanitizing agents are used in manufacturing operations and that they are used in accordance with labeled instructions;

(20) that toxic cleaning compounds, sanitizing agents, and pesticide chemicals shall be identified, held, and stored in a manner that protects against contamination of medical cannabis or cannabis derived products;

(21) that any chemicals used for extraction in the manufacturing process be intended for such usage, and that they be of food or medical grade;

(22) that the water supply is sufficient for the operations intended and is derived from a source that is a regulated water system; private water supplies shall be from a water source that is capable of providing a safe, potable, and adequate supply of water to meet the manufacturing facility's needs;

(23) that plumbing shall be of adequate size and design, adequately installed, and maintained to carry sufficient quantities of water to required locations throughout the facility; and properly convey sewage and liquid disposable waste from the facility;

(24) that there are no cross-connections between the potable and waste water lines;

(25) that the manufacturer provide its employees with adequate, readily accessible, on-site toilet facilities that are maintained in a sanitary condition and good repair;

(26) that all operations in the receipt, inspection, transport, segregation, preparation, manufacture, packaging, and storage of medical cannabis or cannabis derived products are conducted in accordance with adequate security and sanitation principles;

(27) that medical cannabis or cannabis derived products that can support the rapid growth of undesirable microorganisms are stored and transported in a manner that prevents the growth of these microorganisms;

(28) that storage and transportation of usable cannabis is accomplished under conditions that will maintain security and protect medical cannabis or cannabis derived products against physical, chemical, and microbial contamination as well as against deterioration of the medical cannabis or cannabis derived product and the container;

(29) that current material safety data sheets are kept on the premises for all chemicals used, including but not limited to cleaning compounds, sanitizing agents, and pesticides;

(30) that extraction for the purpose of manufacturing concentrates is conducted in a closed system utilizing an oil extractor solvent such as N-butane or carbon dioxide or utilizing ethyl alcohol;

(31) that all containers used for storage or transport of usable cannabis are washable, wipeable, and nonabsorbent;

(32) that if alcohol is to be used for extraction, only food grade, non-denatured ethyl alcohol is used for that purpose;

(33) that all weighting or measuring devices that are used in the production, distribution, or manufacture of usable cannabis be appropriately documented as having undergone certified registration and calibration that is in accordance with applicable requirements of the New Mexico department of agriculture;

(34) that the manufacture of a cannabis derived product by a manufacturer from the cannabis material produced by a personal production license holder is recorded in an electronic tracking system specified by the department;

(35) that the manufacturer or non-profit producer will prohibit its employees and contractors from being under the influence of drugs or alcohol in the workplace;

(36) that the department is notified of any changes to the days or hours of business operation;

(37) that staff who are tasked with conducting compressed gas extraction activities be appropriately trained in the of use of extraction equipment, as well as safety and emergency procedures, by a qualified trainer, prior to beginning extraction activities;

(38) that hemp, hemp extract, and hemp derived products (other than hemp paper) are not combined in any manner with usable cannabis that is intended to be sold or otherwise distributed in the medical cannabis program; and

(39) that cannabis and cannabis derived products that are kept in manufacturing areas at all times be clearly segregated from hemp and hemp derived products.

B. Prohibited products: The use of dimethylsulfoxide (DMSO) in the production of cannabis derived products, and the possession of DMSO upon the premises of a manufacturer or licensed non-profit producer, is prohibited.

C. Imprinting of certain usable cannabis products with universal THC symbol: A manufacturer and a licensed non-profit producer shall ensure that the universal New Mexico THC warning symbol, or a comparable symbol denoting THC content, is embossed or otherwise imprinted directly upon the following usable cannabis products that contain THC, prior to sale or distribution of any such product to a qualified patient or primary caregiver:

(1) chocolate;

(2) soft confections;

(3) hard confections or lozenges; and

(4) pressed pills and capsules

[7.34.4.15 NMAC - Rp. 7.34.4.13 NMAC, 6/23/2020]

7.34.4.16 LABELING OF USABLE CANNABIS; DRUG INFORMATION SHEETS:

A non-profit producer shall not sell or otherwise distribute to the public a usable cannabis product that has not been packaged and labeled in accordance with this rule.

A. Packaging and labels not designed to appeal to children: A package containing usable cannabis shall not display any content that reasonably appears to target minors, including but not limited to, cartoon characters or similar images. A product name or package shall not be modeled after a brand of product that is traditionally marketed toward children.

B. Labeling requirements: A label shall be securely affixed to all usable cannabis product packages, prior to sale or distribution, that is in the format provided at Table 8, Sample Label for Usable Cannabis Products, that is conspicuous and unobstructed, and that uses a font that is clearly legible, not italicized, and is printed in no smaller than 1/16th of an inch. The cannabinoid content specified on a cannabis derived product label shall be ninety percent or greater in accuracy. The label shall identify the following:

(1) the names of the entities that produced and manufactured the product, respectively;

(2) the name of the strain of cannabis contained in the product;

(3) a manufacture date and an expiration date;

(4) for dried, usable cannabis: the total of THC and CBD per package, which shall be expressed by percentage of weight;

(5) for concentrated cannabis derived product: the total of THC and CBD per package, which shall each be expressed by weight in milligrams and by percentage of total weight;

(6) for non-concentrated cannabis derived product: the totals of THC and CBD per package, which shall each be expressed by weight in milligrams;

(7) total product weight, expressed in milligrams, and if the product is in liquid form, total volume, expressed in milliliters;

(8) the name of the strain;

(9) the name of the department approved laboratories that analyzed the product or cannabis contained in the product in accordance with department rule;

(10) for all products containing THC: the universal New Mexico THC warning symbol, the image file for which can be obtained from the department upon request, which shall be reproduced at a minimum size of 1/2 inch by 1/2 inch;

(11) warnings for use that include at a minimum the statements, "Consumption of THC when pregnant, or by a mother who is breastfeeding, may adversely impact an infant's development", "Do not drive a vehicle or operate heavy machinery while under the influence of this product", and "Keep out of reach of children";

(12) for all cannabis-derived products that contain THC and that are intended to be consumed by vaporization: a health warning that states in bolded text, "WARNING: Vaping THC has been associated with cases of severe lung injury, leading to difficulty breathing, hospitalization, and even death.";

(13) a sales barcode that is associated with the product and product batch;

(14) a batch number or code that is associated with the product batch and that is recorded by the non-profit producer or manufacturer in the electronic tracking system specified by the department; and

(15) instructions for use that are specific to the labeled product.

Table 8. Sample Label for Usable Cannabis Products	
Producer:	**Manufacturer:**
Name of strain:	**Total units:**

Net weight: mg	**Manufacture/Production date: / /**	**Expiration date: / /**
Laboratory Analysis		
PER CONTAINER:		
THC: mg / % THC: %		
CBD: mg / % CBD: %		
Testing laboratory:		
Instructions for use:		
WARNING: This product contains medical cannabis. Do not drive a vehicle or operate heavy machinery while under the influence of this product. Consumption of THC when pregnant, or by a mother who is breastfeeding, may adversely impact an infant's development. **WARNING: Vaping THC has been associated with cases of severe lung injury, leading to difficulty breathing, hospitalization, and even death.** **KEEP OUT OF REACH OF CHILDREN.**		

C. Drug information sheets: A non-profit producer shall generate a drug information sheet for every item of cannabis and cannabis derived product that is sold or distributed to a qualified patient or primary caregiver, and shall provide a copy of the drug information sheet to the qualified patient or primary caregiver at the time of sale or distribution, and upon request. A copy of a drug information sheet shall be provided to the department or its designee upon request. A drug information sheet shall be in the format provided at Table 9, Sample Label for Usable Cannabis Products, and shall use a font that is clearly legible, not italicized, and is printed in no smaller than 10 point type. The drug information sheet shall contain, at a minimum, the following:

(1) all of the content of the associated product label, as specified in this rule and identified in Table 8;

(2) a batch number or code that is associated with the cannabis used for the manufacture of the product, that is recorded by a non-profit producer in the electronic tracking system specified by the department;

(3) pesticide(s) used in the production of the cannabis or cannabis-derived product;

(4) for dried, usable cannabis and edible cannabis products: the total of THC, THCA, CBD, and CBDA per package, which shall be expressed by percentage of weight;

(5) for concentrated cannabis derived product: the totals of THC, THCA, CBD, and CBDA per package, which shall each be expressed by weight in milligrams and by percentage of total weight;

(6) for non-concentrated cannabis derived product: the total of THC, THCA, CBD, and CBDA, both per serving and per package, which shall each be expressed by weight in milligrams;

(7) a "best by" date or freeze date for products capable of supporting the growth of infectious, toxigenic, or spoilage microorganisms;

(8) instructions for appropriate storage;

(9) complete list of product ingredients;

(10) product facts or a nutrition fact panel, a statement that the product is for medical use by qualified patients, and a statement that the product is not for resale; and

(11) allergy warnings, including but not limited to information regarding whether the contents of the package were processed in any facility that also processes nuts.

Table 9. Sample Drug Information Sheet for Usable Cannabis Products
Cannabis Facts
Product name:
Product strain:
Producer of cannabis:
Manufacturer of cannabis product:
Net product weight:

Total units:
Manufacture date:
Product expiration date:
Batch number or code for manufactured product:
Batch number or code for cannabis:
Instructions for use:
Instructions for storage:
Nutrition facts:
Product ingredients:
Allergy warnings:
Laboratory Analysis
PER CONTAINER:
THC: mg / % THC: %
THCA: mg / % THCA %
CBD: mg / % CBD: %
CBDA: mg / % CBDA %
Testing laboratory:
WARNING: This product contains medical cannabis. This product is for medical use by qualified patients only. This product is not for resale.

Do not drive a vehicle or operate heavy machinery while under the influence of this product. Consumption of THC when pregnant, or by a mother who is breastfeeding, may adversely impact an infant's development. **WARNING: Vaping THC has been associated with cases of severe lung injury, leading to difficulty breathing, hospitalization, and even death.** **KEEP OUT OF REACH OF CHILDREN.**

D. Expiration date: An expiration date that is identified on a usable cannabis product label shall not be modified, removed, or obscured. In the event that an expiration date specified on a usable cannabis product label has passed, the product shall be wasted in accordance with the terms of this rule and deducted from inventory in the electronic tracking system specified by the department.

E. Failure to comply with packaging or labeling requirements: If a non-profit producer does not comply with any packaging or labeling requirement of this rule, the department may immediately suspend sales and distribution of any such non-compliant product, may order the recall of any such product, may order the relabeling of any such product, and may pursue disciplinary action in accordance with this rule.

[7.34.4.16 NMAC - Rp. 7.34.4.14 NMAC, 6/23/2020]

7.34.4.17 DEPARTMENT-APPROVED TESTING LABORATORIES; GENERAL PROVISIONS:

A laboratory applicant shall comply with the application requirements of this rule, and shall submit such other information as the laboratory applicant wishes to provide or such information as the department may request for initial approval and periodic evaluations during the approval period.

A. Testing categories: A laboratory may apply to become approved by the department as an approved laboratory for the testing of cannabis and cannabis derived products in all or any one of the following categories:

(1) mycotoxin analysis;

(2) microbiological contaminant analysis;

(3) solvent residue analysis;

(4) quantity of THC and CBD; and

(5) such other testing categories as the department may identify.

B. Fee: A laboratory applicant shall submit to the program with each initial application and renewal application for continued approval a non-refundable application fee of two-thousand-two-hundred dollars ($2,200), payable to the medical cannabis program.

