



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
New Mexico**

**Application for 2013  
Annual Report for 2011**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

The central office of the New Mexico Title V MCH Program maintains a reference copy on file in the State MCH program's central office and will be made available upon request. If you would like to request copies, please call the Family Health Bureau Chief at 505-476-8901

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

The Title V Block Grant is available to the public for review at each of the four regional offices of the Public Health Division located in Santa Fe, Albuquerque, Las Cruces and Roswell, as well as the Title V State Office in Santa Fe. A bound copy of the report is placed at in the State Library each year. It is also available on the Department of Health (DOH) website at: <http://www.health.state.nm.us/TitleV/> and there is a link to a public input page where comments are emailed to the Title V address: NM.TitleV@state.nm.us. The public may also send hard-copy comments and inquiries to the physical address for the Title V office at: 2040 S. Pacheco, Santa Fe, NM, 87505. Comments are accepted year-round.

The Block Grant Application is distributed to Public Health Division local health offices as a resource for their use in planning efforts for local areas. The performance measures are aligned with the DOH Strategic Plan. The reports to the legislature and its interim committees are based on the information compiled in the grant proposal.

For the 2010 Needs Assessment, the MCH Epidemiology program developed an online survey of Maternal and Child Health priorities. Respondents were asked to rank order 25 MCH priorities according to which they felt were most pressing in their communities. The survey was promoted in several newspapers and on local radio stations around the state. Over 1,000 New Mexicans responded, and over 200 respondents also utilized the comment box at the end of the survey. The results were published on the DOH website and in the Needs Assessment report.

The Maternal and Child Health programs of the Family Health Bureau solicit and receive public input on an ongoing basis as a regular part of their meetings with stakeholders and community partners. The following is a list of organizations and meetings that that include participation from the public:

ECAN (Early Childhood Action Network) Steering Committee (monthly meetings)  
Multi-Agency Team Meeting (Young Child Wellness Council) Local & State Level (monthly meetings)

FLAN (Family Leadership Action Network) Planning Council and Annual Meeting  
 Certified Nurse Midwives Advisory Board (quarterly meetings)  
 Licensed Midwives Advisory Board (quarterly meetings)  
 Santa Fe County Home Visiting Collaborative (quarterly meetings)  
 Home Visiting Task Force (State level) (quarterly meetings)  
 EPSDT (Early Periodic Screening Diagnostics and Treatment) Meetings (quarterly meeting)  
 DSI (Developmental Screening Initiative) New Mexico Stakeholder's Update Meeting  
 Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) (monthly conference call)  
 Turn the Curve Planning Meetings for ECCS (Early Childhood Comprehensive Systems) Grant and Annual Meeting  
 House Joint Memorial 60 Task Force Meetings (monthly meetings)  
 Title V MCH Block Grant Needs Assessment Regional Meetings  
 Families FIRST Bi-annual Meeting  
 Public Health Division Prenatal Care Planning Meetings and Annual Meeting  
 Project LAUNCH Grantee Meetings (twice yearly)  
 ECCS Grantee Meeting (yearly)  
 Maternal Depression Work Group (monthly meetings)  
 Obstetric Liability Insurance Meetings (as needed)  
 Healthy Weight Council Meetings (3 times per year)  
 Santa Fe County Maternal Child Health Council (monthly meetings)  
 Fatherhood Forum: Whitehouse Faith-Based Initiative (weekly meeting)

Children's Medical Services (CMS) continuously receives public input from its stakeholders and community partners. The MCH Collaborative meets monthly and includes CMS, Family Voices, Parents Reaching Out, and EPICS. The advisory councils for the Genetic Screening program, the Newborn Hearing Screening program and for the CYSHCN program meet regularly to ensure continuing efficacy of CMS programs. These advisory councils include representation from various stakeholders including professionals, families, and other agencies. The CMS Social Workers in the field also participate on community councils and receive input from the public on various local maternal and child health issues.

/2012/Regular meetings with organizations and stakeholders listed above continue to be the most effective way to collect public input. Historically, very few people responded to newspaper advertisements and/or mass e-mail invitations to comment on the Block Grant and Needs Assessment. The Block Grant Report, Application and Five Year Needs Assessment are available to the public on the website for the Department of Health at <http://www.health.state.nm.us/phd/TitleV/index.shtml>.

The Family Planning Program held focus groups with Title X clinical providers statewide in June 2011. The providers were invited to attend a meeting at one of three NM locations: Las Cruces, Rio Rancho or Roswell. At the session, the participants were presented with information on Women in Need from the Guttmacher Institute and 2010 data on the number Family Planning Program clients corresponding to their practice area. Participants were asked to provide input and discussion on three issues related to family planning services in their community: 1) Identify non-Title X reproductive health services providers in your area including PCCs, SBHCs, private physician offices and pharmacies, 2) What are FP clients' needs and barriers to FP services in your area? and 3) Implementing clinic strategies-how do you do more with less in your clinic? Information from these meetings was used in development of the work plan for family planning services for CY 2012.

In the Fall of 2010 the Newborn Genetic Screening Advisory Committee met to discuss the implementation of the 5 Lysosomal Storage Disorders that had been mandated during the past Legislative session. A presentation on new technology for testing for these disorders was delivered by Liquid Logic and the company requested that New Mexico join the pilot study. After the presentation the Committee met and decided that the technology was too new, and still not

FDA approved and declined to participate in the pilot study at this time. The other factor included in the decision was the low birth population in New Mexico.

Input received from stakeholders at the 2008 and 2009 asthma summits showed a high need for more asthma outreach clinics, especially in the southeast part of the state. In addition, data from 2010 showed an increase in asthma in the central NM corridor. CMS responded to this input by adding 12 new asthma clinics over the past three years, concentrating on these areas (Regions 2, 4 and 5). Three clinics have been added in Region 2, 4 in Region 4 and 5 in Region 5.

The Title V team will continue to explore other methods for obtaining public input, as staffing and resources permit.//2012//

## II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### C. Needs Assessment Summary

As a result of the Needs Assessment activities, New Mexico's Maternal and Child Health Title V Program identified the following Priority Needs for 2011-2015:

1. Increase accessibility to care for pregnant women and mothers that provides care before, during and after pregnancy
2. Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence
3. Increase awareness and availability of family planning and STD prevention options
4. Promote awareness of childhood injury risks and provide injury prevention protocols to families and caregivers of children
5. Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options
6. Increase the proportion of mothers that exclusively breastfeed their infants at six months of age
7. Decrease disparities in maternal and infant mortality and morbidity
8. Promote healthy lifestyle options to decrease obesity and overweight among children and youth
9. Maintain specialty outreach clinics for children and youth with special health care needs
10. Improve the infrastructure for care coordination of children and youth with special health care needs

The New Mexico Department of Health FY13 Strategic Plan includes several strategies that directly address maternal and child health status and performance measures:

#### Strategy 3: Community services' reviews and maintenance

- Prenatal services-all communities that we serve have access to prenatal care
- Immunizations need to be accessible to our communities
- Tobacco cessation programs need to be accessible to our communities
- Education-all communities that we serve have access to education through the County Extension Offices

#### Strategy 7: Emphasize social-emotional development of infants through our early intervention services

- Increase levels of prenatal care and participation in Early Periodic Screening Diagnosis & Treatment
- Promote better birth outcomes and healthier mothers & children by providing supplemental nutritious food, nutrition education, and referrals to health and social services

#### Strategy 11: Lead the NM Interagency Council for the Prevention of Obesity

- Build greater alignment across state programs to create sustainable, consistent, and collaborative efforts and messages to increase physical activity, healthy eating, and prevent obesity
- Build and support community-wide obesity prevention efforts
- Coordinate and support obesity prevention policy recommendations and initiatives across state agencies

-Collect routine data from Interagency Council members for the monitoring of progress toward creating environmental, policy, and behavioral changes to increase physical activity, healthy eating, and healthy weights

Changes in the MCH population:

New Mexico's population continues to struggle with poverty, geographic and cultural barriers to health care access, and low insurance coverage. There have been no major changes in the strengths and needs of New Mexico's MCH population during the last five years, however FHB recognizes that the long-term effects of the current recession may not yet be evident.

Changes in capacity

Most of New Mexico's counties are considered to be Health Care Provider Shortage Areas. Since 2005, three hospitals stopped obstetric delivery services, and some providers have left the state or discontinued delivery services because of increasing liability insurance premiums, and low reimbursement rates.

Program and system capacity have increased in many areas. Obesity surveillance, legislation toward injury prevention and domestic violence reporting, laws supporting breastfeeding mothers all reflect buy-in from the public, program staff and politicians on MCH-positive initiatives. The State is now one of five that is participating in piloting the Sudden Unexpected Infant Death Case Registry. (SUIDCR) New Mexico supports its birthing workforce through support for Doula programs, licensing midwives, and via financial support to offset medical liability insurance.

FHB and DOH are relying more on information technology such as the toll-free NurseAdvice hotline, and social marketing through text-messaging (Text4Baby) and web-based information-sharing to reach a greater number of New Mexicans.

FHB programs have successfully secured grant funding to support and pilot programs to address MCH needs. FHB and its partners are responsive to issues as they emerge, which during the previous needs assessment cycle resulted in the creation of the Maternal Depression Working group/pilot study, and the Senate Memorial 19 task-force on Prenatal Substance Abuse, among others.

Finally, New Mexico's MCH population continues to benefit from a strong community-based primary care system.

FHB does not yet know how the Patient Protection and Affordable Care Act will impact the State's capacity to provide services to the MCH population.

The Title V program is conducting an analysis of maternal and child health disparities at county and community level. Results will be shared with communities as part of the current needs assessment cycle.

Needs Assessment 2015

The strategy for the 2015 Needs Assessment will be greatly influenced by the status of the Patient Protection and Affordable Care Act by the end of summer, 2012.

### III. State Overview

#### A. Overview

##### PRINCIPAL CHARACTERISTICS AND THE HEALTH NEEDS OF NEW MEXICO MCH POPULATION

New Mexico's population is one of the most diverse in the United States, consisting of 44% Hispanics, 42% White, Non-Hispanic, 10% American Indians, 2% African-Americans, 1.4% Asian and Pacific Islanders, and 3.2% multi-racial. The state has the second highest percentage of Native Americans. Unfortunately, New Mexico also has high levels of poverty (18.1%) and uninsured individuals (21%). The state is one of the four poorest in the nation, with a median household income of \$41,452. Over a third of New Mexico's population (36.5%) speaks a language other than English at home, the second highest percentage among all states. Reducing health disparities and increasing health equity are keys to addressing the health issues. Reducing these disparities in New Mexico requires enhanced efforts to raise awareness, collect and use data, mobilize communities, increase capacity, prevent disease, promote health, focus resources on targeted populations, and deliver appropriate care. Information on demographic characteristics is captured in most health systems, while socio economic data is not always available. Although health disparities exist across genders and socioeconomic and other strata, some of the most visible differences in health are among racial and ethnic groups.

By raising awareness to and prioritizing health disparities, the Department of Health identified three of its key indicators highlighting significant disparities: births to mothers ages 15 to 17, alcohol related deaths, and diabetes deaths. In addition to the disparity among different New Mexico populations, there also is a disparity between the national rate and New Mexico's higher rate for these key indicators: ***/2013/ The Department of Health under a new Administration has revised the Health Priority Issues by addressing: Adequate health care workforce, Obesity in children, High rate of teen pregnancy, Oral health, Mental health and substance abuse in teens and young adults, Increased deaths due to diabetes, drug overdose, injuries sustained as the result of falls by elderly constituents. //2013//***

##### SOCIO-DEMOGRAPHICS AFFECTING MCH WELL-BEING

According to the Census Bureau, in 2008 New Mexico had the highest percentage (45%) of Hispanics of any state with 83% of these native-born and 17% foreign-born.

POPULATION of New Mexico: In 2006-2008, New Mexico had a total population of 2.0 million - 995,000 (51 percent) females and 967,000 (49 percent) males. The median age was 35.8 years. 26 percent of the population were under 18 years and 13 percent were 65 years and older for people reporting one race alone, 70 percent was White; 2 percent was Black or African American; 9 percent was American Indian and Alaska Native; 1 percent was Asian; less than 0.5 percent was Native Hawaiian and Other Pacific Islander, and 14 percent was Some other race. Three percent reported two or more races. Forty-four percent of the people in New Mexico were Hispanic. Forty-two percent of the people in New Mexico were White Non-Hispanic. People of Hispanic origin may be of any race. ***/2013/ In 2009, 46.3 percent of New Mexicans were of Hispanic origin, and 53.7 percent. were of of non-Hispanic origin.//2013//***

HOUSEHOLDS AND FAMILIES: In 2006-2008 there were 736,000 households in New Mexico. The average household size was 2.6 people. Families made up 65 percent of the households in New Mexico. This figure includes both married-couple families (46 percent) and other families (19 percent). Nonfamily households made up 35 percent of all households in New Mexico. Most of the nonfamily households were people living alone, but some were composed of people living in households in which no one was related to the householder. Source: American Community Survey, 2006-2008. ***/2013/ In 2006-2010 there were 756,112 households in New Mexico. The average household size remained at 2.6 people. The percent of New Mexicans below the poverty level is 18.4 compared to 13.8 in the US. Source: American Community Survey***

//2013//

**NATIVITY AND LANGUAGE:** Ten percent of the people living in New Mexico in 2006-2008 were foreign born. Ninety percent was native, including 51 percent who were born in New Mexico. Among people at least five years old living in New Mexico in 2006-2008, 36 percent spoke a language other than English at home. Of those speaking a language other than English at home, 79 percent spoke Spanish and 21 percent spoke some other language; 29 percent reported that they did not speak English "very well."

**GEOGRAPHIC MOBILITY:** In 2006-2008, 83 percent of the people at least one year old living in New Mexico were living in the same residence one year earlier; 10 percent had moved during the past year from another residence in the same county, 3 percent from another county in the same state, 4 percent from another state, and 1 percent from abroad.

**EDUCATION:** In 2006-2008, 82 percent of people 25 years and over had at least graduated from high school and 25 percent had a bachelor's degree or higher. Eighteen percent were dropouts; they were not enrolled in school and had not graduated from high school. The total school enrollment in New Mexico was 532,000 in 2006-2008. Nursery school and kindergarten enrollment was 56,000 and elementary or high school enrollment was 332,000 children. College or graduate school enrollment was 145,000.

**INDUSTRIES:** In 2006-2008, for the employed population 16 years and older, the leading industries in New Mexico were educational services, health care, and social assistance, 23 percent, and retail trade, 12 percent.

**INCOME:** The median income of households in New Mexico was \$43,202. Seventy-nine percent of the households received earnings and 19 percent received retirement income other than Social Security. Twenty-eight percent of the households received Social Security. The average income from Social Security was \$13,895. These income sources are not mutually exclusive; that is, some households received income from more than one source. ***/2013/ 2010 median income of households in New Mexico was \$43,820./2013/***

**POVERTY AND PARTICIPATION IN GOVERNMENT PROGRAMS:** In 2006-2008, 18 percent of people were in poverty. Twenty-five percent of related children under 18 were below the poverty level, compared with 13 percent of people 65 years old and over. Fourteen percent of all families and 35 percent of families with a female householder and no husband present had incomes below the poverty level. Quickfacts.census.gov

**Teen Births:** The birth rate to New Mexicans ages 15 to 17 has declined over the years but not as quickly as the national rate. Consequently, the gap between the New Mexico rate and the national rate remains. Births to teens are associated with not only negative consequences for the children and their parents but also public costs.

Although anyone older than 12 and younger than 20 is a teen, in the case of early parenthood, the emphasis is on reducing the incidence for girls who are or should be in school. Hispanic teens have the highest birth rates both in New Mexico and nationally. Before 1995, blacks had the highest teen birth rates nationally, but the black teen birth rate declined 59% from 1991 to 2005. This is compared with only a 22% decrease for the national Hispanic teen birth rate.<sup>5</sup> Although Hispanics constitute almost half the female population of 15-to-17-year-olds in New Mexico, their share of teen births is higher, with more than 70% of the births in this age group occurring to Hispanics. Fifty-four out of every thousand Hispanic females ages 15 to 17 in New Mexico give birth in any given year. The Hispanic birth rate is consistently higher than that of the other major population groups in New Mexico, and more than twice the national rate. The teen birth rate for New Mexico Hispanics is four times the rate for non-Hispanic White New Mexico teens and 75% higher than that of American Indians. ***/2012/***The teen birth rate decline has and will have major ongoing societal impacts. A teen birth affects economic and educational opportunities for the

mother as well as the infant. This ripple effect is seen in communities with high rates of teen birth. Ultimately, any of the numerous health trends which are associated with poverty should be influenced by teen birth rates.//2012//

***/2013/ In the last 10 years birth rates for females under 15 years have decreased 45% and birth rates for teens ages 15-19 years have declined 29%. Birth rates were at a record low in New Mexico in 2010 and in the U.S. in 2009. Infant mortality rates continue to decrease with NM rates lower than those for the U.S.//2013//***

Alcohol-related Death: New Mexico consistently has one of the highest alcohol-related death rates in the nation. Such deaths disproportionately impact American Indians. Although it appears that the rate may be declining, the alcohol related death rate for American Indians continues to be substantially higher than that of other populations in New Mexico (Figure 2). In fact, the disparity may be increasing, as the alcohol-related death rates for other New Mexico populations appear to be falling more rapidly. Nearly 17% of all alcohol-related deaths occur to American Indians, who make up less than 10% of the population.

The two principal components of alcohol-related death are those due to chronic diseases that are strongly associated with chronic alcohol abuse, such as liver disease, and deaths due to alcohol related injuries such as motor vehicle accidents, which are strongly associated with acute alcohol abuse. The high rate of alcohol-related deaths for American Indians reflects both components. A recent national report shows the extent to which alcohol accounts for many preventable deaths and years of life lost in the American Indian population.

/2012/The economic costs associated with alcohol abuse in New Mexico in 2007 amounted to an estimated \$2.8 billion, or more than \$1,400 for every person in the state. This estimate represents an 11% increase in both total and per capita costs over the costs reported previously for 2006. This increase was the result of an 11% increase in New Mexico's alcohol-related death rate, from 48.8 deaths per 100,000 in 2006 to 54.2 deaths per 100,000 in 2007. [Roeber, J (2009) The Human and Economic Cost of Alcohol Abuse in New Mexico, 2006. New Mexico Epidemiology Report, 2009(10). Available at:<http://nmhealth.org/ERD/HealthData/SubstanceAbuse/ER%20Alcohol%20related%20costs%20112309.pdf>.]//2012//

***/2013/ Chronic liver disease and cirrhosis ranked 8th in New Mexico with a rate of 16.8, compared to the U.S. rate of 9.2 and a ranking of 12th. For the past 15-20 years, New Mexico's death rate from these diseases has consistently been first or second in the nation, and 1.5 to 2 times the national rate. Rio Arriba and McKinley counties have death rates for diseases associated with chronic alcohol abuse that are 4-5 times the national rate. Source: The State of Health in New Mexico 2011. //2013//***

Diabetic Death: American Indians have the highest rate in New Mexico of deaths due to diabetes. Similar to the trend of alcohol-related deaths, the diabetes death rate for American Indians appears to be decreasing but remains substantially higher than the rate for other populations in New Mexico. Despite the diabetes initiatives of the Indian Health Service, including the development of best practices and model programs, American Indians continue to experience both a high death rate and a high rate of amputations due to diabetes. Hispanics also have a high diabetes death rate and one that is well above the rate of all New Mexico populations other than American Indians. ***/2013/ American Indians had the highest rate of deaths due to diabetes, which was three times higher than that of Whites. For every 100,000 American Indians there were 73 deaths due to diabetes compared to 22 deaths due to diabetes for every 100,000 Whites. //2013//***

Population: The United States Census Bureau, as of July 1, 2008, estimated New Mexico's population at 1,984,356, which represents an increase of 165,315, or 9.1%, since the last census in 2000. This includes a natural increase since the last census of 114,583 people (that is 235,551

births minus 120,968 deaths) and an increase due to net migration of 59,499 people into the state. ***/2013/ The United States Census Bureau as of 2011 estimated New Mexico's population at 2,082,224, which is an increase of 97,868 since 2008. //2013//***

Immigration from outside the United States resulted in a net increase of 34,375 people, and migration within the country produced a net gain of 25,124 people. 7.2% of New Mexico's population was reported as less than 5 years of age, 28% under 18, and 11.7% were 65 or older. Females make up approximately 50.8% of the population.

Preconception and Prenatal Health: From before conception through the first year of life, the health of New Mexico's women and babies depends on many factors including good nutrition, timely access to adequate and appropriate clinical services, health insurance coverage, and a safe home environment. In 2006, 45% of all New Mexico women who gave birth did so after an unintended pregnancy. Preconception health means planning one's pregnancy, avoiding tobacco and alcohol, and taking folic acid before becoming pregnant. Health experts recommend that women of child-bearing age take 400 micrograms of folic acid (a B vitamin) in a multi-vitamin every day. If taken before conception and throughout pregnancy, folic acid can prevent serious birth defects in a baby's brain and spine. Sixty two percent of New Mexico mothers who gave birth in 2006 never took a multivitamin, compared with 25% who reported taking a multivitamin every day.

Adequate prenatal care is measured by the number and timing of clinical visits, and is associated with healthy pregnancy. Infants born to mothers with low levels of prenatal care are five times more likely to die in the first 27 days of life. In 2006, 11% of women in New Mexico received little or no prenatal care (defined as care that starts in the last trimester, or fewer than five visits). The prenatal care status of 6% of women was unknown. Women in southwest New Mexico were most likely to receive low or no prenatal care. */2012/*Group prenatal care is one strategy that has resulted in more women seeking and receiving adequate care. Efforts are being made to implement and sustain this model of care throughout the state. Other services to ensure healthy pregnancies. such as WIC, Families First, Family Planning and home visiting continue to help New Mexico families have positive birth outcomes. In addition, fatherhood projects to encourage male involvement in healthy births are important. Taos MEN (Men Engaged in Nonviolence), the South Valley Male Involvement Project, New Mexico Young Fathers Project, and the New Mexico Fatherhood Forum all work to increase fathers' knowledge and willingness to participate in healthy families.*//2012//*

***/2013/ In 2008, 72.3% of New Mexico women giving live birth had prenatal care beginning in the first trimester. . In 2006-2008 65.2% had adequate or more than adequate prenatal care as measured by the Kotelchuck Index (also called Adequate Prenatal Care Utilization). Inadequate prenatal care was most prevalent among Native American moms (37%), moms age 15-17 years (33.3%), and women with less than a high school education (29%). Among women who wanted prenatal care, 17.3% had problems because they could not get an appointment when they needed one, 13.9% did not have enough money or insurance, and 10.8% did not have a Medicaid card.//2013//***

Maternal Health: Nine percent of women who gave birth in 2006 reported that they had been abused by their current or former partner before they became pregnant, and 5% reported that they were abused during pregnancy. In that same year, 19% of mothers reported experiencing postpartum depression. Fifty-nine percent of mothers reporting postpartum depression were Hispanic, 26% were Anglo, and 16% were Native American. Of all women who experienced symptoms of postpartum depression, 20% reported that they had been abused by their current or former partner. ***/2013/ In 2008, seventeen percent (16.9%) all NM mothers reported feeling down, depressed or hopeless. New Mexico has a Maternal Depression Workgroup that designed a Perinatal Depression Screening Pilot Project which was conducted by the Families FIRST Case Management Program (NMDOH) and funded by the Human Services Department to assess the need for mental health services and referrals among low-income***

**women in NM. Public Health WIC clients were screened for perinatal mood disorders with the Edinburgh Postnatal Depression Scale during prenatal and postpartum encounters in Santa Fe and Las Vegas, NM. This was a 10 week pilot project with findings indicating that approximately 23% of the women screened tested positive for perinatal depression. Appropriate referrals were made to help the women with positive depression screens and they received a counseling session as well as a one month follow up call to ensure they received medical treatment, counseling or attended a professional group for support. Challenges identified include long waiting lists for mental health treatment for perinatal depression and limited coverage of such services by Medicaid or private insurance companies. //2013//**

In 2006, the New Mexico Women, Infants, and Children program's nutrition services aided 46% of women who had a live birth. The number of women served was 13,733, and the number of infants and children served was 66,575. In the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) survey, 12% of women reported that they "sometimes" do not have enough food to eat. Two percent reported that they "often" do not have enough food to eat.