C. Application materials: A laboratory applicant shall submit to the program with each initial application and renewal application for continued approval the following:

(1) standard operating procedures to be followed by the laboratory, including but not limited to policies and procedures to be used in performing analysis of samples;

(2) a description of the type of tests to be conducted by the laboratory applicant, which may include, but are not limited to, testing for microbiological contaminants, mycotoxins, solvent residue, THC content, CBD content, identity, purity, strength, composition, or nutritional content, and other quality factors;

(3) quality control criteria for the test(s) that the applicant intends to conduct;

(4) evidence that validates the accuracy of the test(s) to be conducted by the laboratory applicant as performed in the applicant's laboratory;

(5) proof that the laboratory applicant is in good standing with the New Mexico taxation and revenue department;

(6) copies of the laboratory applicant articles of incorporation and by-laws, as applicable;

(7) a list of all persons or business entities having direct or indirect authority over the management or policies of the laboratory applicant;

(8) a list of all persons or business entities having any ownership interest in any property utilized by the laboratory applicant, whether direct or indirect, and whether the interest is in land, building(s), or other material, including owners of any business entity that owns all or part of land or building(s) utilized;

(9) a description of the facilities and equipment that shall be used in the operation of the laboratory applicant;

(10) a description of how the laboratory applicant will ensure and document chain of custody of any samples held or tested by the laboratory;

(11) a general written security policy, to address at a minimum safety and security procedures;

(12) an attestation that no firearms will be permitted on any premises used by the laboratory applicant;

(13) a description of the methods and device or series of devices that shall be used to provide security;

(14) training documentation prepared for each employee of the laboratory applicant, statements signed by employees indicating the topics discussed (to include names and titles of presenters) and the date, time, and place the employee received said training;

(15) personnel records for each employee of the laboratory applicant that include an application for employment and a record of any disciplinary action taken;

(16) employee safety and security training materials provided to each employee of the laboratory applicant at the time of his or her initial appointment, to include training in the proper use of security measures and controls that have been adopted, and specific procedural instructions regarding how to respond to an emergency, including robbery or a violent accident;

(17) documented proof of required initial and continuing demonstrations of capability, in accordance with this rule;

(18) proof that no buildings to be used by the applicant are located within 300 feet of any school, church, or daycare center; or alternatively, proof that any school, church, or daycare center that is located within 300 feet of a building to be used by the applicant did not occupy that location prior to the applicant initially seeking to become licensed to operate at the location;

(19) an attestation that the laboratory will not operate in any location within 300 feet of a school, church or daycare center; and

(20) such other materials as the department may require.

D. Materials to be maintained on premises: An approved laboratory shall maintain on its premises, and shall promptly present to the department upon request:

(1) personnel documentation including, but not limited to employment records, job descriptions, education, and training requirements of the laboratory, and documentation of education and training provided to staff for the purpose of performance of assigned functions;

(2) requirements concerning laboratory operations, business licensing, and security procedures;

(3) standards for receipt, handling, and disposition of samples of usable cannabis;

(4) equipment information detailing the type of equipment used, inspection standards and practices, testing and calibration schedules and records, and standards for cleaning and maintenance of equipment;

(5) reagents, solutions, and reference standards including, but not limited to standards for labeling, storage, expiration, and re-qualification dates and records;

(6) reference standards, acquired or internally produced, including the certificate of analysis;

(7) sample analysis procedures including but not limited to procedures for the use of only primary or secondary standards for quantitative analyses;

(8) documentation demonstrating that the analytical methods used by the laboratory are appropriate for their intended purpose; that staff is proficient in the process; and that deviations from approved standards of practice do not occur without proper authorization;

(9) standards for data recording, review, storage, and reporting that include, but are not limited to standards to ensure:

(a) that data is recorded in a manner consistent with this rule, and that it is reviewed to verify that applicable standards of practice, equipment calibration, and reference standards were applied before reporting;

(b) that all data, including raw data, documentation, protocols, and reports are retained in accordance with the requirements of this rule; and

(c) that reports are the property of the business or individual who provided the sample, and reports meet the requirements of this rule.

(10) current material safety data sheets for all chemicals used; and

(11) such other materials as the department may require.

E. Proficiency testing and inspection:

(1) A laboratory applicant shall be subject to proficiency testing by the department or its designee prior to approval, and an approved laboratory shall be subject to proficiency testing, at a frequency and at times to be determined by the

program director or designee. A laboratory applicant or approved laboratory shall cooperate with the department or its designee for purposes of conducting proficiency testing. The department or its designee may require submission of cannabis and cannabis-derived product samples from licensed non-profit producers and approved manufacturers for purposes of proficiency testing.

(2) A laboratory applicant and an approved laboratory shall be subject to inspection(s), at times determined by the program director or designee, in accordance with the provisions of this rule. The department may require the inspection of premises, equipment, and written materials to determine compliance with this rule, and to determine compliance with the application submissions of the laboratory applicant or approved laboratory, including but not limited to standard operating procedures and standards for testing.

(3) Failure of proficiency testing: If the department determines on the basis of a proficiency test that a laboratory applicant has not satisfactorily identified the presence, quantity, or other relevant factor(s) pertaining to a given analyte, the department may deny the application in whole or in part, require additional tests, or require remedial actions to be taken by the laboratory applicant. If the department determines on the basis of a proficiency test that an approved laboratory has not satisfactorily identified the presence, quantity, or other relevant factor(s) pertaining to a given analyte, the department may withdraw approval of the laboratory in whole or in part, require additional tests, or require remedial actions to be taken by the approved laboratory.

F. Retention and inspection of testing records: An approved laboratory shall retain all results of laboratory tests conducted on cannabis or cannabis derived products for a period of at least two years and shall make them available to the program upon the program's request.

G. Identification cards: An employee of an approved laboratory shall carry their department issued employee identification card at all times during their work, and shall present the card to law enforcement officials and to department officials upon request. An employee who is unable to produce their department issued identification card upon request shall not remain on the licensed premises, and shall produce the card for the department's inspection prior to returning to the licensed premises. Identification cards issued by the department are the property of the department and shall be returned to the department upon the termination of the holder's employment with the approved laboratory, upon suspension, or revocation, or upon demand of the department.

H. Reporting of theft to department: A laboratory shall submit to the department notification of any theft, robbery, break-in, or security breach that occurs on the laboratory's premises, no later than 10 calendar days after the laboratory first becomes aware of the event. The description shall include a description of any property that was stolen or destroyed, and the quantity of any usable cannabis that was stolen.

I. Term of approval: Department approval of a laboratory for purposes of this rule shall be for a term of one year, and shall expire after that year, or upon closure of the approved laboratory. An approved laboratory shall apply for renewal of approval annually no later than 60 days prior to expiration.

J. Amended license:

(1) An approved laboratory shall submit to the department an application form for an amended license, and shall obtain approval from the department, at least 30 business days prior to implementing any:

(a) change of location of the laboratory's facilities, change of directors, change of ownership of the laboratory's facilities, change of company name, and any physical modification or addition to the laboratory's facilities; and

(b) substantial change to the laboratory's standard operating procedures or substantial change to the types of tests to be conducted.

(2) Process for incomplete application for amended license: In the event that an application for amended licensure is determined by the program to be incomplete, the program will specify the information or materials that remain to be submitted. If the laboratory does not submit the requested information or material, and does not otherwise contact the department regarding the application, within thirty days of receiving notice of the deficiency, the application will be closed as incomplete, and the laboratory will be required to resubmit the application in order to recommence the application process.

K. Termination: The department may deny, withdraw, or suspend approval of a laboratory in accordance with this rule, upon determination by the department that the laboratory has violated a provision of this rule, upon failure of a proficiency test, upon the refusal of the laboratory to provide requested access to premises or materials, or upon the failure of a laboratory to comply with any standard, procedure, or protocol developed, submitted, or maintained pursuant to this rule.

[7.34.4.17 NMAC - Rp. 7.34.4.15 NMAC, 6/23/2020]

7.34.4.18 DEPARTMENT-APPROVED TESTING LABORATORIES; GENERAL OPERATIONAL REQUIREMENTS:

A. Receipt of test samples: An approved laboratory may receive test samples of cannabis or cannabis derived products from any licensed producer, qualified patient or primary caregiver, and shall apply the testing standards of this rule, including the testing parameters, action levels, reporting levels, and other criteria identified in Tables 1 through 6, to determine whether a sample passes a given test.

B. Testing policies: An approved laboratory or laboratory applicant shall establish and implement policies for sample preparation, documentation, and transport, including:

(1) accepted test sample types;

(2) minimum test sample size;

(3) recommended test sample container;

(4) test sample labeling;

(5) transport and storage conditions, such as refrigeration, as appropriate;

(6) other requirements, such as use of preservatives, inert gas, or other measures designed to protect sample integrity; and

(7) creation of chain of custody documentation for each sample.

C. Recording of samples received: An approved laboratory shall:

(1) record the receipt of every test sample received, the record of which shall include:

(a) the name and contact information of the licensed producer that was the source of the sample;

(b) an appropriately specific description of the sample;

(c) the date of receipt of the sample;

(d) a statement of the quantity (weight, volume, number, or other amount) of the sample; and

(e) a batch number or code that is associated with the product batch and that is recorded by the non-profit producer or manufacturer in the electronic tracking system specified by the department.

(2) inform each licensed producer or individual who submits a test sample of the policies established in accordance with this section.

D. Sample handling, storage and disposal: An approved laboratory shall establish sample handling procedures for the tracking of test samples through the analytical process (by weight, volume, number, or other appropriate measure) to prevent diversion.

(1) An approved laboratory shall store each test sample under the appropriate conditions to protect the physical and chemical integrity of the sample.

(2) Analyzed test samples consisting of cannabis or cannabis-derived product shall be appropriately segregated, controlled, and held in a controlled access area pending destruction or other disposal.

(3) Any portion of a cannabis or cannabis-derived test sample that is not destroyed during analysis shall be:

(a) returned to the licensed producer who provided the sample; or

(b) destroyed in accordance with the wastage requirements of this rule.

E. State and local laws: An approved laboratory and a laboratory applicant shall comply with all applicable state and local laws, including but not limited to zoning, occupancy, licensing, and building codes.

F. Laboratory premises: An approved laboratory and a laboratory applicant shall maintain the premises of the laboratory in a clean and orderly condition; shall equip the premises with such utensils and equipment as necessary to conduct the operations of the laboratory; and shall ensure adequate space for laboratory operations, sample storage, and document storage.

G. Storage: An approved laboratory and a laboratory applicant shall be equipped with one or more secure, controlled access areas for storage of cannabis and cannabis-derived product test samples, cannabis-derived waste, and reference standards. Access to such storage areas shall be limited by the laboratory to authorized individuals.

H. Equipment:

(1) Equipment used for the analysis of test samples shall be adequately inspected, cleaned, and maintained. Equipment used for the generation or measurement of data shall be adequately tested and calibrated on an appropriate schedule, as applicable.

(2) Laboratory operations shall document procedures setting forth in sufficient detail the methods and schedules to be used in the routine inspection, cleaning, maintenance, testing, and calibration of equipment, and shall specify, as appropriate, remedial action to be taken in the event of failure or malfunction of equipment. The procedures shall designate the personnel responsible for the performance of each operation.

(3) Records shall be maintained of all inspection, maintenance, testing, and calibrating operations. These records shall include the date of the operation, the person

who performed it, the written procedure used, and any deviations from the written procedure. Records shall be kept of non-routine repairs performed on equipment as a result of failure and malfunction. Such records shall document the nature of the repair, how and when the need for the repair was discovered, and any remedial action taken in response to the repair.

(4) Computer systems used for the analysis of samples, retention of data, sample tracking, calibration scheduling, management of reference standards, or other critical laboratory management functions shall ensure that electronic records, electronic signatures, and handwritten signatures executed to electronic records are trustworthy, reliable, and generally equivalent to paper records and handwritten signatures executed on paper.

I. Reagents, solutions, and reference standards:

(1) An approved laboratory is authorized to possess reagents, solutions, and reference standards. Such items shall be:

(a) secured in accordance with the approved laboratory's storage policies;

labeled to indicate identity, date received or prepared, and expiration or requalification date; and, where applicable, concentration or purity, storage requirements, and date opened;

(b) stored under appropriate conditions to minimize degradation or deterioration of the material; and

(c) used only within the item's expiration or requalification date.

(2) Deteriorated or outdated reagents and solutions shall be properly destroyed.

(3) An approved laboratory may acquire commercial reference standards for cannabinoids and other chemicals or contaminants, for the exclusive purpose of conducting testing for which the laboratory is approved. An approved laboratory may elect to internally produce reference standards. When internally produced, an approved laboratory shall utilize standard analytical techniques to document the purity and concentration of the internally produced reference standards. An approved laboratory is authorized to obtain cannabis or cannabis-derived product from a licensed non-profit producer for this purpose.

(4) An approved laboratory shall obtain or, for internally-produced standards, shall create a certificate of analysis (COA) for each lot of reference standard. Each COA shall be kept on file and the lot number of the reference standard used shall be recorded in the documentation for each analysis, as applicable.

J. Analysis: An approved laboratory shall:

(1) utilize analytical methods that are appropriate for the purpose of testing cannabis and cannabis-derived products;

(2) require analysts to demonstrate proficiency in the performance of the analytical methods used;

(3) maintain written procedures for the analytical method used for the analysis of each test sample, including:

(a) sample preparation;

(b) reagent, solution, and reference standard preparation;

(c) instrument setup, as applicable;

(d) standardization of volumetric reagent solutions, as applicable;

(e) data acquisition; and

(f) calculation of results.

(4) specify, as applicable to each analytical method used, requirements for accuracy, precision, linearity, specificity, limit of detection, limit of quantitation, and other data quality parameters;

(5) ensure that no deviations from approved protocols or standard operating procedures are made during any analytical process without proper authorization and documentation; and

(6) use only primary standards or secondary standards for quantitative analyses.

K. Recording of analytical data:

(1) An approved laboratory shall ensure that all data generated during the testing of a test sample, except data generated by automated data collection systems, is recorded directly, promptly, and legibly in ink. All data shall be annotated with the date of entry and signed or initialed by the person recording the data. Any change in entries shall be made so as not to obscure the original entry, shall indicate the reason for such change, and shall be dated and signed or initialed at the time of the change.

(2) In automated data collection systems, the individual responsible for direct data input shall be identified at the time of data input. Any change in an entry shall be made so as not to obscure the original entry, shall indicate the reason for such change,

and shall be dated and signed or initialed at the time of the change. A corrective action report (CAR) shall accompany such change and shall be made available to the department, a non-profit producer, and a manufacturer upon their request for up to two years after the analysis is completed.

(3) For each final result reported, an approved laboratory shall verify that:

(a) any calculations or other data processing steps were performed correctly;

(b) the data meet any data quality requirements such as for accuracy, precision, linearity, etc.;

(c) any reference standards used were of the appropriate purity and within their expiration or requalification dates;

(d) any volumetric solutions were properly standardized before use; and

(e) any test or measuring equipment used has been properly tested, verified, and calibrated, and is within its verification or calibration period.

L. Data storage:

(1) An approved laboratory shall ensure that all raw data, documentation, protocols, and final reports associated with analysis of a test sample are retained for two years from the date of the completion of analysis.

(2) An approved laboratory shall maintain the records identified in this section. Such records must be maintained:

(a) in a manner that allows retrieval as needed;

(b) under conditions of storage that minimize deterioration throughout the retention period; and

(c) in a manner that prevents unauthorized alteration.

M. Records maintenance and access: An approved laboratory or laboratory applicant shall designate an individual as responsible for records maintenance. Only authorized personnel may access the maintained records.

N. Data reporting:

(1) Contents of report: A laboratory report of a test conducted at the request of a licensed producer or qualified patient shall contain the following information:

(a) the date of receipt of the test sample;

(b) the description of the type or form of the test sample (leaf, flower, powder, oil, specific edible product, etc.);

(c) the batch number or code that is associated with the product batch and that is recorded in the electronic tracking system specified by the department;

(d) information on whether sampling was performed by the laboratory operation, by the compliant business or individual which submitted the test sample, or by a third-party;

(e) date on which analysis occurred;

(f) the analytical method used, including at a minimum identification of the type of analytical equipment used (e.g., GC, HPLC, UV, etc.);

(g) the analytical results, including units of measure where applicable;

(h) the identity of the supervisory or management personnel who reviewed and verified the data and results and ensured that data quality, calibration, and other applicable requirements were met; and

(i) the name, address, and contact information of the approved laboratory that conducted the test.

(2) The laboratory report shall state that reported analytical results apply only to the test sample received.

O. Department access to materials and premises: An approved laboratory shall promptly provide the department or the department's designee access to a report of a test, and any underlying data, that is conducted on a sample at the request of a licensed producer or qualified patient. An approved laboratory shall also provide access to the department or the department's designee to laboratory premises, and to any material or information requested by the department, for the purpose of determining compliance with the requirements of this rule.

P. Drugs and alcohol: A laboratory shall prohibit its employees and contractors from being under the influence of drugs or alcohol in the workplace.

Q. Failures to meet testing requirements: Repeated failures by a laboratory to comply with the testing requirements of department rule may result in disciplinary action against the laboratory.

[7.34.4.18 NMAC - Rp. 7.34.4.16 NMAC, 6/23/2020]

7.34.4.19 DEPARTMENT-APPROVED TESTING LABORATORIES; INSTRUMENTATION; INITIAL AND CONTINUING DEMONSTRATIONS OF CAPABILITY:

A. Mycotoxin test instrumentation: A laboratory shall utilize HPLC, LCMS, or LCMSMS instrumentation to test for the presence of mycotoxins in usable cannabis and shall analyze for mycotoxins at a concentration as low as 1 µg/kg (ppb). Mycotoxin testing shall be conducted in accordance with the requirements of Table 2, Mycotoxins Testing Requirements.

B. Residual solvents test instrumentation: A laboratory shall utilize gas chromatography – flame ionization detector (GC-FID), gas chromatography tandem photoionization detector/flame ionization detector (GC-PID/FID), or GCMS instrumentation to test for the presence of residual solvents and shall analyze for residual solvents at a concentration as low as 2µg/g (ppm). Residual solvent testing shall be conducted in accordance with the requirements of Table 3, Residual Solvent Testing Requirements.

C. Potency test instrumentation: A laboratory shall utilize HPLC or LCMS instrumentation to test for potency in usable cannabis and shall analyze usable cannabis in accordance with the provisions at Table 4 Potency Testing Requirements.

D. Heavy metals test instrumentation: A laboratory shall utilize Inductively coupled plasma mass spectrometry (ICP-MS) or flow injection mercury system (FIMS) instrumentation to test for the presence of heavy metals in usable cannabis and shall analyze for heavy metals at a concentration as low as 0.2 µg/g (ppm) for lead (Pb) and cadmium (Cd), as low as 1.0 µg/g (ppm) for arsenic (As) and 0.1 µg/g (ppm) for mercury (Hg). Heavy metals testing shall be conducted in accordance with the requirements of Table 5, Heavy Metals Testing Requirements.

E. Pesticide test instrumentation: A laboratory shall utilize high performance liquid chromatography (HPLC), gas chromatography mass spectrometry (GCMS), liquid chromatography - mass spectrometry (LCMS), or liquid chromatography with tandem mass spectrometry (LCMSMS) instrumentation to test for the presence of pesticides in usable cannabis and shall analyze for pesticides at a concentration as low as 100 µg/kg (ppb). Pesticide testing shall be conducted in accordance with the provisions of Table 6, Pesticide Testing Requirements.

F. Initial and continuing demonstrations of capability required: A laboratory or laboratory applicant shall submit to the department an initial demonstration of capability (IDC) for every test identified in this rule that the laboratory or applicant intends to conduct. A laboratory shall submit a continuing demonstration of capability (CDC) annually as part of the laboratory's application for renewal of licensure. The IDC shall be submitted to the department prior to the laboratory or laboratory applicant conducting tests pursuant to this rule. Each IDC and CDC shall describe how quality control samples (negative control samples, positive control samples, low-positive controls, and

instrument performance check controls), internal standards, and surrogate standards are to be assessed to determine if the data from an analytical batch are acceptable. The laboratory shall maintain a documented procedure for performing every IDC and CDC. The laboratory shall retain documentation verifying the IDC and CDC for each test required by this rule and make this documentation available to the department upon request. The IDC and CDCs shall follow the same parameters as outlined in the requirements of this rule. Every IDC and CDC that is submitted shall be conducted within one year of application (excluding mycotoxins).

(1) An IDC shall be reconducted and resubmitted to the department:

(a) whenever there is a change in method;

(b) whenever an instrument has been moved;

(c) whenever a new instrument is installed; and

(d) whenever the method has not been performed by the laboratory or sampler within a 12-month period.

(2) Every IDC and CDC shall include the following elements:

(a) Demonstration of method calibration: The calibration range shall use at least five calibration points consisting of five different concentration levels of target compounds. The calibration range shall include a low calibration point equal to, or less, than the required minimum reporting level for each targeted compound. The calibration range shall include a calibration point equal to the action level for each targeted compound (mycotoxins and residual solvents). A laboratory or laboratory applicant shall provide the equation and the type of curve fit used for the calibration range, and the percent relative standard deviation or the goodness of fit. The percent relative standard deviation shall be less than twenty percent, or the goodness of fit (correlation coefficient) shall be 0.995 or better.

(b) Demonstration of method accuracy and precision: A laboratory or laboratory applicant shall supply the quantitation data for five positive control samples analyzed by its testing method utilizing a median or mid-level calibration concentration. A laboratory or laboratory applicant shall calculate and provide the calculated mean (average) result and the standard deviation. The percent relative standard deviation shall be less than fifteen percent, and the mean shall be within fifteen percent of the expected concentration. For laboratories using GC-FID, GC-PID/FID, or GCMS platforms for residual solvents, the percent relative standard deviation may be within twenty percent, and the mean may be within twenty percent, of the expected concentration for the targeted compounds propane, n-butane, isobutane, and methanol.

(c) Demonstration of method detection limit: A laboratory or laboratory applicant shall supply the quantitation data of seven low-level or minimum action level

positive control samples. The concentration of these low-level positive control samples is set equal to the lowest calibration point the laboratory uses. These data are then used to calculate a standard deviation, which is then used to calculate method detection limit (MDL) using the following equation: (3.14267 x standard deviation = method detection limit). The calculated method detection limit for each targeted mycotoxin and residual solvent shall be less than the required method reporting level. For potency testing, quantitation values of all the seven low-level positive controls fall within fifty perecent to one hundred and fifty percent% of the expected concentration for the cannabinoids THC, THCA, CBD, and CDBA

(d) Demonstration of low system background: A laboratory or laboratory applicant shall supply the analytical data of at least three negative control samples that do not contain any mycotoxins, residual solvents, or cannabinoids. For mycotoxins and residual solvents, the quantitation values shall be less than the minimum detection limit or a non-detect. For potency testing, the quantitation values shall be less than one-third of the value of the method reporting level.

(e) Demonstration of analyte identification: A laboratory that uses, and a laboratory applicant than intends to use, HPLC, GC-FID, or GC-PID/FID instrumentation shall supply analytical data where each targeted compound is analyzed as a single compound giving it its characteristic retention time. A laboratory that uses, and a laboratory applicant than intends to use, GCMS, LCMS, or LCMSMS instrumentation shall supply analytical data with the characteristic mass spectrum of each targeted compound.

G. Use of internal standards: A laboratory shall utilize an internal standard chemical compound in the instrumental analysis (testing methods) of cannabinoids, residual solvents, mycotoxins, heavy metals, and pesticides, which are collectively referred to as the tested analytes. The internal standard compound shall be used to determine the characteristic relative chromatographic retention times of these tested analytes to ensure proper analyte identifications (qualification) whenever mass spectral data are not obtained by an instrument. The internal standard compound shall be used to determine the relative instrument response of the tested analytes to ensure the proper measurement of analyte concentrations (quantitation).

H. Reporting results: A laboratory shall use no more than two significant figures to report a positive result. A laboratory shall report a non-detect of an analyte as less than the laboratory’s minimum reporting level. A laboratory shall also report a pass or fail evaluation with the reported result. A pass evaluation is assigned to a reported result less than the analytes action level listed. A fail evaluation is assigned to a reported result equal to or greater than the action level for each given analysis, consistent with the requirements of this rule.

[7.34.4.19 NMAC - N, 6/23/2020]

7.34.4.20 DEPARTMENT-APPROVED COURIERS; GENERAL PROVISIONS:

A. Approval of couriers: The department may approve a courier for the purpose of transporting usable cannabis from one or more licensed non-profit producers to qualified patients, primary caregivers, other non-profit producers, approved manufacturers and approved laboratories.