In 2005, 59% of New Mexico births were paid for by Medicaid. In 2005 and 2006, 15% of women from ages 19 to 64 in New Mexico had no health insurance.

Infant Health: From 2004 to 2006, the infant mortality rate in New Mexico was 5.8 per 1,000 live births, which was lower than the national rate. The lowest infant mortality rate was among the Hispanic population. The rate was 2.5 times higher for African-Americans, 1.5 times higher for Native Americans, and 1.1 times higher for White, non-Hispanics.

Breastfeeding: Recent studies show that babies who are not breastfed exclusively for six months are more likely to develop ear infections, diarrhea, and respiratory illnesses, and to have more hospitalizations. Infants who are not breastfed have a 21% higher post-neonatal mortality rate in the U.S. For mothers, breastfeeding lowers the risk of breast and ovarian cancers, and possibly the risk of hip fractures and osteoporosis after menopause as well. According to results from the National Immunization Survey of children born in 2003 and 2004, 33% of New Mexico mothers exclusively breastfed their babies for at least three months, and 14% exclusively breastfed for at least six months.

/2012/The 2010 WIC Report Card showed that 75 percent of New Mexican WIC mothers decided to breastfeed, which was a five percent increase compared with the previous year's Report Card. New Mexico mothers are exceeding the national rates in other important measures of breastfeeding success and have surpassed the Healthy People 2010 goal for breastfeeding initiation. The highlights in the CDC data for New Mexico infants are: 82 percent breastfed at birth, 49 percent breastfed until six months, and 24.8 percent breastfed until 12 months. Forty-seven percent breastfed exclusively (nothing but breast milk) until three months—an increase of 13.5 percent from the previous year. For the past decade, the NM WIC program has been consistently promoting breastfeeding for the first six months to reduce reducing maternal and child health risks. The program has expanded and improved food packages for exclusively breastfeeding WIC participants and has made breast pumps readily available to WIC mothers to support them in the decision to exclusively breastfeed and to avoid unnecessary supplementation, which can lead to early weaning.//2012// **//2013/ The percent of infants born between fiscal 2007 and 2011 who initiated breastfeeding has increased nearly 20 percent. The increase can be attributed to New Mexico's WIC program's focus on: Increased breastfeeding education and support to families during the prenatal period; enhanced WIC staff member training; Expanding and improving the food package for exclusively breastfeeding mothers; Increasing community awareness on the importance of breastfeeding through media campaigns and physician outreach projects; expansion of the New Mexico WIC Programs Peer Counselor Program giving moms greater access to breastfeeding support and encouragement. //2013//**

In 2007, the workplace breast pump bill was passed, requiring New Mexico employers to provide a clean, private space that is not a bathroom where a mother can pump breast milk for her baby. The space must be near the employee's workspace, and the bill also requires that employers allow mothers flexible break times for pumping milk.

Exposing infants to cigarette smoke is a risk factor for respiratory illness and Sudden Infant Death Syndrome (SIDS). Ninety-four percent of mothers in the 2006 PRAMS survey reported that their babies were never exposed to second-hand smoke, and 6% reported that their infants were exposed to second-hand smoke at least one hour per day. Seventy six percent of 19-to-35-month-olds received a full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, and pertussis in 2006. ***2013/ During 2006-2008 the number of infants exposed to cigarette smoke decreased to 4.9%.//2013//***

Placing babies on their backs to sleep reduces the risk of SIDS, also known as "crib death." In 2006, 62% of PRAMS survey mothers reported that they placed their babies on their backs to sleep. Twenty-three percent placed their babies on their sides, and 10% placed them on their stomachs or used a combination of positions. ***2013/ New Mexico reached the Healthy People 2010 target with 70.6% of mothers most often placing their infant to sleep on their back in 2008.//2013//***

Oral health is integral to overall health. Oral health means much more than healthy teeth. It means being free of chronic oral-facial pain conditions, including throat cancers, oral soft tissue lesions, birth defects such as cleft lip/palate and other diseases. Many people may suffer from tooth decay, periodontal disease, and other chronic oral conditions and injuries. Preventive measures include good oral hygiene practices, regular visits to a dental provider, consumption of fluoridated water, eating healthy, and the use of preventive measures such as dental sealants. Poor oral health in children, young people and in adults may result not only in dental decay, eventual tooth loss, and impaired general health, but also in compromised nutrition.

Prevention: The United State Surgeon General reported that "dental caries [tooth decay] is the single most common chronic childhood disease, five times more common than asthma and seven times more common than hay fever." Oral disease can be prevented through good nutrition and oral hygiene practices, drinking fluoridated water, smoking cessation, and regular visits to a dental provider. Fluoride protects teeth via the water supply for children during the tooth forming years and by direct contact with teeth throughout life. Community water fluoridation is the controlled addition of a fluoride compound to a public water supply to achieve a concentration level optimal for the prevention of tooth decay. Topical fluoride is an important source of prevention of tooth decay.

The 2006 New Mexico Oral Health Surveillance Survey reports that 76% of New Mexico water systems are fluoridated but only 18% received water with the appropriate levels adequate for preventing dental caries. Dental sealants are thin plastic coatings applied to the chewing surfaces of the molars to prevent decay. Most tooth decay in children and adolescents occurs on these surfaces. Permanent molars are the most likely to benefit from sealant application. In 2007, 1,100 New Mexico 3rd grade children received a dental sealant.

Tooth decay is one of the most common chronic infectious diseases among U.S. children. This preventable health problem begins early as 28 percent of children aged 2-5 years already have decay in their primary (baby) teeth. By the age of 11, approximately half of children have experienced decay, and by the age of 19, tooth decay in the permanent teeth affects 68 percent of adolescents. New Mexico low-income children experienced twice as many untreated cavities as children in families with higher incomes. In 1999-2000 an oral health survey of NM third graders conducted by the Department of Health estimated that 43.2% had one or more sealants on their permanent first molar teeth, 64.6% had caries experience, and 37.0% had untreated decay.

Children and adults with disabilities and people with mental illness tend to have fewer teeth, more

untreated decay and more periodontal disease than society at large. Individuals with disabilities have the same entitlement to good oral health as the rest of the population. A number of oral health prevention and treatment programs throughout the state serve individuals with disabilities.

The 2008 Legislature approved the Birthing Workforce Retention Fund which provides malpractice premium assistance for providers. Funds were also appropriated for domestic violence programs, childhood immunizations, and contraceptive cost increases. ***/2013/ Funds over the years has decreased however the amount of awards is significant for approximately 6-8 providers per year.//2013//***

The NM SAFE KIDS Coalition provided car seat clinics, including free car seat checks and/or seat replacements for infants and children.

The NM Breastfeeding Task Force, a coalition of roughly 100 individuals interested in breastfeeding, worked to increase the frequency and duration of breastfeeding in New Mexico.

The NM Statewide Immunization Information System, a web-based database with immunization records of New Mexico children, helped ensure that they are current with their recommended schedules of vaccination.

New Mexico continues to strive to ensure that all New Mexico women and children have enough nutritious food to eat, that all women and children have comprehensive health insurance that includes mental health services, that women are provided culturally appropriate prenatal care for hard-to-reach rural and frontier populations, that healthy mother-infant relationships and breastfeeding through extended paid maternity leave for all new mothers are encouraged, and that services for women leaving abusive relationship are provided.

There are multiple factors that determine the health and wellness of children: physical, social, emotional, economic, educational, and environmental. Unfortunately, New Mexico children rank 48th in child well being according to the Annie E. Casey Foundation's annual KIDS COUNT Data Book 2008.

Twenty-six percent of children under the age of 18, including 29% of children under the age of 6, live in families with incomes below the federal poverty level. 41% of children under the age of 18 live in families where no parent has regular, full-time employment. 29% of children ages 10-17 are overweight or obese and 51% of children ages 6-17 do not exercise regularly. 8% of children under the age of 18 were affected by asthma during the past year. 14% of children ages 0-5, and 19% of children ages 6-17 were not covered by health insurance at any point during the past year.

New Mexico ranks second in the nation, along with Florida, for the highest percentage of children without health insurance. Through an aggressive outreach and enrollment campaign over the past two years, the number of children eligible for and enrolled in the State Children's Health Insurance Program (SCHIP) and Medicaid are at an all-time high. As of May 2008 195,711 children (birth to age 12) were enrolled in Medicaid or SCHIP.

New Mexico Medicaid provides many health services for children under a federal Medicaid policy which requires that children receive Early Period Screening, Diagnostic, and Treatment (EPSDT). This policy includes preventive health services, maintenance health services, and treatment of medical conditions. It also includes mental health or behavioral health services. Children may go to a doctor, a nurse practitioner or a physician's assistant for a well-child exam and do not need to have a specific complaint to be seen.

Children with Special Health Care Needs: In 2005-2006, the second national survey of Children with Special Health Care Needs (CSHCN) estimated that 12.1% (59,535) of New Mexico children have special health care needs. A positive finding from the survey was the percent of children in

New Mexico who were screened early and continuously for special health care needs (64.1%). The survey showed that while New Mexico has experienced improvement in several categories since the first survey in 2001, families continue to need increased coordinated, family centered, community based care. Due to a scarcity of providers, economic hardship, lack of or under-insurance, agencies and providers continue to strive towards addressing the need.

Data from two National Health and Nutrition Examination Surveys (NHANES) show that during the past 30 years, prevalence of overweight for children aged 2-5 increased from 5.0% to 13.9%. For those aged 6-11, prevalence increased from 6.5% to 18.8%. In 2007, 10.7 percent of New Mexico children under age five were overweight. Among children age two and under, 14.5% were considered to be "at risk" for overweight, while 12% were overweight. Rates in New Mexico were slightly lower than national rates for that year. Approximately 50% of New Mexico children ages 2-5 are served by the WIC program. In 2007, 5.4% of these children were underweight, 13.6% were overweight, and 12.7% were obese. From 2006-2007 there was a 3.4% increase in the number of WIC children who were overweight and a 5.8% increase in the number who were obese. Childhood overweight is associated with various health-related consequences including psychosocial risks, cardiovascular disease risks, asthma, sleep apnea, and Type 2 diabetes.

In spite of the fact that the overall well being of some children in New Mexico is poor, good things are happening. Screening children early and often allows for diagnosis, referral, and treatment of developmental delays and other disabilities and disorders, affording more positive short and long term outcomes. Medicaid reimburses providers for certain screenings, and more children are now eligible for Medicaid. While the percentage of overweight children is increasing, the issue is a priority for the Governor and is being addressed by state agency programs.

The Early Childhood Action Network (ECAN) is a statewide policy forum that makes recommendations on how to improve the well being of young children from birth to five and their families. ECAN supports the Family Leadership Action Network (FLAN), an initiative designed to promote parent involvement and build family leadership in shaping the system that impacts their lives and their children's future.

//2012/Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), ECAN and the Families FIRST perinatal case management program have combined efforts to provide statewide training to providers, Early Head Start providers and early child care givers in the Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social Emotional (ASQ/SE) screening tools. This effort was to promote the early screening of children and obtaining early treatment for children found to have developmental delays. This effort was met with great interest from around the state.//2012//

The Developmental Screening Initiative (DSI) at UNM solicits input from many stakeholders across the state to promote best practices in developmental screening for children birth to five years of age. New Mexikids (Children's Medicaid and State Children's Health Insurance Program) covers children through 18 years of age with household incomes up to 235% of the Federal Poverty Level. New Mexico needs to continue outreach to increase the number of children covered by New Mexikids to promote Early Periodic Screening, Diagnostic, and Treatment (EPSDT) for all children, increase coordinated, family centered, community based care for children and families, and encourage health providers to practice in underserved areas of New Mexico.

Nativity: There were 30,605 births to New Mexico resident mothers in 2007, translating to a birth rate of 14.9 births per 1,000 population. New Mexico's birth rate has declined from a rate of 19.1 in 1985. In 2006, the latest year for which United States data is available, the national birth rate was 14.2, a slight increase from the 2002 birth rate of 13.9, a record low for the United States. The state birth rate has been consistently higher than the national rate, although since 2000 New Mexico's rate has dropped closer to that of the United States New Mexico Selected Health Statistics Annual Report, Volume 1, 2007

## N.M. DEPARTMENT OF HEALTH PRIORITIES AND TITLE V MCH PROGRAM ROLES AND RESPONSIBILITIES

New Mexicans require access to basic health care services to maintain their health. Lack of access to key services is a cause of unnecessary disease and mortality. If basic health care services are not accessible, people may postpone seeking treatment until they become seriously ill. In addition, screening and health education conducted in clinical settings are important preventive services.

The DOH under the direction of the new Cabinet Secretary, Dr. Alfredo Vigil, restructured its Strategic Plan and its priorities for FY 2011. The Department's priorities were restructured to include goals with objectives to address each goal. The goals and the objectives are:

### Goal 1: Improving Individual Health

#### Individual Objective 1:

Increase immunizations for all New Mexicans, especially for children and adolescents.

#### Individual Objective 2:

Reduce teen births.

#### Individual Objective 3:

Increase the proportion of new mothers who had recommended levels of health care before, during and after pregnancy to assure optimal physical, mental and oral health.

#### Individual Objective 4:

Decrease the transmission of infectious diseases and expand services for persons with infectious diseases.

#### Individual Objective 5:

Reduce suicide among all populations, specifically children and adolescents.

#### Individual Objective 6:

Reduce the abuse of alcohol, drugs and tobacco.

#### Individual Objective 7:

Ensure quality developmental disabilities services and improve outcomes for New Mexicans with developmental disabilities.

### Goal 2: Improving Community Health

#### Community Objective 1:

Reduce health disparities in New Mexico.

#### Community Objective 2:

Prevent and control chronic diseases.

#### Community Objective 3:

Reduce obesity and diabetes.

#### Community Objective 4:

Reduce intentional and unintentional injury.

#### Community Objective 5:

Ensure preparedness for health emergencies, including pandemic influenza.

#### Community Objective 6:

Identify and reduce environmental exposures which adversely impact public health.

### Goal 3: Improving the Health System

#### System Objective 1:

Improve accountability and responsiveness of our services within the Department of Health.

#### System Objective 2:

Expand health care for school-age children and youth through school-based health services.

#### System Objective 3:

Create an oral health system that provides children, low-income rural populations and people with developmental disabilities with preventive and restorative oral health services.

#### System Objective 4:

Improve emergency medical services and the trauma care system across the state.

System Objective 5:

Improve the scientific laboratory's ability to provide laboratory analytical services to state programs.

System Objective 6:

Improve resident care services in Department of Health facilities.

System Objective 7:

Eliminate abuse, neglect or exploitation of seniors and vulnerable adults.

System Objective 8:

Increase the number of state licensed providers who receive a regular and periodic review of provider compliance.

System Objective 9:

Improve recruitment, retention and training of health care providers in rural, American Indian and border communities.

System Objective 10:

Increase use of technologies to improve health outcomes.

The 2011 Department of Health Strategic Plan incorporated three new Objectives that reflect an increasing demand in the following areas:

Reduce intentional and unintentional injury: Injuries are the leading cause of death among people ages 1 to 44 in New Mexico. Each day, an average of five people die from injuries, another 40 are hospitalized due to injuries; more than 700 are seen in emergency departments, and more than 2,000 visit other health care facilities for treatment of their injuries. Most are preventable. As with chronic disease, we must reach beyond individual education. /2012/A change in administration has brought about a new Department of Health Cabinet Secretary, Catherine D. Torres, MD, and management staff are currently in the process of revising the DOH Strategic Plan Objectives.//2012//

***/2013/ The current administration has developed new DOH Strategic Plan Objectives, prioritizing and addressing some of New Mexico's most pressing health concerns.***

- ***Adequate health care workforce***
- ***Obesity in children***
- ***High rate of teen pregnancy***
- ***Oral health***
- ***Mental health and substance abuse in teens and young adults***
- ***Increased deaths due to diabetes***
- ***Drug overdose (intentional and unintentional)***
- ***Injuries sustained as a result of falls by elderly constituents //2013//***

New Mexico's deaths by unintentional injury ranked 3rd in the nation in 2005, with a rate of 66.3/100,000 population. However, the main causes of unintentional injury death vary by age group: Drowning or motor vehicle crashes led among children 0-4 years. Motor vehicle crashes were the main cause of death among the 5 to 24 year age group. Poisoning death led among the 25-64 year age group. Fall deaths were most common among the elderly. An estimate of non-fatal injuries for 2004-2006 showed that prior to age 65 years, a variety of injuries led to hospitalization. Among persons 65 years and older falls were the most common cause of injury hospitalization. The big success story in unintentional injury prevention of the last 25 years has been the reduction in deaths and injuries from motor vehicle crashes. The state has invested in well-enforced seat belt and child safety seat laws, initiated child helmet use laws, set tighter standards against drinking while driving, and improved roadway design. From 1985 to 2006, the NM crash death rate declined 29%, and the alcohol- involved crash death rate decreased 59%. The state's seat belt-use rate is over 90%. Still, motor vehicle crashes were the cause of 25% of all injury deaths in 2006 and of those killed 43% were not restrained by a safety belt. Ongoing promotion of child seat and seat belt use, and increasing recognition that booster seats can improve safety for 5-11 year olds in motor vehicles, receives strong public and private sector

support. Two-thirds of all injury deaths in New Mexico are from unintentional causes, motor vehicle crashes, poisoning (primarily drug overdose), and falls. These are often called "accidents" although most are predictable and often preventable. From 2004 through 2006 these three causes accounted for 86% of all unintentional injury deaths, a 3.5% increase from the 1999-2002 period.

Head injuries are among the most disabling, as they can lead to loss of independence and create the need for costly caregiver and support services. An estimated 36,000 New Mexicans currently live with a disabling brain injury. Increased collection of non-fatal injury data would improve understanding of the impact of brain injury in the state. Approximately 1,069 New Mexicans were hospitalized with a traumatic brain injury in 2006. Many fatal or disabling head injuries from riding bicycles, skateboards, scooters, skates, horses, and all terrain vehicles can be prevented by the use of helmets. Statewide promotion and education initiated through the Off Highway Vehicle Safety Board since 2006 and the NM Helmets for Kids Coalition since 2007, have helped to inform citizens about the importance of complying with these laws for the protection of their families.

Prevent and Control Chronic Diseases: Heart disease, cancer, stroke, lung disease and diabetes are responsible for six out of every ten deaths in New Mexico. Arthritis is the top cause of disability for New Mexico adults. Although chronic diseases are more common among older adults, they affect people of all ages. Many chronic diseases are at least partly preventable. Preventing disease requires improving the health status of people at every stage of life. Such a task is not possible one person at a time; it can be achieved only by improving the surrounding social and physical environments, such as access to recreational areas, affordable healthy foods, clean air, and work and educational opportunities.

Increase the proportion of new mothers who had recommended levels of health care before, during, and after pregnancy to assure optimal physical, mental and oral health: The incidence of birth defects and low birth weight are decreased when women receive good health care before, during and after pregnancy. New Mexico ranks in the bottom 5% of states for care beginning in the first three months of a woman's pregnancy. This ranking is due to many factors, including education and poverty levels, lack of providers in rural areas and disinterest on the part of some pregnant women to seek prenatal care. In FY11, the Department of Health will place an added effort on addressing those factors. We will also work to expand oral health care services. Evidence suggests that most young children who have the bacteria that cause tooth decay got it from their mothers, who experienced poor oral health during pregnancy.

HEALTH CARE COVERAGE AND ELEMENTS OF THE NM SAFETY NET: some of the NM population has no health insurance coverage for a variety of reasons including but not limited to immigrant status and employment without insurance coverage. The safety net for direct health services is comprised of the following:

County Indigent Funds: each county has specific criteria for eligibility. In the 2005 needs assessment, county level public health professionals cited the difficulties for families who may move from one county to another.

State General Fund, Healthier Kids Fund: this fund, \$800,000 in 2004, is administered by Children's Medical Services (CMS) and purchases services for primary care needs of children who have no possible source of coverage.

Title V MCH Block Grant, Children's Medical Services (CMS): funds are used to procure high risk insurance for children who have no coverage, and who have serious conditions requiring specialty care.

Title V MCH Block Grant, High Risk Prenatal Fund: funds are used directly and cover prenatal and delivery costs for women at high risk and have no possible source of coverage.

NM Department of Health, MCH Services in Local Health Offices: selected Maternal Health

services are offered in areas where there are no prenatal or well child providers; case management for children with special health care needs and family planning clinical services are offered in every county. Registration does not include residential status and DOH policy forbids denial of service based on race, ethnicity, age, sexual orientation or other potential reasons for a person to feel marginalized or the object of discrimination.

Maternal Health Services in Federally Qualified Health Centers and Community Health Centers: limited Maternal Health services, particularly prenatal care, are offered due to provider preferences, training and the cost of malpractice insurance.

#### What Is Primary Care?

Primary care is defined as basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social.<sup>1</sup> Medical care is the focal point of primary care services; integrated preventive, dental, and behavioral health services also are components. The aim of primary care is to assure coordinated entry into the health care system.

#### Barriers to Access

Several barriers can prevent individuals from receiving the basic care they require. Important ones include: geographic barriers which are created by substantial distances to the nearest source of primary care services and financial barriers. Individuals may have inadequate resources to secure all the basic health services they need. Even those with health insurance may not have adequate coverage. Co-payments, deductibles, and limitations on scope of coverage may make even insured individuals have problems affording medical coverage. It also is not uncommon for people with medical insurance to have inadequate resources for dental or behavioral health needs.

#### Linguistic and Cultural Barriers

When health care services are not provided in the language of a patient, individuals may not actively seek these services. In addition, the services may not be effective even if patients seek them, particularly if patient education must be provided about follow-up and self-care. Similar barriers can exist if health care providers are not culturally competent and act in ways that patients do not understand. The efforts of the Department of Health and other public agencies are designed to reduce these barriers to basic health care, with a focus on the high-risk underserved, including uninsured New Mexicans, rural/frontier populations, minority populations, and the homeless and migrant/farm worker populations.

#### Access to Basic Health Care

A significant portion of New Mexicans are at risk for lack of access to needed primary care. The federal government has designated all or part of 30 of the state's 33 counties as Health Professional Shortage Areas (HPSAs) for medical services. More than 700,000 people live in these areas. Similarly, the federal government has designated all or part of 26 of the state's counties as HPSAs for dental services, with over 700,000 New Mexicans living in these areas.<sup>2</sup> While not everyone in the HPSAs is without care; many people clearly get less health care than they need.