B. Application requirements: An applicant who seeks department approval to operate as a courier shall provide the following materials and information to the department in order to be considered for approval; and an approved courier shall promptly submit revisions in the event that the materials or information changes:

(1) a plan for delivery;

(2) a plan for security, including a description of facilities and containers intended for use in storing and transporting usable cannabis;

(3) a plan for safety, to include at a minimum a description of measures to be taken by the courier and its employees to ensure the safety of qualified patients, primary caregivers, and courier staff;

(4) a description of all vehicles used or intended to be used for the transport of usable cannabis;

(5) a complete list of employees;

(6) clear, legible photocopies of current New Mexico state-issued identification cards of all courier personnel;

(7) completed nationwide and statewide criminal history screening documentation;

(8) a description of the courier's hours of operation;

(9) a description of the locations or type(s) of locations where the courier will offer delivery of usable cannabis;

(10) a description of all licensed non-profit producers for whom the courier will deliver usable cannabis, and copies of all agreements between the courier and licensed non-profit producers for the delivery of usable cannabis;

(11) a description of all fees to be charged by the courier;

(12) protocols for contacting and communicating with qualified patients and primary caregivers regarding deliveries;

(13) training materials for drivers;

(14) confidentiality training materials that address the confidentiality of qualified patient and primary caregiver information;

(15) proof that the applicant is in good standing with the New Mexico taxation and revenue department (TRD);

(16) copies of the applicant's articles of incorporation or organization, as applicable;

(17) copies of the applicant's by-laws, as applicable;

(18) a list of all persons or business entities having direct or indirect authority over the management or policies of the courier, as applicable;

(19) a list of all persons or business entities having any ownership interest in any property utilized by the courier, whether direct or indirect, whether the interest is in land, building(s), or other material;

(20) proof that no buildings to be used by the courier are located within 300 feet of any school, church, or daycare center; or alternatively, proof that any school, church, or daycare center that is located within 300 feet of a building to be used by the applicant did not occupy that location prior to the applicant initially seeking to become licensed to operate at the location;

(21) if the courier will base its business at a location that is not owned by the applicant: a written statement from the property owner or landlord of the location that grants to the courier permission to possess cannabis on the premises;

(22) an attestation that the courier will not distribute cannabis within 300 feet of a school, church or daycare center, in accordance with the provisions of this rule;

(23) an attestation that no firearms will be permitted on any premises or in any vehicle used by the courier; and that no employee will possess a firearm when transporting or distributing cannabis; and

(24) an attestation that the courier will not transport cannabis across state lines.

C. Application fee: A courier applicant shall submit to the program with each initial application and renewal application for continued approval a non-refundable application fee of one-thousand-five-hundred dollars ($1,500), payable to the medical cannabis program.

D. General requirements: An approved courier shall adhere to each of the following requirements:

(1) a courier may contract with a licensed non-profit producer to deliver usable cannabis from the non-profit producer to qualified patients, primary caregivers, other non-profit producers, approved manufacturers and approved laboratories; a courier that provides service to more than one licensed non-profit producer shall offer their service at a uniform price for all non-profit producers for whom they deliver; an approved courier shall not transport a cannabis product that is not individually packaged, or that is not labeled in accordance with this rule;

(2) an approved courier shall not request or receive payment from a qualified patient or primary;

(3) upon obtaining a package of usable cannabis from a licensed non-profit producer, an approved courier shall hold the package in a secured area or areas that are locked and otherwise resistant to tampering or theft, until the package is delivered to its intended recipient or returned to the licensed non-profit producer;

(4) an approved courier shall not relinquish possession of usable cannabis unless and until the package of usable cannabis is either successfully delivered or returned to the licensed non-profit producer; for purposes of this section, a package of usable cannabis is successfully delivered only upon the approved courier's verification that an intended recipient has taken actual, physical possession of the package; an approved courier shall not leave a package at any location for any reason, unless the package is successfully delivered to its intended recipient;

(5) an approved courier shall not deliver a package to any person or entity who is not identified by the licensed non-profit producer as an intended, authorized recipient;

(6) at the time of delivery, an approved courier shall verify the recipient's identity by requiring presentation of the recipient's department-issued medical cannabis identification card and New Mexico-issued photo identification card or a passport; an approved courier shall not deliver usable cannabis to any person whose identity is not verified in accordance with this rule; an approved courier shall document having verified the recipient's identification in accordance with this rule for each transaction;

(7) an approved courier shall not possess usable cannabis for a time period greater than seven days; an approved courier shall return any usable cannabis that is not successfully delivered to its intended recipient to a licensed non-profit producer within this time period;

(8) an approved courier shall not distribute cannabis at locations that are within 300 feet of a school, church, or daycare center; provided that, for purposes of this provision, delivery to the residence of a qualified patient or primary caregiver shall not be deemed "distribution";

(9) an approved courier and its personnel shall at all times take measures to ensure confidentiality and safety in the transport and delivery of usable cannabis;

(10) an approved courier shall appropriately train its personnel regarding the confidentiality of information concerning qualified patients and primary caregivers; confidentiality training shall describe confidentiality requirements applicable under both federal and state law; an approved courier shall conduct confidentiality training of its personnel at least once annually, and shall maintain training materials on its premises, and document the training of individual staff;

(11) personnel of an approved courier shall not possess a firearm while distributing or otherwise possessing cannabis; an approved courier shall not possess or permit the possession of a firearm on any premises, including a building or vehicle, utilized by the courier; and

(12) an approved courier shall not, when transporting usable cannabis to a qualified patient or primary caregiver, utilize a delivery vehicle that advertises or otherwise displays signage, logos, or symbols that would indicate that the vehicle is used for the transport of cannabis.

E. Identification cards: The department shall issue an identification card to each authorized employee of an approved courier authorizing that individual to transport cannabis from a non-profit producer to a qualified patient or primary caregiver. An employee of an approved courier shall carry their department issued employee identification card at all times during their work, and shall present the card to law enforcement officials and to department officials upon request. An employee who is unable to produce their department issued identification card upon request shall not remain on the licensed premises, and shall produce the card for the department's inspection prior to returning to the licensed premises. Identification cards issued by the department are the property of the department and shall be returned to the department upon an approved courier's withdrawal from the program, upon the termination of a card holder's employment with the approved courier, upon suspension or revocation, or upon demand of the department.

F. Term of approval: Department approval of a courier shall be for a term of one year, and shall expire after that year, or upon closure of the courier. A courier shall apply for renewal of approval annually no later than 30 days prior to expiration.

G. Amended license:

(1) An approved courier shall submit to the department an application form for an amended license, and shall obtain approval from the department, at least 30 business days prior to implementing any:

(a) change of location of the courier's facilities, change of directors, change of ownership of the courier's facilities, change of company name, and any physical modification or addition to the courier's facilities; and

(b) substantial change to the courier's methods for storing, transporting and delivering cannabis-derived products, and any substantial change to the courier's security plan.

(2) Process for incomplete application for amended license: In the event that an application for amended licensure is determined by the program to be incomplete, the program will specify the information or materials that remain to be submitted. If the courier does not submit the requested information or material, and does not otherwise contact the department regarding the application, within thirty days of receiving notice of the deficiency, the application will be closed as incomplete, and the courier will be required to resubmit the application in order to recommence the application process.

H. Reporting of theft to department: A courier shall submit to the department notification of any theft, robbery, break-in, or security breach that occurs on the courier's premises, no later than 10 calendar days after the courier first becomes aware of the event. The description shall include a description of any property that was stolen or destroyed, and the quantity of any usable cannabis that was stolen.

I. Drugs and alcohol: A courier shall prohibit its employees and contractors from being under the influence of drugs or alcohol in the workplace.

J. Inventory and sales equipment: The department may require a licensed courier to utilize specified equipment, software, and services for purposes of tracking distribution, inventory, and other information, and for the purpose of reporting that information to the department of health.

K. Chain of custody: A courier shall adopt, maintain, and enforce chain of custody procedures and documentation requirements to ensure appropriate tracking and inventory of usable cannabis. A courier shall also adopt, maintain, and enforce security requirements to ensure that usable cannabis transported by the courier is secured, and to promote the safety of courier personnel, as well as qualified patients and primary caregivers who receive packages from the courier.

L. Confidentiality: An approved courier may obtain contact information of a purchasing qualified patient or primary caregiver, as permitted by agreement between the courier and a respective licensed non-profit producer, and may utilize such information solely for the purpose of arranging a delivery location and time with the qualified patient or primary caregiver. An approved courier shall not otherwise disseminate, disclose, or use identifying information or contact information concerning a qualified patient or primary caregiver.

[7.34.4.20 NMAC - Rp. 7.34.4.17 NMAC, 6/23/2020]

7.34.4.21 QUALIFIED PERSONAL PRODUCTION APPLICATION AND LICENSURE REQUIREMENTS:

A. A qualified patient may apply for a personal production license for either the qualified patient or the qualified patient's primary caregiver to produce medical cannabis solely for the qualified patient's own use.

B. A qualified patient may obtain no more than one personal production license, which license may be issued for production to occur either indoors or outdoors in no more than one single location.

C. No more than two personal production licenses may be issued for a given location, with proof that a second registered patient currently resides at the location. Multiple personal production licenses may not be issued for non-residential locations.

D. Qualified patients shall provide the following in order to be considered for a personal production license to produce medical cannabis:

(1) applicable non-refundable fee;

(2) a description of the single indoor or outdoor location that shall be used in the production of cannabis;

(3) if the location is on property that is not owned by the applicant: a written statement from the property owner or landlord that grants to the applicant permission to grow cannabis on the premises;

(4) a written plan that ensures that the cannabis production shall not be visible from the street or other public areas;

(5) a written acknowledgement that the applicant will ensure that all cannabis, cannabis-derived products and paraphernalia is accessible only by the applicant and their primary caregiver (if any), and kept secure and out of reach of children;

(6) a description of any device or series of devices that shall be used to provide security and proof of the secure grounds; and

(7) a written acknowledgement of the limitations of the right to use and possess cannabis for medical purposes in New Mexico.

[7.34.4.21 NMAC - Rp, 7.34.4.18 NMAC, 6/23/2020]

7.34.4.22 NON-PROFIT PRODUCER APPLICATION AND LICENSURE REQUIREMENTS:

An applicant for initial or renewal non-profit producer licensure shall provide materials and information to the department, in accordance with the provisions of this section, in order to be considered for a license to produce medical cannabis. A licensed non-profit producer shall also promptly submit revised versions of any such materials in the event that the materials or their content change.

A. Organizational information and materials: An applicant for non-profit producer licensure shall submit to the department:

(1) proof that the private entity is a non-profit corporation in good standing with the NM secretary of state pursuant to Section 53-8-1 *et seq*., NMSA 1978;

(2) proof that the non-profit producer is in good standing with the New Mexico taxation and revenue department;

(3) copies of the entity's articles of incorporation;

(4) copies of the entity's by-laws;

(5) verification that the board of directors of the non-profit includes, at a minimum, five voting members, including one medical provider limited to a physician (MD or OD), a registered nurse, nurse practitioner, licensed practical nurse, or physician assistant, and three patients currently qualified under department regulations and the Lynn and Erin Compassionate Use Act, Section 26-2B-1 *et seq.*, NMSA 1978;

(6) a list of all persons or business entities having direct or indirect authority over the management or policies of the private entity;

(7) a list of all persons or business entities having any ownership interest in any property utilized by the non-profit producer, whether direct or indirect, and whether the interest is in land, building(s), or other material, including owners of any business entity that owns all or part of land or building(s) utilized;

(8) the identities and financial information, including information concerning loans and monetary investments, of all creditors currently holding a security interest in the non-profit producer or premises of the non-profit producer, if any; and

(9) a business plan showing how the private entity intends to fund its operations and become a successful producer, including information concerning personnel, horticulture, technology, and funding sources.

B. Production and distribution information and materials: An applicant for non-profit producer licensure shall submit to the department:

(1) an acknowledgement that production, at any time, shall not exceed the total of cannabis plants that the non-profit entity has been approved to produce as well as an inventory of usable cannabis that reflects current patient needs;

(2) a production plan that includes the non-profit entity's plan for the growth, cultivation, and harvesting of medical cannabis;

(3) a written set of distribution criteria for qualified patients or primary caregivers appropriate for cannabis services that describes the method by which and locations at which distribution will occur;

(4) a complete written description of the means that the non-profit entity shall employ to safely dispense cannabis and cannabis-derived products to qualified patients and qualified patients' primary caregivers;

(5) an attestation that qualified patients shall not be permitted to consume cannabis or cannabis-derived products on the entity's property, unless the consumption occurs in a department approved cannabis consumption area;

(6) an attestation that the entity will require the presentation of a department-issued identification card and a valid New Mexico photo identification card or a passport prior to selling or otherwise distributing cannabis or cannabis derived products to qualified patients and primary caregivers;

(7) a description and sample of the packaging of the usable cannabis and cannabis-derived products that the non-profit producer shall utilize, including a label that satisfies the labeling requirements of this rule; and

(8) a written quality assurance plan.

C. Facility information: An applicant for non-profit producer licensure shall submit to the department:

(1) a description of the facilities and equipment that shall be used in the production distribution of cannabis, and manufacture of cannabis-derived products (as applicable);

(2) proof that the facilities are not within 300 feet of any school, church, or daycare center; or alternatively, proof that any school, church, or daycare center that is located within 300 feet of a building to be used by the applicant did not occupy that location prior to the applicant initially seeking to become licensed to operate at the location; and

(3) a description of the methods and device or series of devices that shall be used to provide security.

D. Educational methods and materials: An applicant for non-profit producer licensure shall submit to the department:

(1) a description of the private entity's means for educating the qualified patient and the primary caregiver on the limitation of the right to possess and use cannabis;

(2) a description of the means the private entity shall employ to make qualified patients or the primary caregiver aware of the quality of the product;

(3) a description of ingestion options of usable cannabis provided by the private entity;

(4) a description of inhalation techniques that shall be provided to qualified patients;

(5) a description of potential side effects and how the private entity will educate qualified patients and the qualified patient's primary caregivers regarding potential side effects;

(6) a description of the means the private entity shall employ to make qualified patients or the primary caregiver aware of how to report adverse events related to medical cannabis use; and

(7) a description of the means the private entity shall employ to make qualified patients or the primary caregiver aware of how to report concerns regarding the private entity's products and services.

E. Sales record forms: A licensed non-profit producer that applies for renewal of licensure shall submit to the department a sample of the non-profit producer's sales record form(s), which shall identify (among other items) the name of the purchaser, the date of the sale, the quantity, and price of medical cannabis sold. A non-profit producer that applies for renewal of licensure shall additionally submit a profit and loss statement and balance sheet quarterly and as requested by the department.

F. Business licensure; TRD certificate: An applicant for non-profit producer licensure shall submit a current business license and tax and revenue registration certificate.

G. Policies and procedures: An applicant for non-profit producer licensure shall submit to the department copies of policies and procedures developed, implemented, and to be maintained on the premises of the private entity's facility. The applicant shall verify that the private entity will comply with the stated terms of the policies and procedures as written and submitted to the department.

H. Personnel records: An applicant for non-profit producer licensure shall submit to the department:

(1) separate nationwide and statewide criminal history screening documentation, in accordance with the provisions of this rule;

(2) samples of the personnel records to be retained by the private entity for each employee as required by this rule, including:

(a) a sample application for employment;

(b) state and federal employment documentation;

(c) a sample written job descriptions or employment contracts developed for all employee positions, to include duties, authority, responsibilities, qualifications, and supervision;

(d) payment or payroll records for all individuals associated with a non-profit producer renewal applicant's production and distribution facility, to include board members, persons having direct or indirect authority over management or policies, and employees submitted quarterly and as requested by the department.

(3) an on-site training curriculum (unless the private entity intends to enter into contractual relationships with outside resources capable of meeting employee training needs) that addresses, at a minimum, the following topics:

(a) state and federal confidentiality laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

(b) professional conduct and ethics;

(c) the Lynn and Erin Compassionate Use Act and department of health rules;

(d) informational developments in the field of medical use of cannabis;

(e) employee safety and security training addressing, at a minimum, the proper use of the security measures and controls that have been adopted, and specific procedural instructions on how to respond to an emergency, including a robbery or violent accident;

(f) robbery awareness and conflict de-escalation training for all employees;

(g) general food safety training.

(4) proof of HIPAA certification for all individuals associated with the private entity, including all board members, persons having direct or indirect authority over management or policies, and employees.

I. Other materials: An applicant for non-profit producer licensure shall submit to the department:

(1) a description of the department approved laboratory or laboratories that the non-profit entity will utilize for testing usable cannabis in accordance with this rule, and the type(s) of testing that the approved laboratory or laboratories will perform for the non-profit entity;

(2) the name of any courier that the non-profit entity intends to use for transport of usable cannabis to qualified patients and primary caregivers; and

(3) such other information as the private entity wishes to provide and such other information as the department may reasonably request.

J. Patient identification and sales records: A licensed non-profit producer shall retain clear, legible photocopies or electronic copies of current registry identification cards and current New Mexico photo identification cards of all qualified patients and primary caregivers served by the non-profit entity. A licensed non-profit producer shall also create and retain materials that document every instance in which usable cannabis was sold or otherwise distributed to another person or entity, including documentation of the recipient, type, quantity, and batch of the usable cannabis.

K. Material safety data sheets: A licensed non-profit producer shall maintain current material safety data sheets on-site for all chemicals used, including but not limited to cleaning compounds, sanitizing agents, and pesticides.

L. State and local laws: A licensed non-profit producer shall comply with all applicable state and local laws regarding construction, occupancy, and operation of a facility or building, including but not limited to zoning, occupancy, licensing, and building codes.

[7.34.4.22 NMAC - Rp, 7.34.4.19 NMAC, 6/23/2020]

7.34.4.23 SECURITY REQUIREMENTS FOR LICENSED PRODUCERS:

Private non-profit entities licensed to produce medical cannabis shall comply with the following requirements to ensure that production and distribution facilities are located on secure grounds.

A. The non-profit producer shall provide and maintain in each facility a fully operational security alarm system.

B. The non-profit producer shall conduct a monthly maintenance inspection and make all necessary repairs to ensure the proper operation of the alarm system and, in the event of an extended mechanical malfunction that exceeds an eight hour period, provide alternative security that shall include closure of the premises.

C. The non-profit producer shall maintain documentation for a period of at least 24 months of all inspections, servicing, alterations, and upgrades performed on the security alarm system; all documentation shall be made available within 24 hours of a department representative's request; failure to provide equipment maintenance documentation within the 24 hour period shall subject the licensed producer to the sanctions and penalties provided for in this rule; the 24 hour period shall not include holidays and weekends.

[7.34.4.23 NMAC - Rp, 7.34.4.11 NMAC, 6/23/2020]

7.34.4.24 RECALLS OF USABLE CANNABIS:

A. All non-profit producers and approved manufacturers shall establish and implement written procedures for recalling usable cannabis and products that have been sold or otherwise distributed to qualified patients, primary caregivers, or other cannabis establishments. Recall procedures shall be made available for the department's inspection upon request. The recall procedures shall identify:

(1) The circumstances in which a recall will be conducted, including but not limited to circumstances involving the mislabeling of products and the contamination of products.

(2) Personnel responsible for implementing the recall procedures.

(3) Procedures for notification of all customers who have, or reasonably could have, obtained an affected product, including communication and outreach via media, as appropriate.

(4) Procedures for notification of any other cannabis establishment that supplied or received the recalled product.

(5) Instructions to be provided to qualified patients, primary caregivers, and cannabis establishments for the return or destruction of the recalled product.

(6) Procedures for the collection and wastage (as may be required by this rule) of any recalled product, which shall meet the requirements of this section.

B. All recalled products that are intended to be destroyed shall be wasted in accordance with the wastage requirements of this rule.

C. The licensee shall notify the department of any recall within 24 hours of initiating the recall.

D. The department may order the immediate recall of a usable cannabis product if it deems such action necessary to protect public health and safety.

[7.34.4.24 NMAC - N, 6/23/2020]

7.34.4.25 DENIAL OF AN INITIAL PRODUCER LICENSE:

A. Administrative review of license application denials: An applicant whose initial application for a producer license is denied by the medical cannabis program director or designee may request an administrative review by the administrative review committee. The written notice of denial shall include a statement of the right to request such a review.

B. No administrative review of determinations made by the secretary: An applicant whose initial application for a producer license was for any reason not approved by the secretary (rather than the program director or designee) shall not be entitled to further review by the department, but may reapply at a later date.

C. Procedure for requesting informal administrative review:

(1) An applicant given notice of an application denial by the medical cannabis program director or designee may submit a written request for a record review. To be effective, the written request shall:

(a) be made within 30 calendar days, as determined by the postmark, from the date of the denial notice issued by the department;

(b) be properly addressed to the medical cannabis program;

(c) state the applicant's name, address, and telephone numbers;

(d) state the applicant's proposed status as a licensed producer; and

(e) provide a brief narrative rebutting the circumstances of the application denial.

(2) If the applicant wishes to submit additional documentation for consideration, the applicant shall include such additional documentation when submitting the request for administrative review.

D. Administrative review proceeding: The administrative review proceeding shall be a closed proceeding that is limited to an administrative review of written application materials and documents offered to verify eligibility. The administrative review is not an

adjudicatory hearing. The administrative review shall be conducted by the administrative review committee. In cases where the administrative review committee finds the need for additional or clarifying information, the review committee shall request that the applicant supply such additional information within the time set forth in the committees' request.

E. Final determination:

(1) Content: The administrative review committee shall render a written decision setting forth the reasons for the decision.

(2) Effect: The decision of the administrative review committee is the final decision of the informal administrative review proceeding.

(3) Notice: A copy of the decision shall be mailed to the applicant.

F. Judicial review: Except as otherwise provided by law, there shall be no right to judicial review of a decision by the program director or designee, the administrative review committee, or the secretary.

[7.34.4.25 NMAC - Rp, 7.34.4.21 NMAC, 6/23/2020]

7.34.4.26 PROHIBITIONS, RESTRICTIONS, AND LIMITATIONS ON THE PRODUCTION AND DISTRIBUTION OF MEDICAL CANNABIS AND CRIMINAL PENALTIES:

A. Participation in the medical cannabis licensing program by a licensed producer or approved entity, or the employees or contractors of a licensed producer or approved entity, does not relieve the producer, approved entity, employee, or contractor from criminal prosecution or civil penalties for activities not authorized in this rule and the act.

B. Locations of production, distribution, and manufacture: Production of medical cannabis and distribution of medical cannabis to qualified patients or their primary caregivers shall take place at locations (or, with respect to distribution, categories of locations) described in the non-profit producer's production and distribution plan approved by the department, and shall not take place at locations that are within 300 feet of any school, church, or daycare center. For purposes of this rule, delivery to the residence of a qualified patient or primary caregiver shall not be deemed "distribution".

C. Fraudulent misrepresentation: Any person who makes a fraudulent representation to a law enforcement officer about the person's participation in the medical cannabis program to avoid arrest or prosecution for a cannabis-related offense is guilty of a petty misdemeanor and shall be sentenced in accordance with the provisions of Section 31-19-1 *et seq.*, NMSA 1978.

D. Unlawful distribution: If a licensed producer or employee of a licensed producer sells, distributes, dispenses, or transfers cannabis to a person not approved by the department pursuant to this rule and the act, or obtains or transports cannabis outside New Mexico in violation of federal law, the licensed producer or employee of the licensed producer shall be subject to arrest, prosecution, and civil or criminal penalties pursuant to state law.

E. Revocation of registry identification card, licensed primary caregiver card, license to produce or distribute: Violation of any provision of this rule may result in disciplinary action, in accordance with this rule.

[7.34.4.26 NMAC - Rp, 7.34.4.22 NMAC, 6/23/2020]

7.34.4.27 CANNABIS CONSUMPTION AREAS:

A. General provisions: The smoking, vaporizing, and ingestion of medical cannabis products by qualified patients is permitted within cannabis consumption areas, designated by the department, that are located on the premises of licensed non-profit producers. Cannabis consumption areas may only be operated by licensed non-profit producers, at medical cannabis dispensary locations designated by the department. Alcohol is prohibited in cannabis consumption areas. A licensed non-profit producer that operates a cannabis consumption area shall comply with all applicable state and local laws, including but not limited to zoning, occupancy, licensing, and building codes. Additionally, a licensed non-profit producer that operates a designated cannabis consumption area shall:

(1) restrict access to the cannabis consumption area to qualified patients and their primary caregivers and authorized personnel of the non-profit producer;

(2) ensure that consumption of cannabis in the cannabis consumption area is not visible from any public place or from outside the cannabis consumption area; and

(3) require that qualified patients who consume cannabis in a cannabis consumption area either leave the non-profit producer’s premises with a designated driver or utilize other lawful means of transportation from the non-profit producer’s premises.