New Mexicans living outside HPSAs also face access problems. The state has one of the highest percentages of population without health insurance. In 2007, 22% of its adults had no health insurance, compared with 14% in the entire United States. During the same period, 26% of the non-elderly adults in the state had no health coverage, compared with 17% for the country as a whole. Among adults with health care coverage, only 8% reported that cost had kept them from obtaining necessary medical care in the previous year, while cost prevented 42% of those without coverage from obtaining necessary care in the same year.<sup>2</sup>

The impact of the lack of health care coverage can be demonstrated by comparing use of important clinical preventive services by those who have health care coverage with their use by those without such coverage. From 2004 through 2006, 77% of women ages 50 or older with health care coverage reported having a mammogram in the previous two years, while only 47% of those without coverage reported a mammogram in that period. During the same time span, 55% of adults 50 or older with health care coverage reported having had a screening endoscopy for colorectal cancer, while only 26% of those without coverage reported having had an endoscopy for this purpose. Among adults with diabetes, 49% of those with health care coverage reported receiving all recommended diabetes management services in the previous 12 months, while only 30% of those without coverage met this important standard.

Adults without coverage also may have greater need for coverage. In 2007, those without coverage were more likely to smoke tobacco and report binge drinking of alcohol, and were less likely to report leisure-time physical activity than adults with coverage.

#### Community-Based Primary Care

For more than 20 years, there has been an effort to build a system of community-based primary care centers for New Mexico's underserved. This has been a collaborative effort, linking federal, state, and local programs with community groups and non-profit agencies. The impact has been considerable; there are primary care centers in more than 85 underserved communities in the state. Most of these are operated by non-profit agencies; all are governed by local boards dedicated to meeting the primary care needs of their communities.

Collectively, these centers serve more than 290,000 patients--14% of the total New Mexico population. They also generate more than 900,000 patient visits, including medical, dental, and other primary care service visits.

Centers operate in both urban and rural areas. More than 80% of the clinical locations are in rural and frontier areas, reflecting the state's non-urban nature. More than 70% of the patients that these centers serve are either uninsured or supported by Medicare or Medicaid. This also reflects the health safety net nature of the primary care center sector.

#### Improving Access

Primary care centers are serving approximately half of the unmet need in New Mexico, making clear the necessity of continuing to build the primary care center sector. Under the Federal Primary Care Cooperative Agreement, NMDOH will continue its work facilitating the expansion of primary care centers. While the focus of these centers is on medical services, there is an increased emphasis on expansion of dental services in the primary care setting. Fewer than half of primary care clinic sites have dental service capacity. But even with this limited capacity, primary care centers provide more than 20% of all Medicaid dental services in New Mexico. The community-based primary care sector in New Mexico is a major public health success story. Few other states have as widespread a system caring for such a large percentage of the state's underserved population. The sector has been built upon local initiative, community governance, federal, state, and local financial support, and staffing from government health professional programs.

#### What's Being Done

Community-based primary care centers are being funded. Physicians, dentists, and other health care providers are being recruited, and community-based primary care centers are receiving retention assistance. Low-interest loans are being granted for community-based primary care center facilities and equipment. Planning assistance is being given to community groups and agencies developing or expanding community-based primary care centers.

#### What Needs to Be Done

Expansion of primary care centers to meet the needs of more underserved people. Continue to strive for the expansion of dental services for primary care center clients. Expansion of basic behavioral health services within the primary care setting and expansion of health promotion and disease prevention services and chronic disease management capacity in the primary care

centers.

## **B. Agency Capacity**

III B 1: Office of the Bureau Chief/Title V Director

As noted in the overview New Mexico's population is one of the most diverse in the United States, consisting of 44% Hispanics, 42% White, Non-Hispanic, 10% American Indians, 2% African-Americans, 1.4% Asian and Pacific Islanders, and 3.2% multi-racial. The state has the second highest percentage of Native Americans.

The Department of Health 2011 Strategic Plan Community Health Objective 1: Reduce Health Disparities; addresses cultural competency in 5 of the 9 strategies.

Cultural competency is focused throughout services provided in the Maternal Health (MH) program. Prenatal care focuses on meeting the needs of the Mexican & Native American women. Ten local Public Health Offices provide Prenatal Care (PNC), & each has native Spanish-speaking clinical staff or translation services available for clients. The MH program also contracts with private providers to provide MH services, each of these providers have Spanish speaking clinical staff or translation for clients who are Spanish speaking only, and where possible, for clients who speak other languages. ***//2013/The Department of Health FY 2013 Strategic Plan under Public Health Program Purpose Statement: Public Health fulfills the DOH mission by working with individuals, families and communities in New Mexico to improve health status, eliminate disparities, and ensure timely access to quality, culturally competent health care.//2013//***

The MH program also promotes Facilitated Group PNC to improve cultural relevance for all women. This model has proven valuable by increasing satisfaction, increased attendance & increasing breastfeeding & self care initiatives. Six clinics have been established for Spanish speaking women. Another two agencies provide Facilitated Group PNC exclusively for teen mothers & their partners. All Educational materials are translated.

The Family Planning program provides training to health offices & contractor staffs to assure services are culturally appropriate.

The DOH website will post the Limited English Proficiency policy & a statewide list of translator/interpreter resources.

Mandated CLAS Standards

Standard #4: Health care organizations must offer & provide language assistance services, including bilingual staff & interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard #5: Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard # 6: Health care organizations must assure the competence of language assistance provided to limited proficient patients/consumers by interpreters & bilingual staff. Family & friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard #7: Health care organizations must make available easily understood patient-related materials & post signage in the language of the commonly encountered groups &/or groups represented in the service area.

### III B 2 Maternal and Child Health

The Maternal Health Program (MH) focuses cultural competency in prenatal care (PNC) on meeting the needs of Hispanic and Native American women. The ten Public Health Offices providing PNC each have Spanish-speaking clinical staff or expert translation available for clients. A Nurse Practitioner and Physician both originally from Mexico serve three of these ten clinics. Maternal Health contractors provide Spanish-speaking clinical staff and/or expert translation for Spanish speaking clients and other non-English speaking clients. Printed client education resource materials provided by MH are made available in both English and Spanish.

Focus groups of Hispanic and Navajo women, young and old, urban and rural, have guided PNC promotion. MH actively promotes the model of Centering Pregnancy, a facilitated group PNC approach, designed to improve cultural relevance for all women. This model has been proven to increase satisfaction with and attendance at PNC, as well as self-care and breastfeeding. MH assisted six clinics to develop Centering groups for Spanish-speaking women. Two agencies in Albuquerque provide Centering care exclusively for teen mothers, their partners and support persons. Efforts to support Indian Health Service clinics in starting a group PNC option continue. MH, Public Health Offices, and community partners continually collaborate to identify cultural barriers to PNC, and to eliminate them.

#### Preventive and Primary Care Services for Pregnant Women, Mothers and Infants:

In 2007, over 58% of New Mexico's pregnant women and infants had care paid by Medicaid and S-CHIP through its Managed Care Organizations (MCOs) and fee-for-service sites. The Maternal Health Program (MH) directly and indirectly oversees prenatal care services through a variety of programs and provider agreements. In 10 of the 54 public health offices (PHO) direct prenatal care services are provided for about 800 women who are financially or geographically unable to obtain prenatal care in the private sector. MH administers the High Risk Prenatal Care Fund (HRF) contracting with 21 qualified private care providers, clinics and hospitals throughout the State to care for more than 1200 medically indigent women with high-risk perinatal conditions per year. The HRF also contracts with the University of New Mexico Hospital (UNMH) to provide prenatal care to high and low-risk medically indigent women in Albuquerque, and to any patients referred to them from providers throughout the state. This care includes high risk outreach clinics in 5 counties, prenatal laboratory services, ultrasounds and other perinatal testing as indicated. A similar Maternal Health Program agreement uses New Mexico General Funds to pay for perinatal services for more than 150 medically indigent women in Las Cruces.

MH indirectly provides for prenatal care through the licensing and regulation of midwifery care in NM. MH regulates both Licensed Midwives (LM) and Certified Nurse Midwives (CNM). MH heads advisory boards for both types of midwives, meeting quarterly to review regulations, policy and disciplinary actions. In 2007, over 33% of births in New Mexico were attended by midwives, and untold hours of prenatal and postpartum care were provided by these midwives.

In late 2008, Maternal Health Program did a survey of delivery services in each of New Mexico's 33 counties. 12 of the 33 counties have no hospital that provides delivery services except in emergencies. 11.6% of the state's births in 2006 were to residents of these counties. A survey of physicians by the New Mexico Health Policy Commission in 2001 showed that 13 (40%) New Mexico counties lacked an Ob/Gyn practicing obstetrics. In 2006, a repeat of the survey showed that 17 (51%) counties lacked an Ob/Gyn practicing obstetrics. Between 2005 and 2008, three hospitals terminated delivery services. Only 9 counties have providers for out-of-hospital deliveries.

Increasing liability insurance premiums and low reimbursement rates have driven some providers to leave the state or to quit providing obstetric services. In 2008 the legislature approved the Birthing Workforce Retention Fund which is administered by the Maternal Health Program. This fund provides up to \$10,000, per provider, to help defray the cost of malpractice insurance for

some qualified rural perinatal health care providers. Additionally, the state participates in the development of proposals for alternatives to the torts system for compensating those who suffer poor birth outcomes and for reducing negligent practice. The goal being that such an administrative systems could reduce the burden of liability insurance costs and the stresses of litigation, thus potentially increasing the number of obstetric providers and the public access to services.

The Families FIRST Program (FF) will join the MCH Section. FF receives no Title V funds; it is supported by contracts with the MCOs. The goals and activities of the FF Program fit with those of the MCH Section. Partnering with FF will strengthen the Section's ties to direct services. FF provides case management for Medicaid-eligible pregnant women and children 0-3 years. Its goals are to improve birth outcomes, to decrease high-risk pregnancies and identify children with special health care needs for early intervention. FF case managers conduct verbal assessments of the mother and child's health including emotional, social, educational and other needs. The FF CMs refer clients to needed services, including nutrition counseling, parenting classes, and education sources. FF has contracts with the three Medicaid MCOs. It has case management providers in 45 sites. The number of clients served increased by about 80% from 7/01/01-6/30/04.

/2012/Certain medical supplies and drugs for children are purchased through Title V funding and dispensed through the Public Health Offices throughout the state. An Early Childhood Coordinator (ECC) was hired in 2010 to work across agencies to align and coordinate all state-level early childhood programs and services to create an effective and efficient structural, functional, and operational system to offer early childhood services for children, birth through eight, and their families.//2012// **/2013/Early childhood and family friendly initiatives have been developed. //2013//**

### III B. 3. Maternal and Child Health Epidemiology

The Maternal and Child Health Epidemiology program collects, analyzes and reports on maternal, infant and child health for special populations throughout New Mexico. Ongoing reports describe the health status of Native American, U.S. Mexico Border, and Hispanic women and children. Survey tools are translated into Spanish by a professional translator with the New Mexico Department of Health or with the Centers for Disease Control and Prevention. The NM PRAMS survey is conducted in both Spanish and English, statewide, and within NM tribal boundaries to include data collection among Navajo, Pueblo, and Apache women. County-level PRAMS data are readily available through geographic sample stratification to ensure survey participation in each Public Health region. The MCH Epidemiology program (PRAMS) and the Navajo Tribal Epidemiology Center maintain data sharing agreements, and collaborate on Navajo-specific PRAMS surveillance reports. Representatives from Navajo-area Indian Health Service and NM's two Tribal Epidemiology Centers actively participate in the PRAMS Steering Committee. Behavioral Health Collaboratives participate with the multidisciplinary NM Maternal Depression Work Group to bring PRAMS data and information regarding perinatal depression to medical and mental health service providers in several areas of the state, including U.S./Mexico Border counties and the Navajo Nation. The workgroup was developed to address the prevalence of postpartum depression among NM women giving live birth. NM PRAMS and Tewa Women United share data and prepare reports, grants and community improvement projects together to improve the health of Native American families in Northern New Mexico. New Mexico and the Navajo Nation work to coordinate their Youth Risk Behavior Survey (YRBS) so that respondents and administrators avoid "survey fatigue," and the Navajo YRBS plans to incorporate many of New Mexico's resiliency questions into future Navajo surveys. Vital Records birth and death files are regularly examined to assess racial and ethnic disparities in Maternal and Child Health outcomes. /2012/<http://ibis.health.state.nm.us/> is an online data query system, available to the public, where much of NM's MCH data can be found//2012//

### III. B. 4. Family Planning

NM DOH FPP has served as the NM grantee for the Federal Title X of the Public Health Service Act fund for more than 20 years. Family Planning is an integral component of the NM DOH's efforts to reduce teen pregnancy, prevent unintended pregnancy and sexually transmitted infections (STIs), prevent recourse to abortions, reduce infant mortality and morbidity, and improve the health of women and men of all ages. In NM, 237,020 women are in need of contraceptive services. Of these women, 139,520 need publicly supported contraceptive services because they have incomes below 250% the federal poverty guidelines (107,100) or they are sexually active teens (32,420) [Alan Guttmacher Institute. (2009). Contraceptive Needs and Services, 2006. Retrieved February 2, 2010, from [www.guttmacher.org/pubs/win/index.html](http://www.guttmacher.org/pubs/win/index.html)]. In 2009, NM DOH FPP provided clinical services to 45,693 people, 37,683 female clients and 8,010 male clients. Clinical reproductive health services were provided to 14,207 teens (female and male ages 19 and younger). The clinical services include providing a contraceptive method and/or a clinical exam visit. The services are provided statewide at over 120 sites in Public Health Offices (PHOs), Primary Care Clinics & School-Based Health Centers. /2012/In 2010 the statewide Title X clinics served 39,628 unduplicated clients (35,106 females and 4,522 males). Clinical reproductive health services were provided to 11,544 teens (female and male ages 19 and younger). The clinical services include providing a contraceptive method and/or a clinical exam visit. The services are provided statewide at over 100 sites in Public Health Offices (PHOs), Primary Care Clinics & School-Based Health Centers.//2012// The clinical exam visit includes: a medical history/physical, family planning counseling, pregnancy testing (if needed), laboratory tests (as needed), testing and counseling for STIs, and dispensing supplies of a contraceptive method of choice. This comprehensive health screening may include mental health and drug abuse risk assessment.

The three long-term program impacts of NM DOH FPP are to reduce teen pregnancy, reduce unintended pregnancy and reduce chlamydial infections among young women. NM DOH FPP works to impact these health outcomes by promoting and providing comprehensive family planning services, including clinic-based, community education and outreach services, to promote health and reproductive responsibility. In order to uphold standard for delivery of care, NM DOH FPP evaluates program and management practices.

NM DOH FPP has met the long term impact goal of reducing the teen birth rate among young women aged 15-17 by 1% annually.

It is difficult to say with certainty what contributed to the decline in the NM birth rate, but there has been an increase in programming in NM in Doña Ana County and an increase in service learning with the Teen Outreach Program (TOP) statewide. In 2007 and 2008, the teen birth rate decreased in the most populous counties (Bernalillo, Doña Ana, McKinley, Santa Fe, Sandoval and Valencia). Also, the South Valley Male Involvement Project in Albuquerque has provided education using the Wise Guys curriculum at middle and high school sites and promotes services and refers clients to the male reproductive health clinical services offered at PHOs since 2003. By partnering with community based health providers, SVMIP and PHO staff provide needed services such as STI and HIV prevention education, counseling, and testing.

/2012/Despite NM's high teen birth rates, there has been a significant decline over the past 11 years. The teen birth rates for 15-17 year olds in NM decreased by 32%, from 1998 to 2009. The overall decline in NM's teen birth rate is comparable to the decline in the US teen birth rate of 33%. There are multiple factors that contributed to the decline in the NM teen birth rate. Some of these factors are: 1) the teen pregnancy prevention initiative in Doña Ana County; 2) County support for programming in Bernalillo County; and 3) the increase in programming with the Teen Outreach Program (TOP). Other contributing factors are strategies used for teen clinical services at NM DOH Family Planning Program funded clinics. These strategies are: 1) Low to no cost confidential services at over 90 sites statewide; 2) Family planning services providing walk in access for ECP at 48 Public Health Offices and Immediate provision of birth control pills and 3) injectable contraception without examination (Quick Start) at 48 Public Health Offices. There has been success, NM teen pregnancy prevention strategies and partnerships have worked to reduce teen births. Teen births for 15-17 year olds reduced by 13.4% from 2006-2009 and there haven't

been any pregnancies among participants in the Teen Outreach Program.//2012//

Since 2006, based on national evidence-based research, NM DOH FPP and New Mexico Teen Pregnancy Coalition (NMTPC) have recommended and utilized five strategies to prevent teen pregnancy. These strategies are:

Family Planning Services offering access to confidential, comprehensive reproductive health services including clinic-based services and community education and outreach, to promote health and reproductive responsibility.

Comprehensive sex education that teaches about abstinence as the best method for avoiding STIs and unintended pregnancy, but also teaches about condoms, contraception, interpersonal and communication skills to help young people make responsible decisions about reproductive health.

Service learning programs that include community based volunteer service and curriculum guided discussions and activities.

Adult-teen communication programs such as Plain Talk to give adults information and skills to communicate effectively with young people about reducing risky sexual behavior.

Male involvement programs for prevention efforts that specifically target boys and young men through hard-to-reach and/or vulnerable populations, such as adolescents, the incarcerated and people with limited English proficiency.

NM DOH FPP funds and monitors evidence-based education programs at 19 sites in 10 counties. The main focus of this school and community-based programming is TOP at 17 sites in 10 counties. NM DOH FPP has been working with TOP since 2004. In 2007, when state funding started to be available for teen pregnancy prevention programming, the decision was made to focus on TOP because of service learning component and the success of the program at a school in northern NM. Of the 715 teens participating in evidence-based adolescent pregnancy prevention programming annually, the majority (585) is in TOP.

### III. B. 5. Children's Medical Services

The New Mexico Title V program for Children and Youth with Special Health Care Needs (CYSHCN) is titled the Children's Medical Services (CMS) that collaborates with partners statewide. With limited resources, CMS has maximized its capacity to ensure an effective system of statewide services to CYSHCN.

State Program Collaboration: CMS collaborates with Oregon State Public Health Laboratory and UNM Metabolic Consultants in the provision of Newborn Genetic Screening. CMS works with the School for the Deaf, STEP HI Program for newborn hearing screening and follow-up; UNM Hospital OB GYN Department and several peri natologists in Albuquerque for the Birth Defects Registry and Neural Tube Defect surveillance. CMS also collaborates with the Health Systems Bureau for networking with the RPHCA funded centers. The NM Sickle Cell Council provides education, screening and follow-up for sickle cell and other hemoglobinopathies. CMS worked with Medicaid to reimburse midwives for expanded Newborn Genetic Screening. Medicaid and CMS work together to increase enrollment of children due to expanded eligibility requirements. CMS staff are trained in enrolling clients through presumptive eligibility and Medicaid on site application services. CMS is working with the Commission for the Deaf and Hard of Hearing and the Commission for the Blind and Visually Impaired to address unmet needs for children in these communities. CMS continues to collaborate with Medicaid, WIC, UNM, the Commission for the Blind and the Commission for the Deaf and Hard of Hearing to address needs of CYSHCN and children identified on newborn genetic screening and newborn hearing screening. /2012/The MCH Collaborative meets monthly to support Title V activities in the state and to address issues as a collaborative. Participants include the Title V CYSHCN program, Family Voices, Parents Reaching Out, EPICS, the LEND program and the Pediatric Pulmonary Program. All participants receive MCHB funding. CMS works with Hands & Voices NM Chapter to increase family involvement of CYSHCN in Title V activities.//2012//**2013/CMS is working with Medicaid to integrate relevant components of the Affordable Care Act.**//2013//

The Child Health program applied and was awarded the Project LAUNCH grant given to six states to include one tribal entity. This grant requires a multi agency team work with the Early Childhood Comprehensive Systems (ECCS) team to create a comprehensive strategic plan that all agencies can provide input and have similar goals in which to work towards. The ECCS workgroup in New Mexico also known as the Early Childhood Action Network (ECAN) has worked for several years with other state and private entities towards early childhood services and advocacy. Combining these two groups will enhance the work provided by the multi-agency team and ECAN to push early childhood issues forward.

#### State Program Support for Communities:

CYSHCN who are covered by CMS, Medicaid/SCHIP and private insurance can receive clinic services in multidisciplinary CMS/UNM/Presbyterian pediatric specialty outreach clinics, and care coordination by CMS social workers. Children under three with complex medical diagnoses go through the CMS Family, Infant Toddler Program (FIT) and are transitioned to CMS CYSHCN social workers at age three, assuring ongoing medical management and coordination of care. The number of CMS eligible children with high cost conditions enrolled into the New Mexico Medical Insurance pool increases yearly with an emphasis on meeting unmet orthopedic needs. CMS developed a new relationship with Presbyterian Health Services in 2008 and added 12 more asthma clinics statewide.

CMS currently provides payment for premiums and co-pays for over 200 clients enrolled in the NMMIP. The legislature approved \$300,000 to be used in CMS specialty clinics in 2008. CMS was able to add 10 more asthma clinics statewide and enrolled 50 clients onto NMMIP. In 2009-2010 CMS enrolled 53 more clients onto NMMIP and increased the number of asthma clinics to 33 total, despite severe budget cuts to the CMS program.

Coordination with Health Components of Community Based Systems: CMS's network of 45 social workers is located and co-located with other health services in NM. CMS has experienced a statewide vacancy rate of 30% over the past several years due to budget issues and a statewide hiring freeze. The program had 60 social workers when fully staffed. They coordinate health care for CMS CYSHCN statewide. CMS works with community councils and services with the Title XVIII Medicaid and Title XXI SCHIP program, the largest providers of medical care, in an effort to provide and model family centered, community based, culturally competent coordinated care. CMS social workers provide a statewide system of oversight and care coordination for infants identified through the Newborn Genetic Screening and Newborn Hearing Screening state mandated programs, ensuring that they receive a continuum of care. After initial care for the first 3 years under the CMS/ FIT, children are transferred to CYSHCN social workers to continue care coordination. In this current fiscal year 2010 CMS-FIT was not funded by DDS and the CMS FIT Coordinator position was eliminated from the personnel rolls thus the program had to be closed. The remaining CMS FIT staff will resort to providing services to the special needs population. CMS Social Workers will continue to partner with the statewide FIT program by providing critical care coordination and social work services to the birth to three population with special needs and/or complex medical conditions. /2012/ Vacancies and inability to hire social workers continue. The remaining staff work to cover vacant caseloads within the Regions. //2012//

House Bill 479 was passed in the 2005 legislation that required expanded screening for all newborns born in the state of New Mexico, from six diagnoses to 28. CMS is worked with the State Lab, Genetic Advisory Committee and Pediatric Advisory Board to strengthen the follow-up. The CMS CYSHCN Program and the State Lab Division worked together to select an outsourcing laboratory for tandem mass genetic screening. The expanded screening was implemented in January 2006.

Oregon State Public Health Lab (OSPHL) was selected to provide testing and follow-up for the Newborn Screening program. Oregon provides short term and long term follow-up with their genetic and metabolic experts directly to Primary Care Providers (PCPs) who are caring for

newborns with presumptive or confirmed screens. OSPHL coordinates with UNM Metabolic specialists after diagnosis. In January 2010 the NM Legislature passed House bill 201, mandating that five new conditions be added to the Newborn Screening. The conditions, which are all lysosomal storage disorders, will be added when testing is available and feasible as determined by the New Mexico Secretary of Health.