B. Application; operations plan: A licensed non-profit producer shall apply for and obtain prior approval from the department before operating a cannabis consumption area. The licensed non-profit producer shall include an operations plan with its application that includes the following:

(1) operating hours of the cannabis consumption area;

(2) plan for limiting access to qualified patients and primary caregivers access and verification process;

(3) security plan addressing overall security measures, including but not limited to plans for video surveillance, fire safety, public disturbances, refusal of service, and emergency evacuation;

(4) plan for ensuring that only qualified patients, primary caregivers, and authorized staff can access cannabis consumption areas;

(5) plan for educating patients and primary caregivers about the dangers of driving under the influence of cannabis;

(6) plan concerning disposal of wasted cannabis and cannabis-related paraphernalia;

(7) plan concerning measures to limit potential allergic reactions by qualified patients and primary caregivers who visit the cannabis consumption area;

(8) plan to ensure that qualified patients who are minors are accompanied by their primary caregiver at all times while on the premises of a cannabis consumption area;

(9) attestation that access to cannabis consumption areas will be limited to qualified patients and their primary caregivers and authorized personnel of the non-profit producer;

(10) attestation that consumption of cannabis in the cannabis consumption area will not be visible from any public place or from outside the cannabis consumption area;

(11) attestation that the non-profit producer will require that qualified patients who consume cannabis in a cannabis consumption area either leave the non-profit producer's premises with a designated driver (who shall be identified to the non-profit producer by the qualified patient or primary caregiver) or utilize other lawful means of transportation from the non-profit producer's premises; and

(12) such additional information or materials as the department may require.

C. Amended license: The licensed non-profit producer shall apply for amended licensure, and shall obtain approval from the department, at least 30 days prior to implementing any change of location of a cannabis consumption area or any substantial change to any portion of the non-profit producer's cannabis consumption area operations plan.

[7.34.4.27 NMAC - N, 6/23/2020]

7.34.4.28 [RESERVED]

[7.34.4.28 NMAC - Rp. 7.34.4.28 NMAC, 6/23/2020; A, 10/8/2020; A, 3/23/2021; Repealed, 2/22/2022]

7.34.4.29 ENFORCEMENT OF PARENTAL RESPONSIBILITY ACT:

A. The medical cannabis program's approval of an employee of a non-profit producer or an approved entity to work for such producer or approved entity may be suspended, and a request for an individual to be approved to work for such a producer or approved entity may be denied, for failure of the approved employee or prospective employee to comply with a judgment and order for child support issued by a district or tribal court or a subpoena or warrant relating to paternity or child support proceedings, as provided in the Parental Responsibility Act, Section 40-5A-1 et seq., NMSA 1978.

B. Procedures for enforcement of the Parental Responsibility Act:

(1) List of obligors: The New Mexico human services department (HSD) will issue to the medical cannabis program a certified list of obligors (meaning persons who have been ordered to pay child support pursuant to a judgment and order for support issued by a district or tribal court) not in compliance with their judgment and order of support or a subpoena or warrant relating to paternity or child support proceedings.

(2) Notice of non-compliance: Upon determination by the medical cannabis program that the name and social security number of an approved employee or prospective employee of a non-profit producer or an approved entity appear on the certified list of obligors, the medical cannabis program shall notify the approved employee or prospective employee in writing. The medical cannabis program may send a copy of the notice of non-compliance to the non-profit producers or approved entities affiliated with the approved employee or prospective employee. The notice shall state that the medical cannabis program intends to suspend the approved employee's approval to work for the non-profit producer or approved entity, or deny the prospective employee's approval to work for the non-profit producer or approved entity, unless the approved employee or prospective employee, within thirty days of the date that the written notice is issued, provides to the medical cannabis program a certified statement from the human services department that he or she is in compliance with a judgment and order for support or subpoenas or warrants relating to paternity or child support proceedings.

(3) Notice of contemplated action: If the approved employee or prospective employee of a non-profit producer or approved entity does not provide to the medical cannabis program the certified statement of compliance from HSD within thirty days of the date that the written notice is issued, the medical cannabis program shall issue a notice of contemplated action to the approved employee or prospective employee, stating that the medical cannabis program has grounds to suspend or deny the individual's authorization to work for the non-profit producer or approved entity, and that the medical cannabis program shall take such action unless the individual mails a letter (certified mail, return receipt requested) requesting a hearing within 20 days after

service of the notice requesting a hearing, or provides the bureau, within 30 days of receipt of the notice of contemplated action, a statement of compliance from HSD. The medical cannabis program may send a copy of the notice of contemplated action to the non-profit producers or approved entities affiliated with the approved employee or prospective employee.

(4) Disputes regarding findings of non-compliance: If the approved employee or prospective employee disagrees with the finding of non-compliance, or wishes to come into compliance, the approved or prospective employee shall contact the HSD child support enforcement division.

(5) Hearings: The hearing process of this rule part shall apply to hearings conducted pursuant to this section; provided that, in any such hearing, the following standards shall also apply:

(a) The presence of an individual's name and social security number on the HSD list of obligors is deemed conclusive evidence of an individual's non-compliance that requires the medical cannabis program to deny or withdraw approval of an individual to work for a non-profit producer or approved entity, unless the individual provides the medical cannabis program with a certified statement of compliance, in which case the medical cannabis program shall be precluded from taking further action under this section;

(b) When an action is taken against an approved employee or prospective employee of a non-profit producer or approved entity because the individual is not in compliance with a judgment and order of support or a subpoena or warrant relating to paternity or child support proceedings, the order shall state that the individual's approval to work for a non-profit producer or approved entity shall be reinstated upon presentation to the medical cannabis program of a certified statement of compliance from HSD; and

(c) The secretary may also include in the order any other conditions necessary to comply with requirements for reapplication and re-issuance of licensure, including, but not limited to, requiring payment of a surcharge fee of $50, in addition to any other applicable fees.

[7.34.4.29 NMAC - N, 6/23/2020]

7.34.4.30 MONITORING AND CORRECTIVE ACTIONS:

A. Monitoring:

(1) The department or its designee may perform on-site assessments of a licensed producer or producer-applicant, an approved manufacturer or manufacturer-applicant, an approved laboratory or a laboratory-applicant, and an approved courier or courier-applicant, to determine compliance with these rules or submissions made

pursuant to this rule. The department may enter the premises of a licensed producer, approved manufacturer, approved laboratory, or approved courier at any time to assess or monitor.

(2) 24 hours' notice shall be provided to personal production license holders prior to an on-site assessment, except when the department has reasonable suspicion to believe that providing notice will result in the destruction of evidence, or that providing such notice will impede the department's ability to enforce these regulations.

(3) The department may review any and all records of a licensed non-profit producer, a qualified patient or primary caregiver, an approved manufacturer, approved laboratory, and approved courier, and may require and conduct interviews with such persons or entities and persons affiliated with such entities, for the purpose of determining compliance with department rules and applicable laws.

(4) All licensed producers, approved manufacturers, approved laboratories, and approved couriers shall provide the department or the department's designee immediate access to any material and information necessary for determining compliance with this rule.

(5) Failure by a licensed producer, approved manufacturer, approved laboratory, or approved courier to provide the department access to the premises or materials may result in disciplinary action(s), in accordance with this rule.

(6) Any failure to adhere to these rules that is documented by the department during monitoring may result in disciplinary action, in accordance with this rule.

(7) The department shall refer complaints alleging criminal activity that are made against a licensed producer, approved manufacturer, approved laboratory, or approved courier to appropriate New Mexico state or local law enforcement authorities.

B. Financial records: A licensed non-profit producer and a manufacturer shall maintain detailed sales records in a manner and format approved by the department, and shall inform the department of the location where such records are kept, and promptly update that information if the records are removed.

(1) Access: The department and its agents shall have reasonable access to the financial records of a licensed non-profit producer manufacturer, laboratory, or courier, including but not limited to sales records and data from point of sale systems, and shall be granted immediate access to inspect or copy those records upon request. A patient shall be granted reasonable access to a licensed non-profit producer's or manufacturer's sales records for that patient upon request.

(2) Audit: A licensed non-profit producer shall submit the results of an annual audit to the department no later than 90 days after the end of each fiscal year of the licensed non-profit. For the purposes of this section, the fiscal year of a non-profit

producer shall be the 12 month cycle identified by the producer in its filings with the New Mexico taxation and revenue department. The annual audit shall be conducted by an independent certified public accountant; the costs of any such audit shall be borne by the private entity. Results of the annual audit shall be forwarded to the medical cannabis program director or designee. The department may also periodically require, within its discretion, the audit of a non-profit producer's financial records by the department.

(3) Quarterly reports: A non-profit producer shall submit reports on at least a quarterly basis, or as otherwise requested, and in the format specified by the department. The quarterly report shall include at a minimum:

(a) number of qualified patients and primary caregivers who purchased usable cannabis;

(b) total number of retail transactions;

(c) average amount (in units) purchased per retail transaction;

(d) number of units provided without charge;

(e) number of cannabis plants in production, including mature plants and seedlings;

(f) number of cannabis plants harvested;

(g) total yield of usable cannabis harvested from cannabis plants (in grams);

(h) average yield per plant (in grams);

(i) amount of cannabis (in grams) sold by wholesale;

(j) amount of cannabis (in grams) purchased by wholesale;

(k) number of live cannabis plants (including clones) and cannabis seeds sold;

(l) amount of dried cannabis leaves and flowers in stock;

(m) average price per gram of dried cannabis leaves and flowers;

(n) total amount of dried cannabis leaves and flowers sold (in units);

(o) total sales of dried cannabis leaves and flowers (in dollars and units);

(p) amount of cannabis derived products in stock (in units);

(q) total amount of cannabis derived products sold (in units);

(r) total sales of cannabis derived products (in dollars and units);

(s) amount of gross receipts tax paid to the New Mexico department of taxation and revenue;

(t) all quality testing reports, to be included as attachments; and

(u) such additional information as the department may request.

C. Corrective action:

(1) If violations of requirements of this rule are cited on the basis of a violation that is directly observed in the course of a monitoring visit at an approved location, or on the basis of a review of financial records, the licensed producer, manufacturer, laboratory, or courier shall be provided with an official written report of the findings within seven business days following the monitoring visit or the review of financial records.

(2) Unless otherwise specified by the department, the licensed producer, manufacturer, laboratory, or courier shall correct the violation within five calendar days of receipt of the official written report citing the violation(s).

(3) The violation shall not be deemed corrected until the department verifies in writing within seven calendar days of receiving notice of the corrective action that the corrective action is satisfactory.

(4) If the violation has not been corrected, the department may issue a notice of contemplated action to suspend, revoke, or take other disciplinary action against the license of the producer, manufacturer, laboratory, or courier, in accordance with the provisions of this rule.

D. Suspension of license without prior hearing: If immediate action is required to protect the health and safety of the general public, a qualified patient, or a primary caregiver, the program director or designee may suspend the license of a non-profit producer or personal production license holder without notice, and may immediately withdraw approval for a laboratory, manufacturer, or courier without notice.

(1) A licensee or approved entity whose license has been summarily suspended or whose approval has been withdrawn may request a record review in accordance with this part.

(2) The record review requested subsequent to a summary suspension shall be conducted by the administrative review committee.

(3) The administrative review committee shall conduct the record review on the summary suspension or withdrawal of approval by reviewing all documents submitted by both licensee and the department.

(4) The sole issue at a record review on a summary suspension or withdrawal of approval is whether the license shall remain suspended or whether the approval shall remain withdrawn pending a final adjudicatory hearing and subsequent ruling by the secretary.