Coordination of Health Services with Other Services at Community Level: Healthy Transition New Mexico is coordinated through the Healthy Transition Coordinating Council with representatives from DVR, Medicaid, and Salud!, CMS, UNM LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, and Statewide Transition Initiative Participants to address medical and psychosocial issues of adolescent YSHCN transition. The Health Transition New Mexico Coordinating Council joined forces with the Statewide Transition Coordinating Council in order to avoid duplicating efforts. This new Council is represented by numerous State, public and private entities and shares information and collaboration on projects affecting youth in transition.

A grant proposal was submitted to HRSA/MCH in 2007 and in 2009. It included the creation of a statewide council for integrated services for CYSHCN. This proposal addressed all CYSHCN goals in an integrated fashion. Experts were identified as key participants to address the medical home with experts including Trish Thomas from Family Voices, Dr. Javier Aceves from Young Children's Health Center, Sally Van Curen from Parents Reaching Out. Dr. Nelson, medical director for Presbyterian Salud! and the Navajo Nation.

CMS was not awarded the HRSA funding. However, the Navajo Nation was awarded and is collaborating with CMS to address Youth Transition.

However CMS continues to work on transition issues and developed a model multi-cultural, bilingual transition plan that is used in all the health offices with youth once they reach the age of 14. /2012/A grant proposal was again submitted to HRSA in 2011 but was not

funded.//2012//**2013/CMS resubmitted the proposal with a focus on youth transition and medical home//2013//**

Other agencies and community partners include: CYFD/child protective services, Food Stamps, ISD, community organizations providing services to multicultural and immigrant populations, i.e. Somos Un Pueblo Unido, local and statewide family organizations, school systems, some faith based service organizations such as Catholic Charities, and community domestic violence and substance abuse coalitions. Agencies and programs receiving Title V Maternal and Child Health Funding participate in a MCH Collaborative addressing transition, Medical Home and other MCH initiatives. CMS is represented on the Family to Family Health Advisory Board with Parents Reaching Out (PRO). The Newborn Hearing (NBH) Coordinator participates on the Deaf/Hard of Hearing (D/HH) Task force at New Mexico School for the Deaf (NMSD) to address unmet needs of D/HH children in their communities. Task force members include NMSD, parents; Commission for D/HH, PED, and local school districts. The CMS Medical Director participates on Multi-Agency Task Force on Early Childhood services in NM

The licensed social workers in CMS are required by statute to engage in eight hours of cultural competence training annually to renew their licenses. The care coordination in CMS is done primarily by social workers, with 2 positions filled by nurses. CMS, located regionally in the health offices decided in past years to learn and address cultural competency regionally. Working with Hispanic communities of different origins and arrival in New Mexico, pueblos and the Navajo Nation, each region develops its own plan to carry out cultural competence training and delivery of services. While the Public Health Division under which falls the CMS Program focuses on translation for services and has allocated funding reimbursement of bilingual, bicultural staff, each region has its own issues and its own plan to assure clients receive culturally and linguistically competent care. These plans are the following:

Region 1/3 (metropolitan Albuquerque area and the Northwestern Region) Cultural and Linguistic Access Services (CLAS) Committee was created in 1998 through the efforts of Dr. Maria

Goldstein Regional Health Officer (retired), Alicia Williams, CMS Program Manager and Lorenzo Garcia, Health Promotion Specialist Program Manager to address issues of cultural competency, linguistic access and health disparities. The CLAS committee is a multidisciplinary team of Public Health professionals that include a Children's Medical Services Social Worker, a Health Promotion Specialist Program Manager, a WIC Nutritionist Supervisor, the Regional Health Officer, a Director of Nursing, other nurses, and clerks from throughout Region 1/3. Activities have included: removing barriers to access of public health services for limited English proficient individuals by facilitating the training of Public Health Staff as bilingual interpreters, educating Public Health staff on how to access interpreters and cultural sensitivity presentations at the Region 1/3 meetings.

While CMS works primarily with children diagnosed with chronic medical conditions, we have discovered that we cannot look at the issue of special healthcare needs in a vacuum. Alicia Williams, Region 1/3 Program Manager for CMS, works with Native American Tribes throughout the State of New Mexico on case reviews and service planning for high- risk Native American adolescents.

Arthur Fuldauer, Family Infant Toddler Social Worker, provides outreach visits to Santo Domingo and San Felipe Pueblos. Arthur performs developmental evaluations and refers eligible children to early intervention services. Formation of Region 3 Diversity Committee was formed with the following goals in mind: Support staff in the area of diversity, support our clients, learn from other cultures on how to provide better services to our clients, listen to what the children we serve are saying as they are letting us know we have a lot of work to do, explore what we can do to support a diverse work force.

In Region 2 (Santa Fe and the Northeastern part of the state) the CMS Cultural Competency Process includes a branch of IMPART Group (Increasing Minority Participation Task Group), has worked on the development and implementation of an Intercultural Communication Training Module. Additionally, Region 2 CMS Cultural Competency committee meet on a monthly basis with a focus on: increasing cultural awareness through planned trainings and cultural learning experiences; sharing resources and advocacy for immigrant communities and increasing outreach and collaboration with Indian Health Services and Pueblo communities especially increasing competency linguistic access. A Region 2 CMS Social Worker serves as board member of the Immigrant Task Force and provides information and updates for the District 2 CMS team regarding legislation and opportunities for the immigrant population served. Region 2 CMS social workers provide service coordination and access to pediatric specialty outreach clinics for children and youth with special health care needs for all Pueblos and Native American's living within the Northeast Region of the state. Social Worker(s) in the Santa Fe office cover San Felipe, Santo Domingo, Cochiti, Pojoaque, Nambe and Tesuque. CMS Social Workers out of the Espanola office covering San Ildefonso, Santa Clara, San Juan. In Taos, one CMS social worker covers Taos Pueblo and Picuris. The Region 2 CMS staff nutritionist provides training in specialized diets for Pueblo schools and Indian School food service for children and teens with chronic illness (i.e.: diabetes). The CMS staff Nutritionist also provides nutritional counseling for Native American families of children with Special Health Care Needs. Ms. Belanger provides medical social work services to Dr. Anne Kusava at her Santo Domingo monthly (children's) chronic disease clinic. Since Dr. Kusava became chief of staff at the Indian Hospital here in Santa Fe, Ms. Belanger meets twice monthly with the physicians to identify children and youth with special health care needs who need service coordination. The physicians reported that they needed a medical social worker to assist families, especially for newborns who are identified as being at risk, and/or diagnosed with conditions thus CMS is a point of entry for all newborns identified as being at risk and/or diagnosed with a condition. The service coordination offered by CMS entails coordination of health, medical and other community resources in order to develop and reach child and family goals. The staff of Region 2 is bilingual and bicultural in every office. /2012/Ms. Belanger recently was promoted to a position within Medicaid as the tribal liaison where she can continue to work on improving systems of care for CYSHCN. The Region 2 Cultural Competency committee continues to meet monthly to promote learning around linguistic

and cultural issues, share resources and improve outreach to the Pueblos and other Native Americans living in the Region.//2012//

Region 4 (the Southeastern part of the state) requires eight hours of cultural training where one or two hours must be related to medical beliefs in a different culture such as the Deaf culture. The training must be approved by the supervisor. This region's quarterly meetings schedule a cultural learning opportunity such as immigration issues. There is a Mennonite Mexican population in this region, where medical needs and beliefs regarding illness and disability, are different than the mainstream. This population speaks Mexican and German and the families work in the dairies and farms. They continue to try and recruit bilingual social workers as much as possible.

Region 5 (the Southwestern part of the state on the border with Mexico) will continue to maintain a bilingual bicultural staff at the existing 90%; and cultural competence continuing education for social workers. CMS experienced need, particularly during Cleft Palate Clinic, for medical interpreters. Several CMS staff completed a medical interpreter's training and receive ongoing training in this specialized area.

The Title V CYSHCN Director continues to be a resource nationally to other programs seeking Cultural consultation. Susan Chacon, the NBHS Coordinator was selected in 2005 to Chair the CDC sponsored EHDI Diversity Committee which meets monthly by conference call to address issues of access to EHDI services for minority and underrepresented populations. The committee consists of representation by state EHDI coordinators, University faculty, CDC, and Indian Health Services. The Committee has developed guidelines and recommendations to programs to assist in the provision of culturally competent care for minorities and underrepresented populations who are in need of EHDI services, including the development of a culturally and linguistically competent handbook for Spanish-speaking families. This material will also be available for University staff and can be used in curriculum when training the next generation of EHDI professionals. Ms. Chacon and representatives of the EHDI Diversity Committee present on outreach to diverse families for EHDI services at national conferences. Ms. Chacon was also selected by the National Center for Cultural Competence at Georgetown University to represent New Mexico in a "Community of Learners" to improve services to culturally and linguistically diverse families who have a child with special health care needs.

### **C. Organizational Structure**

//2012/Susana Martinez was elected Governor of New Mexico in November, 2010. The Lieutenant Governor is John A. Sanchez. Catherine Torres, MD, is the new Cabinet Secretary for the Department of Health.//2012//

The current administration of Governor Bill Richardson consists of 22 State Departments, including the Department of Health. Cabinet members serve at the Governor's discretion and together form a constructive advisory board in assisting the Governor in running the affairs of state, with reporting duties based on their respective agencies. Currently, the Governor's Cabinet is comprised of Secretaries and Directors of nearly thirty agencies each of who deal with particular issues the Governor deems as an important part of the overall health of our state and its people.

The New Mexico Children's Cabinet was created by Executive Order and Governor Richardson appointed Lt. Governor Diane Denish, chairperson. She indicated that early childhood issues would be her top priority. Because the goals of the Maternal and Child Health Bureau/Early Childhood Comprehensive Systems (MCHB/ECCS) grant and Children's Cabinet were aligned, it was decided that the Lt. Governor would convene a group of early childhood stakeholders and experts to develop a comprehensive long term Early Childhood Agenda for New Mexico's young children and their families from birth to age 5. The role of this group is to implement the goals of the MCHB grant and to advise the Children's Cabinet. The Cabinet Secretaries from the Department of Health, Human Services Department, Children, Youth & Families, and the Aging

and Long Term Care Departments also meet once a week to discuss issues that effect their departments and to address State Health and Human Services Initiatives. These four initiatives include the Statewide Comprehensive Health Plan, the Behavioral Health Plan, the Long Term Care Plan for Seniors & Individuals with Disabilities and the Medicaid System Redesign. /2012/As of 2011, the Children's Cabinet is no longer meeting. Other early childhood initiatives are being considered.//2012//**2013/ The NM Children's Cabinet has been revived and is in the early stages of meeting. //2013//**

The Secretary of the Department of Health, Alfredo Vigil, MD, is a Cabinet Secretary and reports directly to the Governor. The three Deputy Secretaries are Jessica Sutin, responsible for Programs, Duffy Rodriguez, responsible for Administrative functions and Katrina Hotrum is responsible for facilities management of 5 hospitals and healthcare centers. /2012/Catherine D. Torres, MD is now the Cabinet Secretary of the Department of Health. Dr. Torres reports directly to the Governor.//2012//

The Secretary's Office houses the Public Information Officer, Chief Medical Officer, Chief Information Officer and the Chief Privacy Officer (HIPAA and related functions), as well as the Office of General Counsel. The Deputy Secretary of Programs oversees three major divisions which include: Public Health Division, Developmental Disabilities Support Services Division, and Health Certification, Licensing & Oversight the Office of Policy and Multicultural Health.

The NM Department of Health (DOH) is a statewide agency organized into 5 Regions with each of the 53 local health offices as a state agency entity.

Previous versions of the Department of Health's strategic plan aligned activities and strategies by Department program areas or division. This format limited cross-divisional thinking and collaboration. This year, the Department of Health's strategic plan has been reorganized to reflect a new framework that promotes new opportunities to think and work across divisions and better collaborate to implement innovative strategies that will improve individual health, community health and the health system. The DOH Strategic Plan has been revised to address issues in 3 Different Goal Areas: The Goals are: Goal 1: Improving Individual Health, Goal 2: Improving Community Health; and Goal 3: Improving the Health System

Goal 1: Individual Objective 1: Increase immunizations for all New Mexicans, especially children and adolescents. Individual Objective 2: Reduce teen pregnancy. Individual Objective 3: Reduce obesity and diabetes in all populations, specifically children and adolescents. Individual Objective 4: Reduce suicide among all population groups, especially youth. Individual Objective 5: Ensure quality developmental disabilities services and improved outcomes for New Mexicans with developmental disabilities.

Goal 2: Community Objective 1: Reduce health disparities in New Mexico. Community Objective 2: Prevent and control chronic diseases. Community Objective 3: Reduce obesity and diabetes. Community Objective 4 Reduce intentional and unintentional injury. Community Objective 5: Ensure preparedness for health emergencies, including pandemic influenza. Community Objective 6: Identify and reduce environmental exposures which adversely impact public health.

Goal 3: System Objective 1: Improve accountability and responsiveness of our services within the Department of Health. System Objective 2: Expand health care for school-age children and youth through school-based health services. System Objective 3: Create an oral health system that provides children, low-income rural populations and people with developmental disabilities with preventive and restorative oral health services. System Objective 4: Improve emergency medical services and the trauma care system across the state. System Objective 5: Improve the scientific laboratory's ability to provide laboratory analytical services to state programs. System Objective 6: Improve resident care services in Department of Health facilities. System Objective 7: Eliminate abuse, neglect or exploitation of seniors and vulnerable adults. System Objective 8: Increase the number of state licensed providers who receive a regular and periodic review of

provider compliance. System Objective 9: Improve recruitment, retention and training of health care providers in rural, American Indian and border communities. System Objective 10: Increase use of technologies to improve health outcomes.

/2012/The current administration is in the process of reviewing and revising the objectives and strategies of the DOH Strategic Plan.//2012//

***/2013/ The current administration has developed new DOH Strategic Plan Objectives, prioritizing and addressing some of New Mexico's most pressing health concerns:***

***Adequate health care workforce***

***Obesity in children***

***High rate of teen pregnancy***

***Oral health***

***Mental health and substance abuse in teens and young adults***

***Increased deaths due to diabetes***

***Drug overdose (intentional and unintentional)***

***Injuries sustained as a result of falls by elderly constituents //2013//***

The Department of Health understands that communities are the center of health care. Thirty-seven local health councils are maintained by the department to gather feedback and recommendations. This allows for modification of services and programs to meet the needs of individual communities. By focusing on community health, the Department will reduce health disparities, the transmission of infectious diseases, and exposure to environmental dangers that can be detrimental to health. DOH will also ensure that communities are prepared to address any health emergency that may arise.

The Public Health Division (PHD) Director is Jack Callaghan, PhD. The PHD Director's Office includes two Deputy Directors. /2012/Maggi Gallaher, MD is the current acting Public Health Division Director. Efforts are underway to fill the Director position. The Director's office continues to have two Deputy Directors.//2012//***2013/The current acting Public Health Division Director is Michael Landen, MD. Maggi Gallaher is the Public Health Division Medical Director and we continue to have two Deputy Directors.//2013//***

The Public Health Division (PHD) consists of 5 Region Offices, an Office of Border Health, a Pharmacy Office, and 5 Bureaus: Program Support, Health Systems, Chronic Disease, Infectious Disease, and Family Health. The Family Health Bureau is the largest bureau in the Public Health Division. The Family Health Bureau Chief is Emelda Martinez.

The Family Health Bureau (FHB) is located in the Colgate Building at 2040 South Pacheco, about six blocks from the main DOH building. Organizational charts for the Family Health Bureau and the Public Health Division of the Department of Health are in the Appendices. Maternal and Child Health is managed by Carol Tyrrell. Susan Lovett is manager of the Family Planning. Family Food and Nutrition (WIC) Program director is Deanna Torres. /2012/The Children's Medical Services (CMS) program manager retired. Susan Chacon, MSW is the new CMS program manager. Susan comes to us with years of CMS experience and knowledge. The Maternal and Child Health Epidemiology program is now overseen by Emelda Martinez.//2012//***2013/ The MCH section manager is currently vacant; FHB chief, Emelda Martinez is currently managing the MCH section. //2013//***

The FHB is organized into five programs: 1. MCH Epidemiology, 2. Family Planning, 3. Children's Medical Services, 4. Family Food and Nutrition and, 5. Maternal and Child Health. The FHB is responsible for carrying out all but two of the Title V programs. The Adolescent Health Program and the Child Safety Program are located within other DOH divisions.

The Adolescent Health Program is housed within the Health Systems Bureau in the Public Health

Division (PHD.) The Child Safety Program has been located in the Injury Prevention and Emergency Services Bureau for several years and recently moved to the Office of School Health, the Adolescent Health Program Manager reports directly to the PHD Deputy Division Director. The Division felt Adolescent Health belonged within that Office due the Governor's initiative to better fund the Office of School Health by providing 34 new school based health centers and to involve youth in policy making for those centers.

Those programs with allotments under the Title V Program are: Children's Medical Services for Children with Special Health Care Needs, the Maternal Health Program, the Child Health Program, the Child Safety Program, Adolescent Health and the MCH Epidemiology Program. Other partner programs administered within the same bureau are: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the WIC Farmer's Market Nutrition Program, the Commodity Supplemental Food Program, the Title X Family Planning Program, the state sponsored Families FIRST Perinatal Case Management Program. The Dental Program continues to be in the Health Systems Bureau, with easy access to the FHB/Title V MCH Agency for consultations on oral health in mothers and children.

The administration of Governor Richardson has benefited the Title V Program due to its focus on children's issues. Due to a current hiring freeze and budget constraints personnel processes and contracting processes are still very inefficient although great effort has been exerted to try to shorten the processes. Many administrative changes took place based upon an analysis done of DOH by a private consultant. However, due to the economic environment many of the processes have been put on hold.

Maternal, Child Health Program (MCH) consists of the Maternal Health Section Manager, the Child Health Program Manager, the Maternal Health Program Manager, a Child Health Consultant and support staff. This small staff obtained the ECCS and Project LAUNCH grants. These grants have provided a unique opportunity to bring together public and private partners to form The Early Childhood Action Network (ECAN) a statewide network of over 300 early childhood champions dedicated to improving the health and well-being of young children in New Mexico by raising awareness of policy makers as well as business leaders, families, educators, early childhood providers, health workers, and community members. The MCH Section, also includes the Families FIRST Program, a state funded perinatal and child case management program, which works very well within the context of the MCH Section and strengthens its ties to daily direct services.

The MCH Epidemiology Program in the Family Health Bureau has been modified to better serve the data and information needs of the FHB and its many partners. It has incorporated the resources that support data, surveillance and epidemiology for child health needs such as birth defects, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group. The MCH Epidemiologist currently utilized to aid in the data collection and evaluation of MCH data, position funded by SSDI, to work on Title V MCH specific data and assessment tasks. This will include assistance with the development of state plan to assess childhood obesity and underweight; coordination of comprehensive assessments; the MCH Block Grant and analysis of WIC data for selected priority topics. **//2013/This section is also responsible for the Infant Mortality data and being on the Infant Mortality workgroup. //2013//**

The organizational Structure of the FHB remains essentially the same. The Bureau is constantly evolving and working to continue to meet the needs of the people of New Mexico despite the staffing shortages and budget shortfalls.

FHB-PHD Organizational Changes Information Technology Consolidation: The Governor's Executive order to consolidate all information technology (IT) operations in State Government has greatly impacted IT and program operations All IT functions and staff were consolidated within cabinet and executive agencies and now report to the agency Chief Information Officer (CIO) of

that agency. The Governor's Chief Information Officer control and manage of all IT expenses within the agency, either by the establishment of an independent IT organizational budget or by the establishment of administrative financial controls of IT expenses within existing agency budgets, subject to the approval of the Cabinet Secretary. The cabinet or executive agency CIO has approval authority over all agency IT-related spending, subject to the approval of the Cabinet Secretary. The cabinet or executive agency submits a complete inventory of agency IT hardware, software and licenses in a standardized electronic format, to the Office of the CIO by June 1.

The difficulties previously encountered with the financial accounting system are being resolved. There have been steps to assist in training needs. The Family Health Bureau (FHB) has implemented a fiscal group designed for senior fiscal staff to assist those that may be experiencing difficulty. This has proven effective. FHB also scheduled a managers training session to assist managers with the financial system, how to obtain reports, view balances, etc. This was well received and a follow up session was requested.

***An attachment is included in this section. IIC - Organizational Structure***

## **D. Other MCH Capacity**

### **III. D. 1. Title V Director's Office**

The Family Health Bureau houses 10 separate programs. The Bureau Chief, the Medical Director and program support staff work collaboratively as a team to use resources strategically to meet identified needs within this population depending on program focus. Bureau Chief, Emelda M. Martinez oversees all programs and works with each of the 8 program managers for direct oversight of each program. Ms Martinez has extensive MCH management and experience. As an RN she worked in the Pediatric Intensive Care Unit at St. Vincent's Hospital for 10 years. She worked with Human Services in the Medicaid Division managing the Maternal, Family Planning, EPSDT and Midwifery programs. She has worked with the Department of Health for 5 years managing the Families FIRST case management program and Maternal and Child Health programs

Dr. Elizabeth Matthews serves as the Title V Medical Director. She is a board certified pediatrician, and served as Medical Director for CYSHCN in New Mexico for the last 4 years. As a pediatrician Dr. Matthews served CYSHCN for fourteen years at the University of New Mexico. ***/2013/Dr. Matthews retired December 30, 2011./2013//***

The programs in the Bureau consist of Women Infants and Children (WIC), which includes two Farmers Market programs and the Breastfeeding program; Children's Medical Services (CMS) includes the Genetic Screening program, Newborn Hearing program and Birth Defects program; Maternal Child Health (MCH) includes the Midwifery program licensing both certified and licensed midwives, the Child Health program, Maternal Health program, High Risk Pregnancy program and the Families FIRST perinatal case management program; The Family Planning section includes the Teen Pregnancy Prevention program, Teen Outreach program and Male Involvement programs. The MCH Epidemiology section consists of two epidemiologists, a clerk and a health educator. As of June, 2010. The positions of program manager and two additional epidemiologists are vacant. It includes Pregnancy Risk Assessment Monitoring (PRAMs) and the State Systems Developmental Initiative program (SSDI), an is responsible for coordinating the Title V Block Grant application, report, and five year needs assessment. The MCH Epidemiology program is responsible for all data collection and analysis between Departments, Divisions and programs.