(5) A licensee or approved entity given notice of summary suspension or summary withdrawal by the program may submit a written request for a record review. To be effective, the written request shall:

(a) be made within 30 calendar days, from the date of the notice issued by the department, as determined by the postmark;

(b) be properly addressed to the medical cannabis program;

(c) state the applicant's name, address, and telephone numbers;

(d) provide a brief narrative rebutting the circumstances of the suspension or withdrawal, and

(e) include attachments of any additional documentation that the individual or entity wishes to be considered in the record review.

[7.34.4.30 NMAC - Rp, 7.34.4.23 NMAC, 6/23/2020]

7.34.4.31 DISCIPLINARY ACTIONS AND APPEAL PROCESS:

A. Notice of disciplinary action: The department may issue notice of an immediate disciplinary action, as specified in this rule, or notice of contemplated disciplinary action. Notice shall be served upon a licensee's contact person of record. Notice shall be served via certified U.S. postal mail. A notice shall be deemed to have been served on the date borne by the return receipt showing delivery or the last attempted delivery of the notice or decision to the addressee or refusal of the addressee to accept delivery of the notice or decision.

B. Grounds for disciplinary action: Disciplinary action may be taken against a producer-applicant, a licensed producer, a manufacturer-applicant or approved manufacturer, a laboratory applicant or approved laboratory, or an approved courier or courier-applicant. Disciplinary action may include revocation, suspension, or denial of an application, license, or department approval, monetary penalties, immediate suspensions and revocations in accordance with this rule, and other action. Disciplinary actions may be imposed in any combination, and the actions described in this

paragraph, including suspension and monetary fines, are not exclusive of one another. Disciplinary action may be imposed for:

(1) A major violation implicating public safety, including:

(a) failure to comply with or satisfy any provision of this rule that implicates public safety;

(b) diversion, inversion, or attempted diversion or inversion, of cannabis or a cannabis-derived product, as determined by the department;

(c) threatening or harming a patient, a medical practitioner, or an employee of the department;

(d) intentionally destroying, damaging, altering, removing or concealing evidence of a violation under this rule, attempting to do so, or asking or encouraging another person to do so;

(e) deliberately purchasing usable cannabis, cannabis-derived products or cannabis plants from out of state or outside the legal medical cannabis system; or

(f) other conduct that shows willful or reckless disregard for health or safety;

(2) A major violation not implicating public safety, including:

(a) failure to pay a required monetary penalty;

(b) failure to comply with the department's requested access to premises or materials;

(c) failure to allow or impedance of a visit by authorized representatives or designees of the department;

(d) falsification or misrepresentation of any material or information submitted to the department;

(e) failure to adhere to any acknowledgement, verification, or other representation made to the department;

(f) failure to submit or disclose information required by this rule or otherwise requested by the department;

(g) failure to correct any violation of this rule cited as a result of a review or audit of financial records or other materials, or cited as a result of a monitoring visit or site inspection;

(h) a pattern of non-major license violations;

(i) non-compliance with tax obligations as determined by a taxation regulatory authority;

(j) exceeding the plant limit of the license; and

(3) Any other violation, including:

(a) failure to comply with or satisfy any provision of this rule that does not implicate public safety;

(b) failure to take a video recording of the wastage of usable cannabis, in accordance with this rule; and

(c) selling or transferring to a qualified patient or primary caregiver a quantity of usable cannabis greater than the maximum amount permitted by department rule.

C. Fines: Disciplinary actions against a licensed non-profit producer, approved manufacturer, approved laboratory, or approved courier may include the imposition of monetary penalties, which may be assessed by the department in the amount of:

(1) up to $50,000 for each major violation implicating public safety;

(2) up to $20,000 for each major violation not implicating public safety;

(3) up to $5,000 for each other violation.

D. Persons and entities who may request a hearing: The following persons or entities may request a hearing to contest an action or proposed action of the department, in accordance with this rule:

(1) a licensed producer whose license has been summarily suspended or who has received a notice of contemplated action to suspend, revoke, or take other disciplinary action;

(2) a personal production licensure applicant whose application is denied for any reason other than failure to submit a completed application or failure to meet a submittal requirement of this rule;

(3) an approved manufacturer whose approval status has been summarily suspended or who has received a notice of contemplated action to suspend, revoke, or take other disciplinary action;

(4) a manufacturer-applicant whose application is denied for any reason other than failure to submit a completed application or failure to meet a submittal requirement of this rule;

(5) an approved laboratory whose approval status has been summarily suspended or who has received a notice of contemplated action to suspend, revoke, or take other disciplinary action;

(6) a laboratory-applicant whose application is denied for any reason other than failure to submit a completed application or failure to meet a submittal requirement of this rule;

(7) an approved courier whose approval status has been summarily suspended or who has received a notice of contemplated action to suspend, revoke, or take other disciplinary action;

(8) a courier-applicant whose application is denied for any reason other than failure to submit a completed application or failure to meet a submittal requirement of this rule; and

(9) a person whose participation with a licensed producer or approved entity is prohibited based on a criminal background check.

E. Closure of applications period: A hearing may not be requested by a person or entity whose application for licensure is denied solely on the basis that the applicable applications period is closed.

F. Timing and content of request for hearing: The appellant shall mail the request for hearing within 30 calendar days of the date that the notice of contemplated action is received, or in the case of an immediate action, within 30 days of the action. The request shall:

(1) be properly addressed to the medical cannabis program;

(2) be mailed to the medical cannabis program via certified U.S. postal mail;

(3) state the requestor's name, address, and telephone number(s); and

(4) include a statement of the issue(s) that the appellant considers relevant to the review of the action.

G. Hearing process:

(1) All hearings held pursuant to this section shall be conducted by a hearing officer appointed by the secretary.

(2) Hearings shall be conducted in Santa Fe, NM or, with the consent of the parties, in another location.

(3) Due to federal and state confidentiality laws, hearings held pursuant to this section that concern qualified patients, patient-applicants, licensed producers or producer-applicants, shall be closed to the public. Portions of hearings may further be closed to prevent the disclosure of confidential information.

(4) The hearing shall be recorded on audiotape or other means of sound reproduction.

(5) Any hearing provided for in this rule may be held telephonically, with the consent of the parties.

H. Scheduling: The department shall schedule and hold the hearing as soon as practicable, however; in any event no later than 60 calendar days from the date the department receives the appellant's request for hearing. The hearing examiner shall extend the 60 day time period upon motion for good cause shown or the parties may extend the 60 day time period by mutual agreement. The department shall issue notice of hearing, which shall include:

(1) a statement of the location, date, and time of the hearing;

(2) a short and plain statement of the legal authority under which the hearing is to be held; and

(3) a short and plain statement of the subject of the hearing.

I. Presentation of evidence: All parties shall be given the opportunity to respond and present evidence and argument on all relevant issues.

J. Record of proceeding: The record of the proceeding shall include the following:

(1) all pleadings, motions, and intermediate rulings;

(2) evidence and briefs received or considered;

(3) a statement of matters officially noticed;

(4) offers of proof, objections, and rulings thereon;

(5) proposed findings and conclusions; and

(6) any action recommended by the hearing examiner.

K. Audio recording: A party may request a copy of the audio recording of the proceedings.

L. Procedures and evidence:

(1) A party may be represented by a person licensed to practice law in New Mexico or a non-lawyer representative, or may represent himself or herself.

(2) The rules of evidence as applied in the courts do not apply in these proceedings. Any relevant evidence shall be admitted. Irrelevant, immaterial, or unduly repetitious evidence may be excluded.

(3) The experience, technical competence, and specialized knowledge of the hearing examiner, the department or the department's staff may be used in the evaluation of evidence.

(4) An appellant's failure to appear at the hearing at the date and time noticed for the hearing shall constitute a default.

M. Conduct of proceeding: Unless the hearing examiner determines that a different procedure is appropriate, the hearing shall be conducted in accordance with the procedures set forth in this rule. The following procedures shall apply:

(1) the appellant shall present an opening statement and the department may present an opening statement or reserve the statement until presentation of the department's case;

(2) after the opening statements, if made, the appellant shall present its case;

(3) upon the conclusion of the appellant's case, the department shall present its case;

(4) upon conclusion of the appellee's case, the appellant may present rebuttal evidence; and

(5) after presentation of the evidence by the parties, the parties may present closing argument.

N. Burden of proof: The appellant shall bear the burden of establishing by a preponderance of the evidence that the decision made or proposed by the department should be reversed or modified.

O. Continuances: The hearing examiner may grant a continuance for good cause shown. A motion to continue a hearing shall be made at least 10 calendar days before the hearing date.

P. Telephonic hearings:

(1) Any party requesting a telephonic hearing shall do so no less than 10 business days prior to the date of the hearing. Notice of the telephonic hearing shall be given to all parties and shall include all necessary telephone numbers.

(2) The appellant is responsible for ensuring the telephone number to the appellant's location for the telephonic hearing is accurate and the appellant is available at said telephone number at the time the hearing is to commence. Failure to provide the correct telephone number or failure to be available at the commencement of the hearing shall be treated as a failure to appear and shall subject the appellant to a default judgment.

(3) The in-person presence of some parties or witnesses at the hearing shall not prevent the participation of other parties or witnesses by telephone with prior approval of the hearing examiner.

Q. Recommended action and final decision:

(1) The parties may submit briefs including findings of fact and conclusions of law for consideration by the hearing examiner.

(2) No later than 30 calendar days after the last submission by a party, the hearing examiner shall prepare and submit to the secretary a written recommendation of action to be taken by the secretary. The recommendation shall propose sustaining, modifying, or reversing the action or proposed action of the department.

(3) The secretary shall issue a final written decision accepting or rejecting the hearing examiner's recommendation in whole or in part no later than 30 calendar days after receipt of the hearing examiner's recommendation. The final decision shall identify the final action taken. Service of the secretary's final decision shall be made upon the appellant by registered or certified mail.

(4) The final decision or order shall be included in a producer's file with the medical cannabis program.

[7.34.4.31 NMAC - Rp, 7.34.4.24 NMAC, 6/23/2020]

7.34.4.32 EXEMPTION FROM STATE CRIMINAL AND CIVIL PENALTIES:

A. No officer, employee, or approved contractor of a licensed producer, approved manufacturer, approved courier, or approved laboratory, nor any qualified patient licensed as a producer or enrolled primary caregiver, shall be subject to arrest, prosecution, or penalty in any manner for the production, possession, distribution, or dispensation of cannabis in accordance with this rule and the act. For the purpose of this section, the department deems approved manufacturers, approved couriers, and

approved laboratories to be ancillaries of licensed non-profit producers, entitled to the protections from criminal liability identified for licensed producers in the Lynn and Erin Compassionate Use Act, Section 26-2B-4 NMSA 1978.

B. Any property interest that is possessed, owned, or used in connection with the production of cannabis or acts incidental to such production shall not be harmed, neglected, injured, or destroyed while in the possession of state or local law enforcement officials. Any such property interest shall not be forfeited under any state or local law providing for the forfeiture of property except as provided in the Forfeiture Act. Cannabis, paraphernalia or other property seized from a qualified patient or primary caregiver in connection with the claimed medical use of cannabis shall be returned immediately upon the determination by a court or prosecutor that the qualified patient or primary caregiver is entitled to the protections of the provisions of this rule and act as shall be evidenced by a failure to actively investigate the case, a decision not to prosecute, the dismissal of charges, or acquittal.

C. In accordance with the Public School Code, Chapter 22 NMSA 1978, and the Lynn and Erin Compassionate Use Act at Subsection G of Section 26-2B-4 NMSA 1978, the department hereby deems New Mexico public schools, school districts, local school boards, locally-chartered charter schools, state-chartered charter schools, and governing bodies of state-chartered charter schools to be licensees, and designated school personnel (including designated employees and volunteers of the foregoing licensees) to be licensee representatives, authorized within the licensees' licensure to possess and store cannabis and cannabis derived products on behalf of qualified students, and to administer cannabis and cannabis derived products to qualified students, in school settings. The department deems the licensees and licensee representatives to be entitled to immunity from arrest, prosecution or penalty, in any manner, for activities conducted within the licensees' licensure and in accordance with the Public School Code.

D. A reciprocal participant shall not be subject to arrest, prosecution or penalty in any manner for the possession of or the medical use of cannabis if the quantity of cannabis does not exceed the limit identified by department rule.

[7.34.4.32 NMAC - Rp, 7.34.4.25 NMAC, 6/23/2020]

7.34.4.33 CLOSURE OF A NON-PROFIT PRODUCER OR AN APPROVED ENTITY:

A non-profit producer, manufacturer, laboratory, or courier that anticipates ceasing its business operations shall notify the medical cannabis program no later than 30 calendar days prior to closure. Any such non-profit producer or approved entity shall post public notice of the anticipated closure in any and all locations of the producer or approved entity that are accessible to the public, including but not limited to dispensary locations, at least fourteen days prior to the closure. Any unused medical cannabis that is held by a non-profit producer or approved entity on behalf of another licensee (such as

cannabis that is owned by a non-profit producer and held by a manufacturer) shall be returned to its owner. Cannabis that is otherwise held by a licensee shall, prior to the licensee's closure, be surrendered to either state law enforcement or local law enforcement, destroyed by the licensee in accordance with the wastage standards of this rule, or donated to patients via a licensed non-profit producer, and the licensee shall submit documentation of the event to the department.

[7.34.4.33 NMAC - N, 6/23/2020]

7.34.4.34 PERSONAL PRODUCTION LICENSE CONFIDENTIALITY:

Personal production license holders and applicants: The department shall maintain a confidential file containing the names, addresses, and telephone numbers of the persons who have either applied for or received a personal production license (PPL). Individual names of PPL producers and PPL producer-applicants shall be confidential and not subject to disclosure, except:

A. to authorized employees or agents of the department as necessary to perform the duties of the department pursuant to the provisions of this rule and the act;

B. to authorized employees of state or local law enforcement agencies, but only for the purpose of verifying that a person is lawfully in possession of the license to produce, or as otherwise expressly permitted in this rule; and

C. as provided in the federal Health Insurance Portability and Accountability Act of 1996.

[7.34.4.34 NMAC - Rp, 7.34.4.26 NMAC, 6/23/2020]

7.34.4.35 STORAGE AND DISPOSAL OF CANNABIS BY LICENSED PRODUCERS:

A. Storage: Medical cannabis, unused cannabis products, and cannabis-derived product waste shall be stored by a licensed producer in a manner that discourages diversion or theft, until such time as the material is transferred, disposed of, or destroyed in accordance with this rule.

B. Disposal by personal production license holders: Unused cannabis, cannabis products, or cannabis-derived product waste that is in the possession of a qualified patient who holds a personal production license shall be disposed of by transporting the unused portion to a state or local law enforcement office, or by destruction of the material.

[7.34.4.35 NMAC - Rp, 7.34.4.279 NMAC, 6/23/2020]

7.34.4.36 ASSESSMENT REPORT:

The department shall evaluate the implementation of the Lynn and Erin Compassionate Use Act and regulations issued pursuant to that act and provide a report to the secretary of the department within one year of the effective date of this regulation. In performing its evaluation, the department shall focus on whether the needs of qualified patients are being met by the department's administration of the act and whether there is a demonstrable need for a state run production and distribution facility. The department's assessment report shall be issued every two years, shall be a public document, and shall contain de-identified data upon which the assessment is based.

[7.34.4.36 NMAC - Rp, 7.34.4.28 NMAC, 6/23/2020]

7.34.4.37 SEVERABILITY:

If any part or application of these rules is held to be invalid, the remainder or its application to other situations or persons shall not be affected. Any section of these rules legally severed shall not interfere with the remaining protections provided by these rules and the act.

[7.34.4.37 NMAC - Rp, 7.34.4.29 NMAC, 6/23/2020]

CHAPTER 35: [RESERVED]

CHAPTER 36: DIALYSIS AND KIDNEY FACILITIES AND TRAINING

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: REQUIREMENTS FOR END STAGE RENAL DISEASE FACILITIES [REPEALED]

[This part was repealed on July 1, 2024, and replaced by 8.370.24 NMAC.]

CHAPTER 37: CLEAN INDOOR AIR

PART 1: GENERAL PROVISIONS [RESERVED]

PART 2: CERTIFICATION OF CIGAR BARS

7.37.2.1 ISSUING AGENCY:

New Mexico Department of Health, Public Health Division.

[7.37.2.1 NMAC - N, 05/30/2008]

7.37.2.2 SCOPE:

These rules apply to all entities seeking to operate under the cigar bar exemption to the smoking prohibition of the Dee Johnson Clean Indoor Air Act, NMSA 1978, Section 24-16-1 et seq.

[7.37.2.2 NMAC - N, 05/30/2008]

7.37.2.3 STATUTORY AUTHORITY:

These rules are promulgated pursuant to the following statutory authorities: Section 9-7-6 E of the Department of Health Act, and Section 24-16-3 B(2) of the Dee Johnson Clean Indoor Air Act.

[7.37.2.3 NMAC - N, 05/30/2008]

7.37.2.4 DURATION:

Permanent.

[7.37.2.4 NMAC - N, 05/30/2008]

7.37.2.5 EFFECTIVE DATE:

May 30, 2008, unless a later date is cited at the end of a section.

[7.37.2.5 NMAC - N, 05/30/2008]

7.37.2.6 OBJECTIVE:

This rule is intended to establish standards for the application and issuance of certificates for cigar bar status under the Dee Johnson Clean Indoor Air Act.

[7.37.2.6 NMAC - N, 05/30/2008]

7.37.2.7 DEFINITIONS:

Unless otherwise defined below, terms used in these rules have the same meanings as set forth in the Dee Johnson Clean Indoor Air Act, NMSA 1978, Section 24-16-1 et seq.:

A. "Applicant" means an establishment or agent of an establishment that has applied for a certificate from the department and whose application has not yet been granted or denied; "applicant" includes an applicant for the renewal of a certificate.

B. "Application" means an establishment's application to the department for a certificate, and includes any supporting materials; "application" includes both an application for initial certification and an application for renewal certification.

C. "Application review period" means the time period allotted under these rules for the department to determine whether to grant or deny an application.

D. "Bar" means an establishment that is devoted to the selling or serving of alcoholic beverages for consumption by patrons on the premises, in which the serving of food in the establishment is only incidental to the consumption of those beverages.

E. "Certificate" means a document issued by the department certifying that an establishment's application to the department for cigar bar status under the Dee Johnson Clean Indoor Air Act, NMSA 1978, Section 24-16-1 et seq., has been approved by the department.

F. "Certificated establishment" means an establishment that has applied for and been granted a certificate from the department, whose certificate has not expired or become otherwise invalid under these rules.

G. "Cigar" means a roll of tobacco that is wrapped in a substance containing tobacco, and that is intended for smoking, and does not include cigarettes.

H. "Cigar bar" means an establishment that:

(1) is a bar;

(2) is engaged in the business of selling cigars for consumption by patrons on the premises;

(3) generated at least ten percent of its total annual sales in the year 2007 from the sale of cigars, not including sales from vending machines; and

(4) generates ten percent or more of its total annual gross revenue or at least ten thousand dollars ($10,000) in annual sales from the sale of cigars, not including sales from vending machines.

I. "Cigarette" means:

(1) any roll of tobacco or any substitute for tobacco wrapped in paper or in any substance not containing tobacco; or

(2) a bidi or kretek.

J. "Department" means the New Mexico department of health.

K. "Establishment" means a business enterprise that encompasses a single, contiguous physical location.

L. "Secretary" means the secretary of the New Mexico department of health.

M. "Smoking" means inhaling, exhaling, burning, carrying or holding any lighted or heated tobacco product, including all types of cigarettes, cigars and pipes and any other lighted or heated tobacco product.

[7.37.2.7 NMAC - N, 05/30/2008]

7.37.2.8 CERTIFICATE APPLICATION:

A. All applications for a certificate under these rules shall be made on the forms prescribed by the department. Forms may be obtained from the public health division of the department.

B. An applicant shall submit sales receipts and invoices for the previous twelve (12) months in support of its application.

C. An applicant shall submit to the department, together with its application, an application fee of three hundred dollars ($300.00). A certificate shall not be issued to an establishment that has failed to submit an applicable fee.

D. All applications shall be submitted to the department via certified U.S. mail.

E. The department shall review the application, and shall determine whether to grant or deny the application within forty-five (45) days from the date that the application was received by the department. If the department determines to grant a certificate to an establishment, it shall mail the certificate via certified U.S. mail to the mailing address identified in the establishment’s application.

F. Notwithstanding the foregoing, in the event that the department deems an application or its supporting documentation to be insufficient to evidence that the establishment meets the definition of cigar bar, the department may either deny the application or request additional information or documentation from the establishment. Upon the department’s rendering of a request for additional information or documentation, the department’s forty-five day application review period shall be tolled and shall not resume until the department receives additional materials in response to its request. Upon the department’s receipt of any additional materials submitted in support of the application (whether or not those materials were requested by the department), twenty (20) days shall be added to the application review period.

G. A certificated establishment applying for renewal of its certificate shall submit a renewal application to the department, complete with all required documentation and

applicable fees, within twelve (12) months of the issuance of the establishment's previous certificate.

H. A certificate shall not authorize a certificated establishment to violate any portion of the Dee Johnson Clean Indoor Air Act, NMSA 1978, section 24-16-1 et seq., nor shall a certificate authorize any certificated establishment to operate in violation of a county or municipal ordinance that is more stringent than that Act.

[7.37.2.8 NMAC - N, 05/30/2008]

7.37.2.9 VALIDITY OF CERTIFICATE:

A. A certificate shall remain valid for twelve (12) months, except as otherwise provided by these rules. The department shall identify on the face of each certificate the date of the certificate's expiration.

B. A certificated establishment that ceases to be a bar shall have its certificate automatically rendered invalid.

[7.37.2.9 NMAC - N, 05/30/2008]

7.37.2.10 EFFECT OF NON-CERTIFICATION, EXPIRATION OR INVALIDATION:

A. An establishment that does not hold a valid certificate from the department may not operate under the cigar bar exemption of the Dee Johnson Clean Indoor Air Act, NMSA 1978, Section 24-16-1 et seq., and may be subject to penalties provided under that Act for its violation.

B. An establishment whose certificate has expired or otherwise become invalid shall (upon the certificate's expiration date or upon the occurrence of the event that results in invalidation) immediately return the certificate to the department via certified U.S. mail; the establishment may not operate under the cigar bar exemption of the Dee Johnson Clean Indoor Air Act, NMSA 1978, Section 24-16-1 et seq., until the establishment applies for and receives a new certificate from the department.

[7.37.2.10 NMAC - N, 05/30/2008]

7.37.2.11 DISCLOSURE OF CHANGE OF NAME OF ESTABLISHMENT OR OWNERSHIP:

An applicant or certificated establishment that changes its name shall submit written notification to the department within thirty (30) days of said change. An applicant or certificated establishment that violates this rule shall have its certificate automatically rendered invalid.

[7.37.2.11 NMAC - N, 05/30/2008]

7.37.2.12 NONTRANSFERABILITY OF CERTIFICATES:

A certificate shall not be transferred to another establishment. This rule shall apply regardless of whether the other establishment shares the same or a common owner or owners. A certificate conveyed to another establishment in violation of this section shall be automatically rendered invalid.

[7.37.2.12 NMAC - N, 05/30/2008]

7.37.2.13 DISPLAY OF CERTIFICATE:

A certificate shall be prominently displayed within the premises of the certificated establishment so that it is in full public view at all times.

[7.37.2.13 NMAC - N, 05/30/2008]

7.37.2.14 ENFORCEMENT OF THE DEE JOHNSON CLEAN INDOOR AIR ACT:

A. Pursuant to NMSA 1978, Section 24-16-16, enforcement of any violation of the Dee Johnson Clean Indoor Air Act shall be conducted by the local fire, police or sheriff's department having appropriate jurisdiction over the location where a violation occurs.

B. Persons may register complaints regarding an alleged violation of the Dee Johnson Clean Indoor Air Act with either the department or the local fire, police or sheriff's department. Upon receiving a complaint, the department shall refer the matter to a local fire, police or sheriff's department having appropriate jurisdiction for enforcement.

[7.37.2.14 NMAC - N, 05/30/2008]