The Bureau administrative staff consists of Monica Montoya, Financial Administrator and Amanda Sandoval, Clerk Specialist, who provide overall Bureau program support. ***/2013/Ms. Montoya retired February 2012./2013//***

### III. D. 2. Maternal and Child Health, Title V Funded Staff

Carol Tyrrell, RN, is Section Manager & supervisor of 5 programs, 4 programs funded by Title V & 1 revenue driven program. She supervises 7 State office staff. ***//2013/Ms. Tyrrell retired November 2011.//2013//***Jaymi McKay, RN, LM, is the Maternal Health Manager, responsible for the High Risk Prenatal program, Midwife Licensure and Regulation & the Maternal Health program. ***//2013/Ms. McKay resigned 2011. Wreatha Carner, RN, CNM is the new Maternal Health program manager//2013//***The Child Health Manager, Gloria Bonner, is responsible for the ECCS Grant, Las Cruces Home visiting contract, & program activities that focus on child health. Health Educator, Diane Denedy-Frank, MSW, assists with segments of the ECCS grant & the child health component of the program. She also assists the Maternal Health Program Manager with special projects. Amanda Romero, Clerk Specialist, provides office support for MCH staff. Administrator II, Rima Varela, performs budget operation processes for MCH program. ***//2012/The Maternal Health Program Manager position is currently vacant.//2012//***

The Families FIRST Program is a revenue driven program obtaining reimbursements negotiated through Managed Care Organization (MCO) contracts & Medicaid (JPA). Maureen Burns, Program Manager, supervises 5 state staff & provides oversight of 4 Regional Coordinators, 24 Care Coordinators, & 5 Clerks. Social Worker Consultant, Laura Sullivan, MSW, develops needs assessments, training to address needs & improve services to clients, & quality assurance. ***//2013/Ms. Sullivan resigned this position has not been replaced. //2013/Marilyn Pearson, Registered Nurse Consultant, provides programmatic direction to 4 Regional Coordinators. She also monitors the Families FIRST Provider network & provides oversight of quality improvement for the perinatal case management population. //2013/Paula Timmerman, RN, has replaced Ms. Pearson//2013//***Care Coordinators provide care coordination for pregnant women & children, assist clients with Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) & the MCO process. They also assist with establishing medical homes, community resources & referral networks. Families FIRST Care Coordinators are located in 23 sites throughout the state. Lorraine De Vargas, Management Analyst, maintains financial processes & budget operations. Jessica Marquez, Medical Secretary, maintains client & claim-processing databases. Rita Carmen Herrera, Clerk Specialist, provides clerical support for Families FIRST staff.

### III. D. 3 Children's Medical Services

Lynn Christiansen, LMSW served as the Title V Children and Youth with Special Health Care Needs (CYSHCN) Director from 1999 until her retirement in April, 2010. A request to post the position to hire her replacement has been submitted. During this time, Ms. Susan Chacon, LISW has been selected to serve as the Interim Title V CYSHCN Director. Ms. Chacon has 10 years of program management within the Maternal and Child Health Program. Ms. Chacon has been working with the CYSHCN program manager for many years. The Title V CYSHCN Director position is the Statewide Program Manager for Children's Medical Services, under which fall the CYSHCN Program, The Multidisciplinary Specialty Outreach Clinic Program; the Newborn Genetic Screening Program; the Newborn Hearing Screening Program, the CMS Family Infant Toddler Program and the Healthier Kids Fund Program. ***//2012/Ms. Chacon was promoted into the role of CYSHCN Director in October of 2010.//2012//2013/Tammy Voisine is now the Newborn Hearing Screening Program coordinator.//2013//***

CMS hired a new Medical Director in 2008, Dr. Janis Gonzales who is a pediatrician with many years of experience working with CYSHCN. Dr. Gonzales is Board Certified in Pediatrics and in Hospice and Palliative Medicine, and has a Masters Degree in Public Health. She previously spent 9 years in private practice and then worked in hospice and in Early Childhood Developmental Screening before joining CMS. She also had a daughter with special needs. Dr. Gonzales serves as the AAP Chapter Champion for the EHDI program and works closely with the newborn hearing screening coordinator.

CMS has 68 staff in 29 field offices throughout the state along with 10 state office staff for a total

of 78 staff presently. All staff are involved in the Title V CYSHCN programs. With a former staff of 120 statewide, this highlights the considerable vacancy rate that has been shouldered by remaining staff. The workload has not diminished, and has, in fact continued to increase in direct service, administrative and fiscal responsibilities. The staff capacity is down 31% in the last decade. Social workers, Supervisors, and Program Managers alike are covering vacant caseloads, traveling long distances to try to assure coverage to CYSHCN statewide. In addition, the program was recently given the administrative task of annual renewal of 700 providers while the Business Operations Specialist and the CMS Financial Manager Positions are vacant. The request to hire has been approved to fill 4 Social Worker positions and 1 Social Worker Supervisor position -- these hires are in process. Five additional field social worker positions are becoming vacant this year and will remain so indefinitely./2012/ The hiring freeze, lack of exemption to hire Public Health Social Workers and movement of staff due to retirement or promotions have had a severe impact of staffing in the field offices and state office. The closure of the CMS FIT program allowed the transfer of CYSHCN cases to the CMS FIT social workers to assist in partially alleviating vacancies in the Regions, but numerous vacancies remain./2012//

#### Region 1

2 Social Workers /2012/One social worker moved from a FIT caseload to a CYSHCN caseload//2012//

#### Region 3

1 Program Manager  
1 Social Worker Supervisor  
5 Social Workers

2 Vacant Social Worker positions /2012/The 2 social work positions are still vacant though the Region is in the process of hiring 1 social worker. One clerk position was eliminated leaving one clerk for the whole region//2012//

#### Region 2

1 Program Manager  
2 Social Worker Supervisors  
6 Social Workers  
1 Nutritionist  
5 Clerks  
1.5 Dental Case Managers

This region has lost 2 Social Worker positions this Spring, with the planned retirement of another Social Worker Supervisor and a Social Worker by Fall, 2010. /2012/Region 2 is now at a 60% vacancy with the retirement of a social work supervisor and 2 social workers. 2 additional social workers moved to different agencies. The vacant positions have not been released for hiring yet./2012//

#### Region 4

1 Program Manager  
2 Social Worker Supervisors  
7 Social Workers  
3 Client Service Agents  
6 Clerks

/2012/One social work position was recently eliminated. The remaining 2 social work positions are vacant and not released for hiring yet. The Nutritionist position was eliminated. The Program Manager is retiring in June 2011 and there is a possible retirement of a Social Work Supervisor in December 2011./2012//

There are 3 vacant social work positions.

Region 5  
2 Social Worker Supervisors  
11 Social Workers  
1 Nutritionist  
9 Clerks

There are 3 vacant Social Worker positions and the Program Manager position is also vacant. /2012/One social worker position was eliminated. Two social worker positions are still vacant. One of the social work supervisors is now the Acting Program Manager as this position remains vacant.//2012//

The CMS State Office is down five crucial positions of fifteen total assigned to State Office. Vacant are: the Title V CYSHCN Director, the CMS Financial Manager, the Health Educator in charge of NMMIP/Youth Transition, the Business Operations Specialist/Clinic Coordinator, and the Family Infant Toddler Program Coordinator. The last three positions have been eliminated and will not be filled. The Financial Manager is in the process of being hired. The CMS program was unable to hire social workers for several years due to retention and recruitment issues and more recently the addition of a statewide hiring freeze initiated in 2008. /2012/The Financial Manager position was filled in June of 2010 by Paul Frey who has many years of financial management. The CYSHCN Director position was filled in October 2010. The Newborn Hearing Screening Coordinator position has been vacant with Ms. Chacon covering both this position and the Director position since April 2010. The program is currently in the process of hiring for the Newborn Hearing Coordinator position. Three positions were eliminated from the CMS State Office: the Health Educator, the CMS FIT Coordinator and the Business Operations Specialist/Clinic Coordinator. The remaining staff is doing their best to cover the duties of these positions.//2012//

The FIT Coordinator resigned her position in 2009 and this position was recently eliminated by DOH. Two FIT social worker positions in Region 4 have remained vacant for several years and there are 2 FIT social workers retiring in Region 2 in 2010. It has been decided by the Public Health Division and the Developmental Disabilities Division that it is no longer feasible to continue the CMS-FIT program. The CMS FIT social workers will become CYSHCN social workers and the clients receiving service coordination will be transitioned to other EI agencies. /2012/The CMS FIT program was discontinued in July 2010. Clients were transferred to other community FIT providers and the CMS FIT social workers began covering CYSHCN caseloads.//2012//

The state office staff consists of the Title V Statewide CYSHCN Program Manager, the CMS Medical Director, two nurse consultants who work with Newborn Genetic Screening, a Newborn Hearing Screening Coordinator whose position is funded by a HRSA/MCHB grant, a clinic coordinator, a financial specialist, a training and development specialist and clerical staff.

The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, regional program managers and key state office staff. The management team meets monthly to review policy issues related to the implementation of the CMS programs.

The Birth Defects Prevention and Surveillance System is maintained by the Office of Epidemiology in the DOH. The data is being housed in the Newborn Screening Tracking system which integrates data for newborn hearing, newborn genetic screening and birth defects.

Working within the program are at least two parents who have children with special health care needs, and others who were children/youth with special health care needs or had sisters or brothers with special needs. In addition, the Title V CYSHCN program contracts with Educating Parents of Indian Children and Hands and Voices to provide support and training of parents. In this way, the program has internal and external family expertise.

The CMS CYSHCN management team participates in the planning and evaluation of the delivery of services to CYSHCN. With a Statewide Program Manager who is a social worker and four District Program Managers who are also required to be social workers, as well as 12 Social Work Supervisors, the 44 social workers in the CYSHCN program receive ongoing supervision and evaluation of their job performance.

The CMS program is working in collaboration with the Family Health Bureau MCH Epidemiology program to improve its data collection and analysis of the newborn screening program and other health indicators especially as reported in the 2001 SLAITS survey. Supervisors evaluate their services in an ongoing fashion, with a computer program that assists them in monitoring caseload size. This system needs to be replaced as it is no longer viable, but a new system has yet to be determined.

#### III. D. 4. Maternal and Child Health Epidemiology

The Maternal and Child Health Epidemiology program coordinates the Title V Block Grant and Needs Assessment, the State Systems Development Initiative (SSDI), and the Pregnancy Risk Assessment Monitory System (PRAMS), and conducts data analysis for other programs. Currently, there are two epidemiologists, a health educator and a clerk. Eirian Coronado, MA, coordinates the PRAMS survey. Alexis Avery, PhD, MPH, coordinates the Title V grant & Needs Assessment, and is the SSDI director. There are two vacant epidemiologist positions, and the position of program manager was dissolved. Due to budget cuts and the hiring freeze, it is unknown when vacancies will be filled. /2012/MCH Epi hired a part-time PRAMS epidemiologist in 2010.//2012//**2013/Dr. Mary Shepherd is now full time with the PRAMS program. //2013//**

#### III. D. 5. The Family Planning Program (FPP):

There are 51 Family Planning Program staff in Public Health Offices throughout the state and 9 State Office staff. /2012/ There are 40 Family Planning Program staff in Public Health Offices throughout the state, with 10 vacancies. There are 12 State Office staff, with 2 vacancies. //2012// The field office staff consists of nurses, clinical nurse practitioners, and clerks who provide direct services to clients. The Program Manger in the State Office manages the statewide Family Planning Program including oversight of budget, personnel, Federal Grant requirements and contact with the Office of Population Affairs in Dallas and Washington, DC. The Program Manager supervises Program staff and ensures coordination of Family Planning Program activities with the Family Health Bureau, the Public Health Division and the Department of Health.

### **E. State Agency Coordination**

#### III. E. 1. Office of Title V Director

The Title V Director, Emelda Martinez, is the Project Director of the Early Childhood Comprehensive Systems (ECCS) Grant. This grant's advisory board, the Early Childhood Action Network (ECAN) is a collaborative of state agencies listed in III E 1 for Project LAUNCH, & also includes public/private partnerships. The public/private partnerships include: UNM Family Development Center, The Center for Developmental Disabilities (CDD), & The NM Pediatric Society.

The MCH programs enhance the capacity of the Title V program through UNM Family Development Center, the NM Pediatric Society, The Center for Developmental Disability, and the County Health Councils. We share available technical resources, data, training, and educational programs.

#### III. E. 2. Maternal & Child Health

Project LAUNCH, a SAMHSA grant, required the formation of a multi-agency team (MAT) consisting of State managers from Human Services Dept. (HSD), Public Education Dept. (PED), Children Youth & Families Dept. (CYFD), & Dept. of Health (DOH). MAT meets on a monthly basis as a collaborative council to support the New Mexico Project LAUNCH initiatives. These same agencies, as well as public/private partnerships, also work in collaboration to support the Early Childhood Comprehensive Systems (ECCS) grant.

The 2009 ECCS Grant supported the hiring of an Early Childhood Coordinator (ECC). The purpose of this position is to align and coordinate all state-level early childhood programs and services to create an effective and efficient structural, functional, and operational system to offer early childhood services for children, birth through eight and their families.

The ECC position is being housed within the Office of the Secretary of the New Mexico Department of Health and will report directly to the Deputy Cabinet Secretary. The ECC is working with the Child & Youth Policy Advisory in the Office of the Lieutenant Governor and will have the authority to work across agencies to discuss and develop implementation of the strategic plan recommendations outlined in the ECCS grant and the 2009-2012 New Mexico Early Childhood Comprehensive State Systems Strategic Plan. The ECC will also work directly with the Secretaries of Health, Public Education, Human Services, and Children, Youth and Families as members of the Children's Cabinet, as well as other agency groups and public/private partnerships, to accomplish the goals of the Strategic Plan.

//2012/The year 2010 was an election year and New Mexico saw a change in administration. The transition of one administration to another has left state agencies with new leadership. Key contacts and partners at the cabinet-agency level are no longer involved with early childhood or children's issues in general. The relationships and commitments that existed just a few months ago are no longer in existence and the task of educating, informing, and building bridges depends on the families, advocates, educators, associations, the Early Childhood Coordinator (ECC), and the grant staff. The ECC has been moved to the Family Health Bureau and now reports to the Title V/ECCS Project Director.//2012//**2013/ The NM Children's Cabinet has reorganized and began meeting in late 2011. Their priorities are: infant mortality, obesity, prescription drug abuse, and early learning. The Early Childhood Coordinator has resigned. //2013//**

#### Pregnancy Care

Federally qualified health centers and primary care association(s): At the state level, the Community Health Systems Bureau oversees the primary care program, administering grants of state money and regularly communicating with each center and association, as well as the New Mexico Primary Care Association. FHB managers are meeting on an ongoing basis with the leadership of the Health Systems Bureau to study access to prenatal care statewide and to strategize how to increase access. University of New Mexico (UNM): DOH prenatal care clinics all refer high-risk patients to primary care or private providers, or UNM Health Sciences Center (HSC). All of these are under agreements with the Maternal Health Program to provide appropriate high risk care. UNM HSC is also under contract to provide low-risk care to 431 medically indigent Albuquerque residents. Maternal Health collaborates with UNM HSC to improve safety-net prenatal services statewide. Tertiary care facilities: Tertiary Care Facilities are so determined by specialty services and capacity. In NM there are two "level III perinatal facilities" with maternal-fetal specialists, neonatal specialists, and facilities to provide specialty care. These are: University of New Mexico Hospital and Presbyterian Hospital, both located in Albuquerque. They have a joint transport system to transport women in pre-term labor from around the state.

#### III. E. 3. Family Planning Program

In order to reach clients statewide, Family Planning Program (FPP) contracts with Primary Health

Care organizations. FPP provides monetary compensation in the form of fee for family planning services and by providing contraceptives, medications to treat STIs, prenatal vitamins, and laboratory testing such as Pap, syphilis, chlamydia and gonorrhea testing. The Primary Health Care clinics provide low/no cost services, which include some preventive and counseling services. This collaboration is crucial to clients' access to family planning services in a rural state like NM where clients may have to travel over 30 miles to the nearest Public Health Office.

FPP has a collaborative relationship within the STD Program for the management of the CDC Regional Infertility Prevention Project for decreasing Chlamydia infection in young women. FPP works with the NM Human Services Department Medical Assistance Division which oversees the NM Family Planning Waiver Program on projects such as the Emergency Contraception Pill Public Media Campaign.

FPP and New Mexico Teen Pregnancy Coalition (NMTPC) collaborate to reduce teen pregnancy with Plain Talk and the Teen Outreach Program (TOP). The Plain Talk program is a community-based initiative proven to help adults develop skills to communicate effectively with teens about reducing sexual risk taking. Plain Talk and TOP are offered in Doña Ana County and Albuquerque. FPP and NMTPC issued Challenge 2010, to reduce teen birth rates for teens from 2006-2010 by 15%. Several counties are meeting the goal of the average birth rate (2006-2008) being at least 15% lower than the baseline birth rate (the average birth rate from 2001 to 2003). Four counties have reached or exceeded the goal for both 15-17 and 15-19 year olds and three counties have reached or exceeded the goal for 15-19 year olds. Two counties reached or exceeded the goal for 15-17 year olds, including Bernalillo County, the county with the highest population in NM. Three other counties are very close to the goal, including Doña Ana County, which in 2006 had its first reduction in birth rates since 1998.

***//2013//In May 2011, FPP in collaboration with the NMTPC introduced "Challenge 2015" to establish a State's goal of reducing teen births by 20% from 2011-2015. The following five counties reached or exceeded the 5% reduction goal for both 15-17 and 15-19 year olds: Bernalillo, Chaves, Eddy, Sandoval, and Valencia. //2013//***

#### III. E. 4. Children's Medical Services

Both UNM and Presbyterian hospitals provide pediatric sub-specialists for 130 DOH Children's Medical Services (CMS) multidisciplinary outreach clinics throughout the state. Clinics provided include asthma, cleft palate, neurology, metabolic, endocrine, genetics and nephrology. Providing services and multidisciplinary clinics statewide, the CMS Program connects with over 700 medical providers, community social service agencies, state agencies and hospitals. These relationships form the basis for critical care coordination that the CMS social workers provide for CYSHCN clients statewide.

CMS works closely with Families First, the WIC Program, and the Title V Child Health Unit as well as all of the State's Human Services Agencies. CMS social workers assess insurance options for clients and assist clients in applying for Medicaid and S-CHIP. The CMS Family Infant Toddler (FIT) program now requires mandatory insurance screening on all clients enrolled in the program. Additional FIT providers have being trained in PE/MOSAA.

CMS-FIT staff works with Children Youth and Families (CYFD) to implement the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) where children birth to three years of age with a substantiated case of abuse or neglect must be referred to early intervention (EI). The CMS Medical Director participates in the New Mexico Interagency Coordinating Council (ICC) which is the advisory body to the FIT program. The Council is made up of representatives from Medicaid, CYFD, Public Education Department, Public Insurance Commission, the NM Pediatric society, local EI providers, UNM and families.

*//2012//The CMS FIT program was closed due to budget issues, however, the CMS CYSHCN*

social workers continue to work closely with CYFD when a CMS covered child is taken into custody. The CMS Director and Medical Director participated in a forum in the fall of 2010 sponsored by CYFD to address the provision of continuous medical care for children taken into custody.//2012//

The CMS Medical Director represents CMS on the Multi-Agency Team which advises Project LAUNCH, a project designed to increase quality in all early childhood service areas. Other team members include representatives from United Way, NM Public Education Department, the Developmental Disability Services Division, the Injury Prevention Program, the NM Hospital Association, the Children, Youth and Families Department, and the Human Services Division (Medicaid).

/2012/The CMS Medical Director worked with Project LAUNCH to develop public service announcements around infant development and bonding. The Medical Director and Project LAUNCH also worked with the NM Pediatric Society and UNM to begin implementation of a web based Medical Home Portal for CYSHCN, families and providers.//2012//**2013/Project Launch will provide initial funding to begin populating the Medical Home portal with NM specific data. The CDD at UNM will provide the technical assistance to complete this activity. An-online Medical Home training for ancillary medical providers is being developed with CMS, the CDD and the Pediatric Society.//2013//**

CMS is represented on the Family to Family Health Advisory Board with PRO, the MCOs and Medicaid. The Newborn Hearing (NBH) Coordinator participates on the Deaf/Hard of Hearing (D/HH) Task force at New Mexico School for the Deaf (NMSD) to address unmet needs of D/HH children in their communities. Task force members include NMSD, parents, Commission for D/HH, The Public Education Department (PED), and local school districts. She is also a board member of Hands and Voices, a parent organization that supports families who have children that are deaf or hard of hearing. The NBH Coordinator also is the chair of the CDC sponsored Diversity Committee which includes federal agencies, state health departments, University faculty, families and those working on improving access to care for minority children who are deaf or hard of hearing.

With the Governors' Insure New Mexico Initiative, coverage has expanded regarding 0-5 programs and youth above age 19 programs for Medicaid-like program for non-Medicaid children and youth. The State Coverage Initiative Program was instituted in FY05 for employers with less than 50 employees. This program requires a minimal payment by both the employer and the employee and provides comprehensive health coverage. Funding varies and currently this program is closed to new enrollment. CMS has been a participant in the Medicaid Outreach Committee, which is actively working to enroll children onto the various Medicaid programs. There are several gaps in coverage in several of the Medicaid programs including lack of coverage for dental, vision and mental health services.

/2012/CMS is monitoring implementation of the Affordable Care Act (ACA) and the development of the Health Exchange in the State. The CMS Leadership and the Title V Director met with the Medicaid Director to explore the possibility of partnering or working collaboratively to provide comprehensive medical home services to children as part of the Section 2703 of the ACA and are looking for ways to have input on behalf of CYSHCN.//2012//**2013/CMS is meeting with Medicaid around care coordination and the Affordable Care Act.//2013//**

In partnership with the Health Systems Bureau and the Office of Oral Health, Region 2 CMS/OOH Social Workers (2) have provided case management and follow-up to improve access to preventative and restorative dental services. The CMS/OOH social workers have provided dental case management services to a total of approximately 500 clients/families per year in Santa Fe and Rio Arriba counties. The dental case management has involved collaboration with numerous agencies, programs and dental offices within the community. In addition to the case management services, there is coordination of Flouride Varnish Clinics for approximately 650

children (per year) who attend Head Start/Pre-K programs in the 2 counties. The screening at these clinics has identified approximately 200 children/families who are provided case management services. The SF Dental Case Manager assists with elementary school based sealant clinics and provides case management services to approximately 300 children/families screened and referred at these clinics. The CMS/OOH Social Workers place a strong emphasis on parent education as well through the various other components of the Oral Health Program. Family education about good oral hygiene and proper nutrition provided has proven very successful in regard to outcomes. Additionally, the CMS/OOH Social Worker in partnership with Community Dental Services have coordinated between 3-10 weeks (per year) of free adult basic dental care clinics in several counties of Region 2 .

CMS participates on the New Mexico Statewide Transition Coordinating Council (STCC) along with the NM Public Education Department (Special Education Bureau), Division of Vocational Rehabilitation (DVR), the ARC of New Mexico, Governor's Division on Disability, Albuquerque Public Schools and others. The NM STCC is designed to enhance interagency collaboration at the state level and cooperation at the local level, creating an infrastructure to develop and improve transition services.

CMS and UNM Hospital have negotiated an increase in the number of outreach clinics, but it has been difficult to provide sufficient clinics statewide due to insufficient funding and a shortage of pediatric specialists in the state. Funding through Governor Richardson's Disability Agenda for Children allowed CMS to increase the number of pulmonary clinics and contract with the Presbyterian Hospital pediatric pulmonologist. The CMS CYSHCN Program together with DOH Epidemiology initiated a series of asthma summits around the state. The summits resulted in recommendations addressing regional needs and helped develop local and state responses and interventions.

/2012/The CMS Medical Director participates in the newly formed NM Coalition on Asthma, a private-public partnership formed to improve asthma care and outcomes. CMS is also working with Project ECHO and with the NM Pediatric Society to increase provider education, especially in the Southeast area of the state where asthma rates are highest.//2012//

CMS contracts with Oregon State Public Health Lab to provide newborn screening in coordination with the CMS Medical Director, Nurse Manager and the nurse case manager, who work with OSPHL to assure short and long term follow-up on infants with a presumptive or confirmed positive. UNMH pediatric sub-specialists in metabolism and genetics are contracted to consult with CMS's Newborn Genetic Screening Follow-up Program.

CMS contracts with EPICS (Education of Parents of Indian Children with Special Needs) to provide leadership training to parents who have CYSHCN and will be participating in the integrated services Dine for Our Children DOC Project with the Navajo Nation with a focus on youth transition. During FY '10 and '11, the funding is provided through the supplemental funding from HRSA through the NBHS program. The contract is also being used to strengthen support and education specifically to Native American families whose children are deaf or hard of hearing. The NBHS program is also working closely with the New Mexico Speech and Hearing Association to provide training opportunities to NM audiologists around the standard of care in pediatric diagnosis of hearing loss. In a pilot project in Gallup, audiology services are being provided via telehealth. The project is in collaboration with UNM Department of Audiology, Project ECHO, Gallup Indian Medical Center, Rehoboth McKinley Christians Hospital, the New Mexico School for the Deaf and Growing in Beauty the early intervention provider on the Navajo Nation.

/2012/ The NB Hearing Screening program received funding for three years from HRSAMCHB. The funding will continue to support the relationship with EPICS who assist the program with outreach to Native American families who have children that are deaf or hard of hearing. EPICS has also developed relationships with the NM School for the Deaf and Presbyterian Ear Institute and is providing cultural competency training around Native American issues to these institutions

to help them better serve this population.//2012//

The MCH Collaborative was reorganized and is now comprised of CMS, Family Voices, Parents Reaching Out, the UNM Lend Program and the Developmental Disability Planning Council and a newly organized Parents of Indian Children with Special Needs (EPICS) 501 c 3 Program. All participants share the personal dedication and commitment to Title V. The rebirth of this collaborative has been supportive and innovative and is now resulting in the submission of collaborative grants that address transition and Native American CYSHCN issues.

### III E. 5. Families FIRST

The Families FIRST program provides case management services in 22 counties, contracting with the Managed Care Organizations (MCOs) provider network and public health offices to address the needs of pregnant women and children 0 to 3 years of age. Efforts have been made to increase Medicaid reimbursement rates and provide uniform services.

DOH is using Medicaid administrative billing across programs with the assistance of a contractor. Currently services may differ from MCO to MCO and from MCO to Medicaid fee for service. Both MCH and Families FIRST are members of the EPSDT Steering Committee.

Both CMS and Families FIRST work in close collaboration with all of the state's Human Services Agencies. Each program assists clients in applying for Medicaid and S-CHIP through the Medicaid On Site Application Assistance (MOSAA) and Presumptive Eligibility applications, and coordinates with the local Income Support Division (ISD) offices to assure quality client service.

### III. E. 6. Oral Health

The New Mexico Department of Health was awarded a grant from the Health Resources Services Administration (HRSA) to develop an infrastructure to implement a NM Oral Health Surveillance System (OHSS). In partnership with the Health Systems Bureau and District II Santa Fe CMS program, the statewide Oral Health Surveillance System (OHSS) pilot program is providing case management to over 300 clients through a part time social worker. The OHSS collects, measures and assesses oral health conditions and disparities in women, children and families. It also improves access to preventative and restorative services. Collaboration continues with numerous agencies, programs, and dental offices within the community.

There has been significant success in promoting oral health care with our participation in community outreach events such as local health fairs, Sealant Clinics, and the CMS Cleft Palate Clinics. People are utilizing the services of the dental case manager and appear eager to learn more about proper dental care for themselves and their children. Case management has been beneficial in helping clients follow through with appointments, accessing oral health care resources (including financial), and providing important educational information about oral health care maintenance. By improving access to oral health care through case management, the expected outcome is to reduce dental caries in children and establish an effective oral health screening and referral service for children and their families.

The Dental program helps individuals and families access dental services in the community through Dental Case Management program that currently serves Santa Fe and Rio Arriba counties. This program has been very successful and the DOH PHD is looking to replicate it statewide. The program also provides oral health and educational outreach in the community, including Head Start Programs and childfind screening clinics (SF and Espanola area), oral health education and dental case management/follow-up with the Fluoride Varnish Program (for children 0-5 years of age), coordination of these clinics in partnership with SF WIC, SF and Rio Arriba Headstart programs. It participates with the Office of Oral Health's Santa Fe Public School Sealant Activities (for children in the first through third grades) in provision of oral health education and dental case management/follow-up. The program coordinates free adult dental clinics throughout Region II in partnership with the Community Dental Services and provides

consultation to Region II Public Health Programs to provide enhancement of dental case management to Public Health clientele.

### III. E. 7. Office of Injury Prevention

The Office of Injury Prevention (OIP) of the Dept. of Health takes the lead on all aspects of unintentional childhood injury and has had a contract with SAFE KIDS Worldwide to be the sponsor for NM SAFE KIDS Coalition for the past 15 years. OIP and its partners provide car seat clinics, including free car seat checks and/or seat replacement, bicycle rodeos, including free helmet fitting checks and/or distribution, and health fair displays, including free smoke and carbon monoxide detector, as well as gun lock, distribution. OIP has also collaborated with the Children, Youth and Families Dept. during the past 5 years to provide home safety training for the 8,000 home daycare providers, and plans to expand the program to foster, adoptive and grandparents.

State coalition members were instrumental in the expansion of the child car seat law from age 1 to age 5. The first booster seat law in 2005 requires mandatory use for ages 5 and 6, and optional use, based on size, for ages 7 through 11. New Mexico is now the first state to require that all children under the age of 18 wear a helmet on every recreational vehicle.

Safety training and home visitation programs are being developed concurrently to serve an expanded population of first time parents. 4-6 counties will be added to the home visitation program in the coming year. As federal funds are diminished, OIP is seeking funds from other sources and permanent state funds. Safety training for home visitation programs will continue to expand. Given budget constraints, it is unknown how many additional programs and counties will be added in the coming fiscal year. The Office of Injury Prevention is actively seeking private charity and foundation funding to augment the programs.

The Network Coalition against domestic and sexual violence continues to expand its influence and function well. The award winning video entitled "Stolen Childhood" has continued to be distributed widely.

### III. E. 8. WIC

WIC Program: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Program safeguards the health of pregnant, breastfeeding and postpartum women, infants and children under five years of age with a household income 185% of FPL who are at nutritional risk. The WIC Program was the first in the nation to pilot a hybrid electronic benefits transfer card for WIC recipients using a cost effective model. WIC and the CMS FIT program developed a plan to increase referrals of children with special health care needs and children with or at risk for developmental delay.

Commodity Supplemental Food: This program provides supplemental nutritious food to low-income women, infants, children and seniors. USDA donates the food. New Mexico is one of the top three states in the country for food insecurity. NM has applied for more caseload from USDA and has not been granted new caseload for several years.

Farmers Market Nutrition Programs (FMNP): This program provides fresh fruits and vegetables from farmers' markets to women, infants, and children who are nutritionally at risk and who are participating in the WIC Program. Participants receive \$28 in coupons to be redeemed at local Farmers' Markets.

The WIC food package has been revised to include a greater variety of healthy food choices that are culturally acceptable. The WIC foods provided to families are specially designed to provide specific nutrients to help with the growth and development. WIC Program received a \$390,000 grant from USDA to reduce childhood obesity. USDA has provided New Mexico funding to serve

67,000 participants per month.

## **F. Health Systems Capacity Indicators**

### Health System Capacity

Poverty and lack of health care coverage are the two most serious problems facing New Mexicans. Moreover, geographic and cultural barriers and provider shortages present major challenges to New Mexico's capacity to address health problems within the MCH population. In 2011, NM ranked 43rd in per capita personal income at \$34,575 which was 83% of the national average. The state's poverty rate remains one of the highest in the nation. The State is among the five states with the highest rates of uninsured children. An estimated 26% of New Mexican women ages 18-49 are uninsured, along with 15% of children. In 2010, nearly 17% of New Mexicans reported that they were unable to get needed medical care because of the cost. Thirty-two of New Mexico's 33 counties are designated by HRSA as either "Medically Underserved," or "Health Professional Shortage Area (HPSA)." They are either entirely or partially underserved. More than 700,000 people live in these areas. Disparities due to race, ethnicity, age, and sex persist.

HSCI 01: The rate of children hospitalized for asthma per 10,000 children less than age 5.

Since 1999 the NM Asthma Coalition has brought community, statewide, and national partners together to address asthma issues in the state. In 2007-08 the Children's Medical Services (CMS) Program and the State Asthma Program of the NM Department of Health (DOH) held 7 pediatric asthma summits throughout the state to present asthma data, to raise awareness, to seek input and information from the community, and to network with local and state resources. A statewide initiative emerged from the summits involving the DOH and many diverse community partners to reassess asthma care in the state and formulate new strategies to address the issues identified in the Summits. Increased numbers of School-Based Health Centers will improve access to asthma care around the state. Project Envision NM and the UNM ECHO Program are bringing asthma education and consultation to health professionals in rural areas. The CMS program provides medical social workers statewide for asthma care coordination but budget cuts have reduced their numbers from 60 to 40. CMS contracts with UNM and Presbyterian Hospital Pediatric Pulmonary teams for 31 asthma outreach clinics throughout the State annually.

CMS will be maintaining the asthma outreach clinics around the state and adding an additional 4 asthma clinics to address the increasing demand for asthma assessment and treatment around the state. Limited funding and budget cuts have affected the program's ability to add additional clinics. CMS is also collaborating with the DOH Asthma Program on their Healthy Homes project, funded through a CDC grant. This project's goal is to reduce or eliminate housing --related hazards to promote housing that is safe, affordable, and accessible. Priority areas include asthma, lead, mold, and radon. Because asthma is one of the priority areas, they are piloting the project in the SE and SW areas of the state where evidence shows high emergency department and hospitalization rates due to asthma.

HSCI 02: The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen & HSCI 03: The percent of State Children's Health Insurance Program (SCHIP) enrollees who age is less than one year who received at least one periodic screen.

The EPSDT Advisory Committee of Medicaid membership is comprised of agencies including the Human Services Department (HSD), Department of Health (DOH), Managed Care Organization (MCO) leadership, and professionals that are involved in assuring infant health care. This committee meets quarterly and is working to improve the ability of providers in an MCO and direct fee-for-service environment to provide EPSDT services. The committee is also working to

promote use of primary preventive care in the EPSDT category by all ages of children. In addition, due to mounting evidence of developmental and behavioral problems among young children ages one through five, the need to screen and refer for anticipatory guidance has been noted as increasingly essential.

The NM Developmental Screening Initiative (DSI) was created through collaboration among the Early Childhood Action Network (ECAN), the Family Infant Toddler Interagency Coordinating Council (FIT/ICC), Envision New Mexico, the Center for Development and Disability (CDD), New Mexico Pediatric Society, and Parents Reaching Out (PRO), with support from the Commonwealth Fund and Assuring Better Child Health and Development. DSI provides the foundation for wide application of training on use of routine, standardized developmental screening and networking across disciplines throughout the system of care serving young children. In the February 2009, DSI published a developmental screening record booklet (in English and Spanish) as a guide for parents to follow and talk with the provider about their child's development, screens, and immunizations. These booklets are given to parents through hospitals, physician offices, midwives, home visitors, head start and early care and education centers, Public Health Offices, WIC offices, parent conferences, and other appropriate venues.

ECAN, the advisory council for the Early Childhood Comprehensive Systems (ECCS) grant is working on actions steps to educate providers about the use of standardized tools and the 96110 Medicaid reimbursement code. NM Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) advisory council is working to facilitate Ages & Stages Questionnaire (ASQ) training for home visitors and early care and education workers.

As of 2012, the EPSDT Steering Committee will be meeting on an annual basis and the focus of the meeting will be the CMS-416 report. The committee will be informed regarding Health Care Reform and the impact on the delivery of children's health care services.

HSCI 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Inadequate prenatal care is associated with increased neonatal mortality and low birth weight. Adequate prenatal care, case management, and community outreach are associated with improved birth outcomes and cost savings, especially for minority women. Women may not be motivated to seek care, especially for unintended pregnancies. Societal and maternal reasons cited for poor motivation include fear of medical procedures or disclosing pregnancy to others, depression, and a belief that prenatal care is unnecessary. Structural barriers include long wait times, the location and hours of clinics, cost of services, lack of child-friendly facilities, and a need for cultural competency.

Capacity is not adequate to meet the needs for prenatal care. The lack of willing and/or able providers results in some primary care clinics providing little to no prenatal care. High liability insurance rates for pregnancy care and the fear of litigation are significant disincentives to providing pregnancy care. In addition, pregnancy care is labor-intensive and not well reimbursed by Medicaid. Geographical access is a barrier to prenatal care in sparsely populated areas of NM, as it is for all health care. In some entire counties prenatal care is not available.

Strategies to increase access to care include supporting Certified Nurse Midwives and Licensed Midwives, who attend more than one third of the deliveries in New Mexico. The High Risk Prenatal Care fund and local health offices serve indigent women, who often start prenatal care late in pregnancy due to lack of funds. Title V supports four primary care clinics providing care to low-risk medically indigent women. The Birthing Workforce Retention Fund provides awards to prenatal care providers to help defray the cost of malpractice insurance premiums.

In 2011, prenatal care services were discontinued in four of the nine public health offices, and

difficulties in finding providers that are willing to work in more isolated areas of the state persist. It is expected that as the Affordable Care Act takes effect that women will be established before pregnancy with a health care provider. This is expected to insure access to both earlier and ongoing prenatal care for pregnant women.

#### HSCI 05 A Percent of low birth weight (<2,500 grams.)

Disparities in low birth weight persist by age, race, marital status, and education. Low birth weight infants are predominant among first-time mothers and women over 34 years of age. Native American women, unmarried women, and women with less than a high school education also have higher proportions of LBW infants compared to all New Mexico women. Preterm births are predominant among first-time mothers, moms over 34 years of age, Native American mothers, and those with less than a high school education.

The recent increase in births by elective and repeat cesarean section (scheduled cesarean section) contributes to the rate of late preterm births, which constitute a large proportion of low birth-weight babies, as there are no perfectly accurate predictors of fetal weight or gestational age against which to plan a delivery. Similarly, increases in elective and scheduled inductions contribute to the cesarean section rate, late preterm births, and low birth-weight babies.

The Maternal Health Program provides support and oversight for prenatal care offered in five of 54 local public health offices for women who cannot otherwise access prenatal care. The Program maintains financial agreements with 20 high risk prenatal care providers or groups in most counties where such providers are present, which require the providers to give care to any medically indigent woman with a high risk pregnancy who presents for care. The Program licenses and regulates all practicing certified nurse midwives and licensed direct-entry midwives, who attend approximately 30% of deliveries in NM, over half of them to medically indigent women. Although New Mexico's cesarean delivery rate is high, it is one of the three lowest in the country. This is partly due to relatively high participation of nurse midwives and direct entry midwives, whose patients are less likely to deliver by cesarean or to have low birth weight babies.

Provider access continues to be a major obstacle to prenatal care, which would reduce the number of low birth weight babies. In addition to the measures listed above, the Program administers a Birthing Workforce Retention Fund, which awards between \$5,000 and \$10,000 to eligible applicants whose liability insurance rates have increased significantly for two consecutive years, to the extent its funding allows. Funding, never sufficient, continues to decrease, further limiting all the Program's efforts, except for the licensing and regulating of midwives.

Several Department of Health Workers attended the HRSA sponsored Infant Mortality Summit in New Orleans in January 2012. This group is working to reduce infant mortality. One approach is through work to reduce preterm births through implementation of methods proven to be effective. As 17 hydroxyprogesterone becomes more widely available (not the expensive brand Makena) through a New Mexico compounding pharmacy, the numbers of very low birth weight infants should decrease.

#### HSCI 05 B: The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State - Infant deaths per 1,000 live births

The most recent birth+Medicaid report was 2000. NM PRAMS is the only current source of data that compares Medicaid with non-Medicaid paid mothers and infants until NM VRHS has adequate resources to link the birth file to Medicaid, and potentially the infant birth+death file to Medicaid.

The infant mortality work group is continuing to develop blueprints for each of two goals related to reduction of infant deaths in the first year of life. This work has resulted in collaborations between

various state agencies, a state university system, and groups of providers. The work targets reductions in preterm births and campaigns to educate providers and the population toward reduction of post-neonatal infant deaths. These efforts are both statewide and directed toward a few particular counties identified through state health data analysis.

HSCI 05 C&D: The comparison of health status indicators for Medicaid, non-Medicaid, and all populations in the State -- Percent of Infants born to pregnant women receiving prenatal care beginning in the first trimester & The percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])

The lack of willing and/or able providers results in some primary care clinics providing little to no prenatal care. Also, high insurance liability rates and the fear of litigation are significant disincentives for physicians to provide pregnancy care. Additionally, pregnancy care is labor-intensive and is not well reimbursed by Medicaid, which reimburses at 85% of the cost of services.

In 2008, The Maternal Health Program conducted phone surveys of prenatal care/delivery services in each of New Mexico's 33 counties. This and other studies indicate deteriorating access to pregnancy care. Since 2005, three hospitals stopped delivery service. Twelve of 33 (36%) counties have no hospital that provides delivery services. Seven of 33 (21%) counties have no prenatal care providers: no obstetricians, no family practice physicians, no midwives. Increasing liability insurance premiums and low reimbursement rates have driven some providers to leave the state or discontinue obstetric services. Initiatives to recruit and retain providers in these underserved areas are continually being developed, evaluated, and reinforced.

The Birthing Workforce Retention Fund was passed as legislation in 2008. This fund makes direct awards to individual doctors and midwives to help defray the costs of their malpractice insurance premiums. NM DOH Rural Healthcare Practitioner Tax Credit Program incentivizes health care providers, including Certified Nurse Midwives, who provide care in rural, underserved areas with an income tax credit of \$3,000 to \$5,000 for each year they maintain a practice in an eligible locale. Proposals are being developed for alternatives to the torts system for compensating those with poor birth outcomes and for reducing negligent practice thereby increasing the number of individual practitioners willing to maintain obstetrical or midwifery practices in the state.

In 2007, NMVRHS began using a new electronic birth certificate system, and in 2008, adopted the new birth certificate based on the 2003 U.S. Standard Birth Certificate. As a result, birth data by payer of care are now available from some hospitals. However, many hospitals in New Mexico refuse to provide payer of care information, therefore it is not yet possible to analyze disparities by payer of care.

Methods used in the past to try to improve access to prenatal care have not proven effective. It is expected that as the Affordable Care Act takes effect that women will be established before pregnancy with a health care provider. As this happens it is expected to ensure access to both earlier and ongoing prenatal care for pregnant women.

HSCI 06 A: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

In New Mexico, infants age 0-1 are eligible for Medicaid if their family income is less than or equal to 185% of the federal poverty level (FPL), provided they meet other criteria. Infants are eligible for SCHIP if their family income is less than or equal to 235% FPL. For infants in households with an income between 185% - 235% of the FPL, some health care services may require a low co-payment at the time those services are provided. Some preventative services such as immunizations do not require a copayment regardless of household income levels.

The Family Health Bureau (FHB) staff participates in the EPSDT-Medicaid Advisory Committee. FHB works with partners to identify statewide strategies to address issues of uninsured or underinsured. New Mexico's public health offices and programs such as Families First, Children's Medical Services and WIC offer Medicaid on site application assistance. The percentage of infants enrolling is believed to have increased while numbers of births have decreased, both reflecting the economic recession in the US. In addition, New Mexico is working to establish the health insurance provisions required under the patient protection and affordable health care act. Because New Mexico has a large impoverished population, it is anticipated that as more parents qualify, their infants under age will also be enrolled. Infants of the poor are often enrolled with assistance from hospital staff at birth as the hospital wants to be paid for their effort. It may be that the parent of the newborn in some of these instances does not realize that their child has been enrolled and may therefore not understand how to maintain enrollment or understand that they should seek regular well child care.

HSCI 06 B: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs -- Medicaid Children

In New Mexico, children <19 are eligible for Medicaid if their family income is less than or equal to 185% of the federal poverty level (FPL), provided they meet other criteria. Children age 1-18 are eligible for SCHIP if their family income is less than or equal to 235% FPL. The Human Services Department has increased the amount of income that can be disregarded and the amounts that can be deducted from gross income, making it possible for children ages 0-5 to receive SCHIP at up to 300% FPL.

HSCI 06 C: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women

Pregnant women are not covered by SCHIP in New Mexico. Pregnant women qualify for Medicaid if their income is less than or equal to 185% FPL, provided they meet other criteria. The New Mexico Medicaid policy was successfully changed, and the Maternal Health Program participated in developing systems so that professional out-of-hospital birth attendants will be paid by Medicaid Managed Care Organizations for delivery services even when liability insurance cannot be obtained at less than 25% of the provider's practice income. A home birth is less expensive, and for some women it is their preference. This should improve pregnancy care access.

Changes in the state Medicaid approach in anticipation of enactment of the Affordable Care Act have created a mild climate of uncertainty. A positive movement in care to pregnant women is that home prenatal care and birth services for women in New Mexico are on the rise and as these services are cost effective, Medicaid is working with licensed midwives to improve communications for proper billing and reimbursements.

HSCI 07 A: The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

According to the 2010 US Census Bureau's most recent "uninsured" data, New Mexico had approximately 66,049 children (0-18 years of age) who were uninsured but eligible for Medicaid/CHIP based on a family income of up to 235% of the Federal Poverty Level (FPL) in 2009. 19.95% of the total numbers of children in NM are therefore below the 235% FPL. The NM Human Services Department (HSD) is working diligently in conjunction with the NM Dept. of Health to decrease the number of uninsured children. The NM Department of Health/Public Health Division currently assists with Presumptive Eligibility and Medicaid On Site Application Assistance (PE/MOSAA) through its Public Health Offices and the Families FIRST Case Management Program. Assistance is given to clients to enroll for Medicaid/CHIP programs by offering them information about the various Managed Care Organizations (MCO's) in the state and helping them complete the application forms. The NM Dept. of Health also continues to work

with Medicaid to improve provider reimbursement rates to increase the number of providers within the Medicaid system.

Medicaid eligibility measurement is complicated by: 1) the automatic eligibility assumption for infants born in NM, 2) the recent frequent changes to enrollment requirements from one per year, to once every six months, and back to once per year, and 3) by the Federal changes in eligibility documentation requirements. Alternate sources of children living at 185% of the poverty level might provide different estimates. State level poverty estimates for children are sparse and may be based on multiple conflicting sources. Other factors possibly affecting enrollment data may be shifting in the time allowed for eligibility recertification. The Department of Health Public Health Offices currently assist with Presumptive Eligibility and Medicaid On Site Application Assistance (PE/MOSAA), which assists many clients with the process of applying for Medicaid as well as the choosing a Managed Care Organization (MCO) to provide services.

HSCI 07 B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

All 33 New Mexico counties are designated as oral health professional shortage areas. Three counties do not have a resident dentist. The dentists in New Mexico are not evenly districted; approximately 50 -- 60% of practicing dentists in the state practice in NE Albuquerque, which is a metro area as compared to the remainder of New Mexico which is rural/frontier. Access to dental care is limited in New Mexico. This can be attributed to the lack of dentists in the state, low reimbursement by Medicaid, and low incomes resulting in large populations without dental insurance. The Office of Oral Health (OOH) has partnered with private providers, especially those linked to schools, to increase the number of children receiving preventive dental sealants and treatment services. OOH is continuing its efforts to work with the NM Dental Board, NM Health and Human Services Department, the NM Oral Health Council, the legislature, and associations to increase access for dental care. OOH continues to support public-private partnerships with the hope of increasing dental services to lower income children.

OOH continues to use general and federal funds to support low-income children who do not qualify for Medicaid but are in need of preventive and treatment services. OOH continues to use general funds to support the ongoing dental sealant program. OOH supported the passage of HB 187 (2011) to expand the scope of practice for a dental hygienist. The NM Health Care Board has recently implemented a new regulation allowing dental hygienists to apply dental sealants after an assessment by the dental hygienist. The rule change will allow for more students to receive dental sealants.

HSCI 08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program

Concern continues over gaps in coverage for chronic orthopedic/rehabilitation needs of uninsured children in New Mexico. The merger of Carrie Tingley Hospital (CTH) with the University of New Mexico Medical Center led to a change in the coverage of rehabilitative services. Currently, CTH is not providing rehabilitative services to patients unless they are able to pay out of pocket although funding was appropriated by the Legislature to CTH in the 1980's to cover such costs. To mitigate this, Children's Medical Services (CMS) places children with certain diagnoses on the New Mexico Medical Insurance Pool. This coverage is far greater than the \$15,000 limit for CMS Children and Youth with Special Health Care Needs (CYSHCN) and it is more comprehensive. The gap in coverage for chronic orthopedic/rehabilitative services results in disparate coverage for immigrant (mostly Hispanic) children, since most are unable to pay out of pocket. The New Mexico Medical Insurance Pool (NMMIP) is the main source of coverage for children with orthopedic conditions that are not eligible for Medicaid/SCHIP.

A contract with the Commission for the Blind is maintained and continues to assist with the purchase of technology for visually impaired children who would otherwise not have access.

SSI beneficiaries are offered care coordination by the CMS CYSHCN program. CMS Social Workers also assist SSI recipients turning 18 to apply for benefits as adults. At one time CMS received a monthly list from Disability Determination Services (DDS) providing names of all families allowed or denied benefits. CMS would contact these families and inform them of services offered by the program, such as care coordination and information about Parents Reaching Out (PRO), a Parent advocacy organization. Due to HIPAA, DDS is unable to provide these reports to CMS.

HSCI 09 A: Please see the attached document detailing availability and linkage capacity of Maternal and Child Health data.

The New Mexico Title V program has access to aggregate data reports and/or individual electronic data files within the DOH and across many agencies for assessment and evaluation purposes. The most important weaknesses are for evaluation studies and benefit-cost analysis, partially due to lack of cost data. Most data are from surveillance or required reporting systems.

The Maternal and Child Health Epidemiology program regularly receives birth and death files from the Bureau of Vital Records and Health Statistics (VRHS), and the PRAMS survey is housed within the MCH Epi program. Both of these inform the majority of Title V data requirements. For NM PRAMS, data are available starting with 1997 births.

In addition, MCH Epi acquires data from the Human Services Department for Medicaid and EPSDT data. WIC data are available through the Family Food and Nutrition program which is housed in the same bureau as the MCH Epi. program (Family Health Bureau.) Vital Records, PRAMS, YRRS and Hospital Discharge data are also on the Department of Health's online data query system IBIS <http://ibis.health.state.nm.us/home/Welcome.html>. The Department of Health recently implemented the Billing and Electronic Health Records (BEHR) system to monitor client encounters in DOH funded facilities, and BEHR staff are working to improve the system's reporting capacity. MCH Epi analyzes and reports data from several national surveys including the National Survey of Children's Health and the National Survey of Children with Special Health Care Needs, and the National Immunization Survey. Children's medical services collects Newborn Hearing Screening and Birth Defects data.

Linkage:

Linkage is an ongoing priority, but is hindered by a lack of personnel resulting from budget cuts and from the hiring freeze that went into effect in November of 2008. A preliminary, descriptive analysis of linked birth defects + birth + death was completed in the first quarter of 2007. VRHS performs linkage of birth and death files annually. PRAMS and WIC data have been linked and need to be analyzed. Birth and Death records are linked annually by VRHS. Birth defects registry data and birth certificate data are linked by the Environmental Epidemiology Program. New Mexico included a request for technical assistance on data linkage and accessibility in this grant report/application for 2010/2012. The Title V Epidemiologist has made this a top priority for the coming year, and is working with data managers to broker mutually beneficial data sharing agreements.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

The priorities and performance measure activities are inherent in the program activities undertaken by the Title V funded programs.

#### IV. A. 1. Maternal Health Program

Maternal Health provides statewide public health leadership to promote and improve maternal health care for underserved women in the state and improve the health of childbearing women by promoting systems that will strengthen community health and improve opportunities to assist families. The program administers the High Risk Prenatal Fund and the Birthing Workforce Retention fund, and is responsible for the budgets and contracts of each program. MH licenses and regulates both Certified Nurse Midwives (CNMs) and Licensed Midwives (LMs) in the state, increasing access to care for women in some of the most rural areas of NM. MH provides protocols, technical assistance and guidance to 10 Public Health offices that provide prenatal care to uninsured and underinsured women.

#### IV. A. 2. Child Health

The Child Health program builds on existing resources, aligns early childhood comprehensive systems and information sharing, and partners with the Children's Cabinet to address disparities in early childhood health and well-being such as: access to early childhood health, education, and family support related activities. The program also provides statewide public health leadership to improve the health of children ages birth-12, emphasizing early childhood wellness and family involvement, and strengthens community health to help families to adopt healthy behaviors for themselves and their children. This work is accomplished through building collaborations with public/private partners to champion services for children and families: Early Childhood Action Network (ECAN), experts in the field of early childhood, connecting theory, research, and practice to develop policy recommendations; Family Leadership Action Network (FLAN) supports family empowerment by promoting parent-to-parent peer coaching with facilitated learning methods. Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) promotes the wellness of young children up to age eight through a demonstration project -- the Santa Fe Children's Project. Additionally, Title V funds a position in the office of injury prevention and the office of adolescent health, both of which work to address federal and state child and adolescent health priorities.

*/2012/The Children's Cabinet is no longer meeting as of 2011. In addition, early childhood programs were disproportionately targeted in the 2011 Legislative Session and are expected to see millions of dollars in cuts. Through the hard work of committed advocates and families, some early childhood funds and waivers were restored, but overall, community providers, direct service providers, schools, and assistance programs will face budgetary challenges throughout State FY12.//2012//*

***/2013/The Children's Cabinet reorganized with the new administration and began meeting in December 2011.//2013//***

#### IV. A. 3. Family Planning Program

To improve maternal and infant health outcomes the NM DOH Family Planning Program provides access to affordable contraceptive services, supplies and information to all who want and need them. Priority is given to persons from low-income families at or below 250% of poverty level. The reproductive health services help women and men to plan their families and prevent unintended, including teen, pregnancies.

NM DOH Family Planning Program provides clinical reproductive health services statewide. Clinical services include providing a contraceptive method and/or a clinical exam visit. The clinical exam visit includes: a medical history/physical, family planning counseling, pregnancy testing (if needed), laboratory tests (as needed), testing and counseling for sexually transmitted infections (STIs), and a supply of a contraceptive method of choice. NM DOH FPP also provides educational services including community education & outreach and evidence-based teen pregnancy prevention programs such as comprehensive sex education, service learning programs, male involvement program and adult-teen communication program.

#### IV. A. 4. Children's Medical Services

Children's Medical Services (CMS) is federally funded through Title V Maternal and Child Health block grant and state general funds to serve as a safety net for the provision of medical management, payment for medical services, diagnostic studies and service coordination for Children and Youth with special health care needs (CYSHCN) throughout New Mexico. CMS is housed statewide in the local Public Health Offices.

##### Children and Youth with Special Health Care Needs (CYSHCN):

This program provides comprehensive medical care and critical care coordination for children with chronic medical conditions ages birth to 21 who are uninsured or underinsured and are not eligible for Medicaid and who meet CMS medical eligibility and income guidelines of under 200% of poverty. In some cases, Medicaid eligible children and youth receive Medicaid for the coverage of their chronic medical conditions and care coordination from a CMS Social Worker.

##### Multidisciplinary Pediatric Specialty Outreach Clinics:

These community-based pediatric specialty clinics provide multidisciplinary, coordinated diagnostic and/or on-going medical care to children and youth with pulmonary, endocrine, cleft palate, neurological, metabolic and genetic conditions. This service is available to all CYSHCN. Fees are charged for these services. Payor sources include private insurance, Medicaid and CMS for those who are not Medicaid eligible. CMS holds approximately 130 clinics per year.

##### Transition services for Youth with Special Health Care Needs.

CMS covers adolescents aged 14-21 years who are uninsured or no longer qualify for Medicaid. Age 14-21 is a critical time to intervene allowing youth to transition from pediatric to adult health care and to become ready for the work place. Care coordination plays a critical role in assisting the youth in obtaining educational support and community services as many of these youth who go unassisted during this life stage "fall through the cracks" and go without support and critical medical care. ***/2013/A proposal was submitted to HRSA to fund improved transition services in the medical home for the State./2013//***

##### Family Infant Toddler Program:

Service Coordination and/or Social Work services for children ages birth to 3 years of age with or at risk for developmental delay.

##### Newborn Screening Program:

Follow up and care coordination for infants, who fail their newborn hearing screen, and/or are found positive on the newborn genetic screening. The program expanded screening for 28 conditions per a legislative mandate in 2005. Newborn Screening for all newborns prior to discharge from the birthing hospital is mandated by New Mexico state law.

##### NM Medical Insurance Pool (NMMIP) Insurance Program

CMS will purchase NMMIP coverage for CYSHCN who have no insurance or Medicaid whose medical conditions are or are anticipated as being very high cost. NMMIP is also purchased for

youth who are transitioning out of CMS and are not eligible for other insurance programs.

## **B. State Priorities**

The ten priorities for the 2011-2015 Needs Assessment Cycle are:

1. Increase accessibility to care for pregnant women and mothers that provides care before, during and after pregnancy
2. Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.
3. Increase awareness and availability of family planning and STD prevention options.
4. Promote awareness of childhood injury risks and provide injury prevention strategies to families and caregivers of children.
5. Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options.
6. Increase the proportion of mothers that exclusively breastfeed their infants at six months of age.
7. Decrease disparities in maternal and infant mortality and morbidity.
8. Promote healthy lifestyle options to decrease obesity and overweight among children and youth.
9. Maintain specialty outreach clinics for children and youth with special health care needs.
10. Improve the infrastructure for care coordination of children and youth with special health care needs.

Many of the priorities encompass the priorities from the previous cycle. Two were replaced, and one was added. The following is a discussion of why the current priorities were selected:

### Access to Care

2005: Improve access to and use of health and health related services including health insurance and other coverage such as Medicaid, S-CHIP for all MCH population groups.

Access to care was the number one priority identified through the regional meetings and in the online survey. The 2005 priority was replaced with the 2010 priority to reflect a more realistic scope for the Family Health Bureau (FHB).

2010: Increase access to care for pregnant women and mothers that provides care before, during and after pregnancy

### CSHCN

2005: Improve the transition from childhood ages to young adulthood for children and youth with special health care needs to assure uninterrupted access to health care and related transition services.

The CMS program and its stakeholders elected to replace the 2005 priority with the two priorities below to more accurately reflect their greatest current need and capacity with regard to staffing and resources.

2010: Improve the infrastructure for care coordination of children and youth with special health care needs, and  
Maintain specialty outreach clinics for children and youth with special health care needs.

### Maternal Health

2005: Improve indicators of health in the preconception and perinatal periods, including but not limited to smoking, alcohol, folic acid use, family violence, intention of pregnancy, access to and use of health care, and maternal depression.

The 2005 priority was replaced with the following four priorities to identify more specific areas of focus that are within the scope of the Family Health Bureau, and that reflect the organizational structure of FHB and its partners. For example, FHB collaborates with Children, Youth and Families Department (CYFD) to address violence, and with various clinical practitioners for maternal screening and treatment.

2010: Increase accessibility to care for pregnant women and mothers that provides care before, during and after pregnancy

2010: Decrease disparities in maternal and infant mortality and morbidity.

2010: Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.

2010: Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options.

#### Violence

2005: Reduce indicators of violence affecting the MCH population with focus on reducing the number of children witnessing violence, the rate of substantiated child abuse and on reducing the percent of women who report physical abuse before and during pregnancy.

The 2005 priority was rephrased for simplification and to indicate a specific focus on infrastructure, and to include attention to youth interpersonal violence.

2010: Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.

#### Teen Births

2005: Reduce unintended births to teens, and the related prevalence of sexually transmitted infections among teens.

The 2005 indicator was rephrased to include all persons, including men, who benefit from family planning services, and to fit in to the scope of FHB and Title V programming.

2010: Increase awareness and availability of family planning and STD prevention options.

#### Healthy Weight

2005: Promote healthy weight and physical fitness among parents and their children; reduce overweight and obesity in the MCH population with focus on early childhood and adolescents to reduce psychological and chronic disease problems.

The 2010 priority reflects the results of the meetings and online survey. Maternal weight was not among the 25 priorities identified by Needs Assessment participants.

2010: Promote healthy lifestyle options to decrease obesity and overweight among children and youth.

## Injury

2005: Reduce rates of fatal and non-fatal unintentional injury among children and teens, with emphasis on interventions to prevent motor vehicle crash and household accident injuries.

The 2010 priority was rephrased for simplicity.

2010: Promote awareness of childhood injury risks and provide injury prevention protocols to families and caregivers of children.

## Youth Development, Mental Health

2005: Promote positive youth development experiences with emphasis on building personal and social assets at the family, school and community levels, and with a view to reduce the proportion of youth who engage in risk behaviors that have serious life-long consequences.

The 2005 priority was replaced with the following two priorities to better reflect the scope of FHB's Title V programs.

2010: Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options.

2010: Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.

A new priority was selected for 2010:

2010: Increase the proportion of mothers that exclusively breastfeed their infants through six months of age.

Increasing exclusive breastfeeding was identified as a priority that would likely respond well to New Mexico's current efforts, and that benefits mothers and infants with relation to other priorities above such as healthy weight and infant morbidity.

Replaced:

2005: Strengthen the role of males in MCH through promotion of effective initiatives in healthy fatherhood and in reproductive health through male involvement strategies.

Male Involvement ranked near the bottom in the survey in all counties and by all demographic groups.

2005: Monitor the health of immigrants in the MCH population.

The immigrant population is part of the larger MCH population. It was not specifically identified as a priority during the needs assessment regional meetings.

Adoption of the new State Performance Measures:

FHB managers and staff considered the new state performance measures in the context of S.M.A.R.T (Specific, Measureable, Attainable, Realistic and Timely) criteria, and with regard to the capacity of the Family Health Bureau and its partners. All of the State priorities above are addressed through the National and State Performance measures.

The State priorities that did not meet the S.M.A.R.T. criteria were:

SPM 01: pertaining to counties and tribal entities implementing positive youth development strategies. This was replaced because the state has very limited capacity to measure it.  
SPM 04: pertaining to children witnessing violence.  
This measure was replaced because it is primarily the responsibility of another department. (CYFD)

SPM 05: pertaining to the healthy birth "index."  
This measure was replaced because most of the criteria are addressed in other measures and indicators, and the likelihood that the State could effect improvement on all six criteria collectively was deemed low.

SPM 08: pertaining to syphilis screening for new mothers  
This measure was replaced because the state has limited capacity to measure it and FHB felt that other issues were more urgent.

State Performance Measures that were retained were:

SPM 02 (Now SPM 01): Increase the percent of mothers receiving support services through community home visiting/support programs  
SPM 03 (Still SPM 03): Reduce unintended pregnancy in New Mexico to less than 30% of live births.  
SPM 06 (Now SPM 07): Reduce the proportion of women who report being physically abused by their husband or partner during pregnancy

New state performance measures are:

SPM 02 Decrease the percent of women with a live birth who had no health care coverage for prenatal care  
SPM 04: Decrease the percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted  
SPM 05: Increase the percent of children under age 12 who are appropriately secured while in a motor vehicle  
SPM 06: Decrease the percent of middle school students that report using alcohol within the past 30 days  
SPM 08: Increase the proportion of mothers who exclusively breastfeed their babies through six months

Two measures that may be added later depending on FHB's capacity to measure them are:

1. Increase the percent of asthmatic children that have an asthma action plan
2. Increase percent of women who are clients of public health offices that are screened for depression during prenatal and postpartum health office encounters.

//2012/Priorities remain the same for the State's Title V Programs. Priorities for the Department of Health, and for the State of New Mexico as a whole are being reviewed and revised under the direction of the new administration.//2012//

## **C. National Performance Measures**

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	15	30	20	29	36
Denominator	15	30	20	29	36
Data Source		CMS	CMS	CMS	CMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2009**

Confirmed cases needing treatment were:

- Phenylketonuria
- congenital Hypothyroidism
- Sickle Cell Disease
- Biotinidase Deficiency
- Congenital Adrenal Hyperplasia
- Cystic Fibrosis

**a. Last Year's Accomplishments**

Direct: 8 outreach metabolic clinics include long term follow-up of adults after age 21 with metabolic disorders, Care coordination provided to families by community based CMS social workers.

Enabling: Long-term services begin with diagnosis through life-span Positive case referred for care coordination by a Children's Medical Service (CMS) social worker, overseen by CMS Newborn Screening Nurse consultant. Follow-up system consists of Oregon State Public Health Lab, Oregon State Specialists, and CMS Nurse Consultant, UNM specialists, CMS social worker, UNM genetic counselor, and metabolic nutritionist.

Population-Based: Preventive intervention includes working with 34 birthing facilities & midwives to improve collection of newborn screens. Disease prevention through long-term follow-up program: CMS nurse consultant, CMS social workers, and specialists. Public education includes information on Newborn screening: brochures, waiver translated in Spanish. Newborn Screening website accessible for both Public & professional staff & updated yearly.

Infrastructure Building: Activities: training, educational materials & support to Labs, OB staff who collect Blood spots. Each facility receives updates monthly of practice profile, a QA tool updating them on their progress. Educational materials are provided to physicians, nurses, midwives, social workers. Database linkage between newborn genetic screening, hearing screening program & vital records, electronic birth certificates are being strengthened.

**Table 4a, National Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Monthly Memo's sent out with practice profile, informing			X	

facilities on their performance on newborn screens submitted.				
2. Continued Development of standard/guidelines for expanded screening. Collaboration of a data system to include Newborn screening, newborn hearing, vital records and birth defects.				X
3. Monitor implementation of a long-term comprehensive Follow-up system. Which will include CMS Nurse Consultant, CMS social workers, Medical specialists, PCP's, Family and Oregon State Public Health Lab				X
4. Working with facilities on a QA plan, for education, and training of staff ongoing.				X
5. Working with OB doctors to distribute Newborn screening pamphlets to mothers prior to delivery.			X	X
6. Work with UNM Hospital to develop guidelines to start entering their long-term follow-up data.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Direct: UNM will provide outreach clinics and follow-up to clients across New Mexico that requires their services. Social workers for CMS will receive referrals from the Newborn Genetic Screening (NGS) program for care coordination.

NGS nurse consultant works with families to ensure medical home placement...

Enabling: The NGS program works with UNM metabolic team & Sickle cell counsel to strengthen long-term follow-up process. Programs meet quarterly to review referred cases for continuity of care, to ensure families or clients receive optimal care.

All hemoglobinopathies referred to Sickle Counsel for education and further testing of family members. Each case is reviewed quarterly to ensure follow-up.

Midwives going through licensing in the State of New Mexico are required to do a face to face NGS training. This has increased awareness of and participation in the program.

Population: Preventive includes referring clients to specialists, case management, and follow-up on presumptive positive cases to ensure that confirmatory testing is done.

Infrastructure: Quality assurance through monthly practice profile reports to each birthing facility and Midwives. Updating facilities/Midwives on current events on NGS by monthly memos. Placement of Newborn screening kits in Public Health areas to ensure families have access to forms for repeat screens. NGS program developed and distributed guidelines for emergency preparedness in Newborn Screening.

**c. Plan for the Coming Year**

Direct: 8 outreach clinics and follow-up to clients across the State of New Mexico who requires services. Assist Adults in attending clinics across the state if needed.

University Genetic counselors to work closely with education and setting up of CF sweat testing for individual clients, with positive newborn screening for Cystic Fibrosis.

Enabling: To ensure quality care is provided to all clients with a positive test, they are referred to

social workers statewide for case management, UNM Specialists, PCP's, Presbyterian specialists and Oregon State Public Health Labs and their Specialists. Clients with positive tests will be followed through our long-term follow-up system.

The newborn screening program along with a nutritionist at university hospital will work closely to advocate, to assist clients with special formula needs, will receive formula from insurances. The Newborn screening program offers a small fund for formula for families if needed for up to 3 months.

The Newborn Screening program will be gathering outcome data from CMS Social workers for long term follow-up. Data will be entered through the new data base challenger soft, where reports can be generated. Collection of long-term data from UNM Metabolic program will be implemented this year as of July 2012.

**Population Based Services**

Education of prenatal mothers by sending educational materials to OB doctors statewide to handout to pregnant mothers.

**Infrastructure Building Services**

To continue quality of care and proper collection process, the Newborn Screen program plans to re- Visit birthing facilities and midwives statewide to educate on current events in the newborn screening program. To assure follow-up all hospitals are kept updated on implementation of new disorders. University Hospital specialists will assist in education of specific disorders as we implement to screening panel.

Education has been done to all NICU's in the State on the new guidelines for screening Preterm, low birth weight, and sick newborns. All NICU"s are working with the new guidelines. Education done to new NICU's extension of major hospitals.

**Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated**

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	<b>26414</b>					
<b>Reporting Year:</b>	<b>2011</b>					
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>	<b>(C) No. Confirmed Cases (2)</b>	<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	25600	96.9	0	0	0	
Congenital Hypothyroidism (Classical)	25600	96.9	361	19	19	100.0
Galactosemia (Classical)	25600	96.9	44	0	0	

Sickle Cell Disease	25600	96.9	2	2	2	100.0
Biotinidase Deficiency	26500	100.3	5	0	0	
Cystic Fibrosis	25600	96.9	181	4	4	100.0

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	52	55	55	55	55
Annual Indicator	53.2	53.2	53.2	53.2	67.9
Numerator					
Denominator					
Data Source		NCSHCN	NCSHCN	NCSHCN	NCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	70	70	70	70	70

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Data results from the 2009-2010 survey will be released in Fall of 2011.

**Notes - 2009**

Please see notes from 2006 and 2007.

**a. Last Year's Accomplishments**

Direct: Children's Medical Services (CMS) continued efforts to expand medical home concept by discussing the concept at meetings/conferences. CMS social workers continued family-centered approach in care coordination, including involving youth in transition planning.

Enabling: Ensured family participation in Maternal and Child Health (MCH) Collaborative, New Mexico Interagency Coordinating Council, Newborn Hearing Screening Advisory Council, and AMCHP Conference. CMS contracted with family organizations to ensure that families partner in decision-making at all levels. CMS sponsored the Parent Leadership Training through Education for Parents of Indian Children with Special Needs (EPICS). A few participants from the previous year's Institute were trainers at this year's Institute. CMS contracted with Hands and Voices -- New Mexico chapter to provide counseling in advocacy and leadership, and provide training for parents of children with hearing loss on partnering with school systems. The Newborn Hearing Screening (NBHS) program sponsored a parent to attend the National EHDI Conference.

Population-Based: Family Organizations provided input into Program Activities during meetings. Family Organizations were invited to provide input into CYSHCN Program Activities utilizing information from previous Title V Performance Measures submitted.

Infrastructure Building: CMS program manager served on the CYSHCN Integrated Services board for the Navajo Nation with a focus on youth transition. The NBHS coordinator served on the board of the Family to Family Health Information Center with PRO.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish contracts with family organizations and/or selected family members to assure family involvement in decision making.			X	
2. Family organizations will provide education & training to CMS social workers and other providers on family involvement practices.		X		
3. Establish new or utilize existing councils to review CYSHCN survey outcomes and to develop plan for improvement.			X	
4. Analysis of NM specific data in national survey of CYSHCN to identify key issues to improve performance			X	
5. Recruit parent representation onto the Newborn Genetic Screening Advisory Council		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Direct: CMS works to expand medical home concept in New Mexico, promoting the discussion of the concept at professional meetings and conferences. CMS has a family-centered approach in care coordination, including involving youth in transition planning for State CYSHCN Program. CMS makes referrals to family support organizations for family to family connections.

Enabling: CMS sustains family participation in the MCH Collaborative, NM Interagency Coordinating Council (ICC), NBHS Advisory Council, and AMCHP Conference. CMS contracts with family organizations to ensure that families partner in decision-making at all levels; scope of work includes participation in local, State and National meetings/conferences, training for staff/families, and an advisory role regarding policy.

Population-Based: CMS sustains family participation in MCH Collaborative, referrals to PRO, the NM ICC, the NBHS Advisory Council, AMCHP Conference, and efforts to address integration of Medical Home. CMS recruited a parent representative to join the Newborn Genetic Screening

Advisory Council. Family Organizations are invited to provide input into CYSHCN Program activities during scheduled meetings.

Infrastructure Building: CYSHCN Program sustains partnerships with family organizations, seeks input in all Program areas and involves them in decision-making. The NBHS coordinator continues to participate on the board of the Family to Family Health Information Center with PRO.

**c. Plan for the Coming Year**

Direct: CMS will continue efforts to expand the medical home concept in New Mexico, promoting the discussion of the concept continuing at professional meetings and conferences. Continue on-going family-centered approach in care coordination, including involvement of youth in transition planning for State CYSHCN Program. Continue referrals to family support organizations for family to family connections.

Enabling: CMS will continue assisting families to participate in the MCH Collaborative, the NM Interagency Coordinating Council, the Newborn Hearing Screening Advisory Council, and the AMCHP Conference and continue presentations on parent professional partnerships.

Population-Based: CMS will sustain family participation in MCH Collaborative, referrals to PRO, NM Interagency Coordinating Council, NBHS Advisory Council, AMCHP Conference, and efforts to address integration of Medical Home. Family Organizations will be invited to provide input into CYSHCN Program activities during scheduled meetings. A parent satisfaction survey will be distributed to CMS parents to obtain feedback on services provided by the CMS program.

Infrastructure Building: CYSHCN Program will sustain partnerships with family organizations, seeking input in all Program areas and involving them in decision-making. CMS will continue to meet with Family Organizations to discuss ways to improve upon efforts to ensure that families partner in decision-making at all levels and are satisfied with the services they receive. CMS Program will continue to contract with family organizations will support these efforts.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	52	43	43	43	43
Annual Indicator	41.6	41.6	41.6	41.6	34.9
Numerator					
Denominator					
Data Source		NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>

Annual Performance Objective	36	36	38	38	40
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**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Data results from the 2009-2010 survey will be released in Fall of 2011.

**Notes - 2009**

Please see notes from 2006 and 2007.

**a. Last Year's Accomplishments**

Direct: CMS connected CYSHCN clients to a Medical Home through the care coordination and transition services provided by social workers statewide. CMS social workers faxed asthma action plans to the primary care provider and the school nurse after each asthma outreach clinic, providing a link to the Medical Home and wrap-around services.

Enabling Services: CMS social workers empowered parents and youth to partner with their primary care provider in order to ensure their needs are met within the Medical Home.

Population-Based: The Newborn Hearing and Genetic Screening Programs included the medical home during follow-up of infants identified through newborn screening. CMS continued Regional follow-up work (post-summit) on asthma protocols which emphasize linking with a medical home.

Infrastructure Building: The CMS Medical Director sat on the Pediatric Council of the NM Pediatric Society, where discussion of Medical Home was on-going. The Council worked with the Medicaid Managed Care Organizations (MCOs) to establish reimbursement for Pediatricians who provide care within a true Medical Home. The Title V Program contracted with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision-making. CMS leadership met with Medicaid staff to discuss how CMS and Medicaid could collaborate around Medical Home. The CMS Medical Director and leadership from the NM Pediatric Society attended a Mountain States Genetic conference in Feb. 2011 where the Medical Home Portal was presented ([www.medicalhomeportal.org](http://www.medicalhomeportal.org)).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Social Workers connect families with a Medical Home	X			
2. CMS Medical Director works with Pediatric Council to promote Medical Home				X
3. Populate the medical home portal with NM-specific resources				X

and provide Spanish translation for documents on the medical home portal website.				
4. Social workers assist and encourage families to fully partner with PCP within the Medical Home		X		
5. Newborn Screening Programs include medical home in follow-up of identified infants			X	
6. CMS leadership works with Medicaid staff and MCOs on development of Medical Homes/Health Homes in connection with the Affordable Care Act.				X
7. CMS Medical Director and NB Hearing Screening Coordinator work to improve collaboration between the NB Hearing program and the Medical Home in order to improve timeliness of screening and diagnosis of hearing loss.			X	
8.				
9.				
10.				

**b. Current Activities**

Direct: CMS social workers continue connecting CYSHCN clients to a Medical Home. CMS social workers continue to fax asthma action plans to the primary care provider and the school nurse after each asthma outreach clinic, providing a link to the Medical Home and wrap-around services.

Enabling Services: CMS social workers empower parents and youth to partner with their primary care provider in order to ensure their needs are met within the Medical Home.

Population-Based: The Newborn Hearing and Newborn Genetic Screening Programs continue to include the medical home during follow-up when an infant is identified through newborn screening.

Infrastructure Building: The CMS Medical Director continues to work with the Pediatric Council of the NM Pediatric Society on promoting the Medical Home concept with pediatricians and with the MCOs. The Title V Program contracts with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision-making. CMS applied for a HRSA State Implementation grant to promote transition services and medical home. The CMS Medical Director collaborated with Project LAUNCH through the Child Health Program to provide funding to populate the medical home portal with NM-specific resources. CMS continues to try to collaborate with Medicaid around their work on Medical Homes and Health Homes, which they are developing in relation to the Affordable Care Act.

**c. Plan for the Coming Year**

Direct: CMS will continue the work of connecting CYSHCN clients to a Medical Home, through the care coordination and transition services provided by social workers statewide. CMS social workers will continue to work closely with each client's Medical Home to ensure a smooth transfer of information between the family, the specialist and the Medical Home. They will continue to fax asthma action plans to the primary care provider and the school nurse after each asthma outreach clinic, providing a link to the Medical Home and wrap-around services.

Enabling Services: CMS social workers will continue to empower parents and youth to partner with their primary care provider in order to ensure their needs are met within the Medical Home.

Population-Based: The Newborn Hearing and Newborn Genetic Screening Programs will continue to include the medical home during follow-up when an infant is identified through newborn screening. The CMS Medical Director successfully applied for a grant from the AAP to enhance the follow-up of infants with hearing loss in collaboration with the Medical Home. The Newborn Hearing Coordinator and the CMS Medical Director will be conducting a training for pediatricians on how the newborn hearing program can work closely with the medical home to ensure timely follow-up of infants who need diagnostic hearing screening and early intervention.

Infrastructure Building: The CMS Medical Director will continue to work with the Pediatric Council of the NM Pediatric Society on promoting the Medical Home concept. The Title V Program will continue to contract with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision-making. CMS leadership will meet with the MCOs to see if they are willing to include CMS staff as care coordinators as they roll out the Medicaid Health Homes in relation to the Affordable Care Act. If CMS is successful in obtaining the HRSA grant funding, documents on the medical home portal will be translated into Spanish to increase their usefulness for providers and families in NM. The CMS Medical Director will continue to work with Project LAUNCH and the Center for Development and Disability at UNM to populate the medical home portal with NM-specific resources, and to develop medical home online training for home visitors and early intervention providers.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70	59	59	59	59
Annual Indicator	56.6	56.6	56.6	56.6	60.6
Numerator					
Denominator					
Data Source		NCSHCN	NCSHCN	NCSHCN	NCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	62	62	64	64	66

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as

survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Data results from the 2009-2010 survey will be released in Fall of 2011.

**Notes - 2009**

Please see notes from 2006 and 2007.

**a. Last Year's Accomplishments**

Enabling: CMS social workers provided care coordination to approximately 5,200 CYSHCN who were not Medicaid/CHIP eligible. CMS social workers provided assessment of insurance options for clients and assisted with PE-MOSAA's to determine if the children or youth were eligible for Medicaid or CHIP. The social workers assisted clients to enroll in the NM Medical Insurance Pool (high risk pool, NMMIP), the Low Income Premium Program of the NMMIP (LIPP) and SCI, if eligible.

Infrastructure Building: The CYSHCN Program enrolled 53 more children onto the NMMIP this year to provide broad insurance coverage for this high cost population. The CMS Medical Director attended the Board Meetings of the NMMIP in order to stay abreast of changes due to the new federal health reform. CMS continued to work with NMMIP to increase coverage for certain diagnoses. The program continued its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities. The CMS Medical Director attended the Pediatric Council meetings to improve the care of children with asthma in dialogue with Medicaid and the MCOs. The CMS program was represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out, which is addressing insurance coverage for CYSHCN in the state. CMS explored eligibility requirements and gaps in coverage under the multiple plans under Insure New Mexico.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination to CYSHCN, including assistance with Medicaid eligibility and insurance applications	X	X		
2. Expand coverage to children by enrolling onto NMMIP and paying premiums for eligible clients.	X			X
3. Work with the Commission for the Deaf and the Commission for the Visually Impaired to improve services to children in these communities				X
4. Continue work with the Pediatric Council to address coverage by Medicaid and the MCOs for pediatric asthma				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Enabling: CMS social workers provide care coordination to CYSHCN and school-age children who are not Medicaid/SCHIP eligible. CMS CYSHCN Program provides assessment of insurance options for clients and PE-MOSAA's to determine if the children or youth are eligible,

and the social workers assist clients to enroll in NMMIP and LIPP and SCI if eligible. CMS serves as payer of last resort for uninsured clients who meet program eligibility criteria.

Infrastructure Building: The CYSHCN Program continues to enroll eligible children onto the NMMIP to provide broad insurance coverage for this high cost population. The CMS Medical Director attends the Board Meetings of the NMMIP in order to stay abreast of any program changes. CMS is very concerned about the possibility of the high risk pool being dissolved in 2014 after the Health Insurance Exchange is fully operational. This would result in hundreds of CMS clients losing insurance coverage.

CMS continues its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities. The CMS program continues to be represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out, which is addressing insurance coverage for CYSHCN in the state.

**c. Plan for the Coming Year**

Enabling: CMS social workers will continue to provide care coordination to CYSHCN and school-age children who are not Medicaid/SCHIP eligible. CMS CYSHCN Program will continue to provide assessment of insurance options for clients and PE-MOSAA's to determine if the children or youth are eligible, and the social workers will continue to assist clients to enroll in NMMIP and LIPP and SCI if eligible. CMS will continue to serve as payer of last resort for uninsured clients who meet program eligibility criteria.

Infrastructure Building: The CYSHCN Program will continue to enroll more eligible children onto the NMMIP to provide broad insurance coverage for this high cost population. The CMS Medical Director will continue attending the Board Meetings of the NMMIP in order to stay abreast of any program changes, especially in relation to the concern that NMMIP may be dissolved in 2014 after the Health Insurance Exchange is fully implemented. CMS will continue to work with NMMIP to increase coverage for certain diagnoses. The program will continue its work with the Commission for the Deaf and the Commission for the Blind and Visually Impaired to improve services to children in these communities. The CMS Medical Director will continue to attend the Pediatric Council meetings to improve the care of children with asthma in dialogue with Medicaid and the MCOs. The CMS program will continue to be represented on the Advisory Board for the Family-to-Family Health Information Center at Parents Reaching Out, which is addressing insurance coverage for CYSHCN in the state.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70	89	90	90	90
Annual Indicator	85.7	85.7	85.7	85.7	55.5
Numerator					
Denominator					
Data Source		NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	57	57	60	60	63

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Data results from the 2009-2010 survey will be released in Fall of 2011.

Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #05 and the 2005-2006 may be considered baseline data.

**Notes - 2009**

Please see notes from 2006 and 2007

**a. Last Year's Accomplishments**

Direct: Care coordination provided by CMS staff. Maintained 127 specialty clinics.

Direct: Continued care coordination which is provided by CMS staff and available to all CYSHCN and their families; strengthen linkages to early intervention services and the Part C program, increase child find activities with CYFD and pediatric practices; and provide 127 specialty multidisciplinary specialty clinics statewide. UNM Neurology hired an additional neurologist to assist in maintaining the number of clinics for next fiscal year. This year they had to cut 5 clinics due to staff shortages. Presbyterian continued to provide additional asthma clinics. The CMS FIT program has been struggling to maintain statewide coverage due to hiring freeze. The program transitioned its remaining clients to early intervention providers. The CMS FIT social workers became available to provide social work services and care coordination for CYSHCN; and assist with care coordination for 127 specialty multidisciplinary specialty clinics statewide.

Population: CMS CYSHCN Program and the CMS FIT Program work with partners in efforts identified to address assurance of EPSDT screening for children/youth in order to increase the identification and early referral to early intervention services for children with or at risk for developmental delays.

Infrastructure: The Title V Director was the designee to the Children's Cabinet (which was temporarily disbanded), and the MCH Program manager continued Child Health Unit

representative to the Early Childhood Action Network. The program places children onto NMMIP, the Non-Medicaid, Premium Assistance Program, resulting in coverage for many children in New Mexico. The \$300,000 appropriation to CMS from the 2007 Legislature CMS was recurring in the budget but cuts to DOH General Fund appropriation will affect the program. Funds were maintained to the Commission for the Blind to obtain technology for children with vision impairments which are not items not covered by insurance but help to improve quality of life.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide care coordination to CYSHCN	X			
2. Sponsor 127 outreach specialty clinics statewide and explore expansion based on need	X			
3. Continue work with partners to ensure EPSDT screening			X	
4. Provide representation to the Children's Cabinet and Early Childhood Action Network				X
5. Improve provision of service delivery services to Latino children through participation in learning collaborative.				X
6. Increase number of CYSHCN on NMMIP				X
7. Work with Secretary's office to address infrastructure for CYSHCN				X
8.				
9.				
10.				

**b. Current Activities**

Direct: Continue care coordination which is provided by CMS staff and available to all CYSHCN and their families; the number of clinics remained at FY 10 levels due to budget constraints.

Population-Based: CMS CYSHCN Program continues to work with partners in efforts identified to address assurance of EPSDT screening for children to increase the identification and early referral to early intervention services for children with or at risk for developmental delays. CMS staff work to strengthen partnerships with community providers to improve referral network for CYSHCN and their families. CMS will participate in the Improving Ease of Use for Latino Families learning project with AMCHP and the Training Center.

Infrastructure Building: The Title V Director is no longer the designee to the Children's Cabinet as the Cabinet Secretary has assumed more of a role in this body. Ms. Carol Tyrell the MCH Section Manager retired in December 2011 but Child Health Unit continues to provide representation to the Early Childhood Action Network until a replacement is hired. The program will continue to place children onto NMMIP and monitor the effects of the new health reform on access to care for CYSHCN. CMS met with UNM to look at needs for clinic expansion in the next few years based on funds that may be available. The CMS team also met with the Cabinet Secretary to discuss clinic needs. Funds continue to Commission for the Blind.

**c. Plan for the Coming Year**

Direct: Continue care coordination which is provided by CMS staff and available to all CYSHCN and their families; explore increasing the number of outreach clinics to better meet needs if budget is available.

Population based: CYSHCN Program will continue to work with partners in efforts identified to

address assurance of EPSDT screening for children and youth in order to increase the identification and early referral to early intervention services for children with or at risk for developmental delays. CMS staff will continue work to strengthen partnerships with community providers to improve referral network for CYSHCN and their families. Work will continue on populating the Medical Home portal to provide families with quality information and resources.

Infrastructure Building: CMS will continue to support the work of the Children's Cabinet as it addresses health care issues for families. The program will continue to place children onto NMMIP and monitor the effects of the new health reform on access to care for CYSHCN. CMS will continue to work with UNM and Presbyterian to look at needs for speciality clinic expansion in the next few years based on funds that may be available. The CMS team will keep the PHD Leadership and the Cabinet Secretary informed of on-going clinic needs. Funds will continue to Commission for the Blind. CMS will work with AMCHP and the Training Center on Ease of Use to improve service delivery systems for families of CYSHCN with a focus on Latino families.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	47	36	36	36	36
Annual Indicator	33.7	33.7	33.7	33.7	35.7
Numerator					
Denominator					
Data Source		NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	37	37	39	39	41

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Data results from the 2009-2010 survey will be released in Fall of 2011.

Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2009**

Please see notes from 2006 and 2007.

**a. Last Year's Accomplishments**

Direct: CYSHCN Social Workers provided service coordination and transition planning (involving youth) to youth aged 14-21 through the use of a "CMS Youth Transition Plan." This plan was designed to determine support systems - in place, available and needed -- as well as to elicit viability for plans, hopes and dreams for the future. Social workers assisted families in applying for insurance through the State's high risk insurance pool New Mexico Medical Insurance Pool (NMMIP) to ensure health care coverage once clients age out of the Program. Funding for the State Coverage Insurance (SCI) was frozen, but clients are urged to apply anyway so that their names are placed on a waiting list. CMS met with Presbyterian Health Plan, who offers a child-only plan to pursue a possible contract to provide coverage for CMS clients not eligible for NMMIP.

Enabling: CMS administered an insurance assistance program by helping clients enroll in the State's high risk insurance pool, New Mexico Medical Insurance Pool (NMMIP), and by paying premiums and deductibles for qualifying client. This gives clients a head start on obtaining medical insurance once they transition out of the Program. Intense transition planning is done with clients at least 6 months before transitioning out of the Program to ensure that they are able to pay their insurance premiums.

Population Based: CMS participated in the Statewide Transition Coordinating Council along with numerous other State, public and private agencies. The Council had a focus on creating an infrastructure for communities to develop and improve transition services.

Infrastructure Building: CMS Transition Team members reviewed and revised the Transition Section of the CMS Manual of Operating Procedures. Information was updated and/or revised as needed. CMS Manuals were distributed to all CMS employees.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition planning services to youth age 14-21 through care coordination by 45 social workers to cover all 33 counties in New Mexico.	X			
2. Advocate for open door for interagency collaboration at State level to enhance cooperation at local level amongst professionals working with youth & families on all aspects of transition, through efforts of Statewide Transition Coordinating Council.			X	
3. CMS Regional Transition liaisons review issues, resources, etc. to inform policies regarding transition-age CYSHCN				X

4. CMS staff assist families in applying for health care insurance	X			
5. CMS funds premiums/deductibles for qualifying YSHCN enrolled in New Mexico Medical Insurance Pool		X		
6. Use NM Behavioral Risk Factor Surveillance System, data for age 18-24 to monitor transition indicators				X
7. Analysis of NM specific data in national survey of CSHCN to identify key issues to improve performance				X
8.				
9.				
10.				

**b. Current Activities**

Direct: Social workers continue to provide service coordination and transition planning through the CMS Youth Transition Plan and help families apply for a high-risk insurance pool to ensure health care coverage once clients age out of the Program. CMS continues to pursue a contract with Presbyterian Health Child Plan

Enabling: CMS pays premiums and deductibles for qualifying clients enrolled in the NMMIP to give clients a head start on obtaining medical insurance once they transition out of CMS. Intense transition planning is done with clients at least 6 months before, including applying for a Low Income Premium Plan through the Pool.

Population Based: Although there have been changes in the structure of the Statewide Transition Coordinating Council (STCC), CMS continues membership by attending meetings, sharing information between all represented agencies and collaborating on designated projects. CMS staffed an information booth at the Summer Transition Institute sponsored by the New Mexico Department of Education. Transition and Program information including brochures, pamphlets, etc. was distributed to attendees representing schools across the State.

Infrastructure Building: CMS is assessing its policies for CYSHCN Social Workers in transition planning. Clarity on transition planning clients enrolled in the NMMIP was added to the CMS Manual of Operating Procedures. A grant was submitted to HRSA to improve transition services for the state.

**c. Plan for the Coming Year**

Direct: CYSHCN Social Workers will continue to provide service coordination and transition planning (involving youth) to youth aged 14-21 through the use of the "CMS Youth Transition Plan." Staff training will continue as needs arise. Staff will search avenues of obtaining health care insurance for clients aging out of the Program.

Enabling: Staff will pursue captioning (in English and Spanish) of an inspirational transition training video that was created several years ago. Once accomplished, it will be copied and distributed statewide and nationally along with its accompanying discussion guide. CMS will continue to fund premiums and deductibles for qualifying clients enrolled in the New Mexico Medical Insurance Pool to give clients a head start on obtaining medical insurance once they transition out of the Program.

Population Based: CMS will continue membership in the Statewide Transition Coordinating Council (STCC).

Infrastructure Building: CMS will review and update policy as necessary for use by CYSHCN Social Workers in transition planning with youth. Training needs specific to youth transition issues identified will continue throughout FY13. CMS Staff will receive regular updates and resource information on youth in transition through Regional Managers. Transition-specific

pamphlets and booklets will be updated and made available to all staff for use with clients. An electronic copy of the CMS Manual of Operating Procedures will be made available for all staff. If funded : the transition consultative clinic at UNM will begin statewide expansion, a youth leadership/mentorship program will be started, PRO will develop some resources and have a trained staff member to help families with transition, the annual FLAN conference will be supported to include a youth transition tract, the Medical Home portal will be updated with NM specific information and resources on transition in English and Spanish.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	78	82	82	82	75
Annual Indicator	81	79.1	68.2	72.4	80.5
Numerator					
Denominator					
Data Source		NIS	NIS	NIS	NIS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	82	82	84	84	86

**Notes - 2011**

The interpretation of the NIS tables has become more complicated in recent years with the measurement of Hib full series (FS) vs partial series (PS) and the fact that CDC now takes into account brand type of Hib. Rates between years may not be comparable.

2010 and 2011 measure the 4:3:1:3:3:1PS.

2009 measures 4:3:1:3:3:1

Using the 4:3:1:3:3:1 measure:

2007 = 76

2008 = 77

2009= 68.2

2010 = 70.9.

4:3:1:3:3:1 is not available for 2011.

**Notes - 2010**

<http://www.cdc.gov/vaccines/stats-surv/nis/data/ta>

**Notes - 2009**

Immunization information is from the Centers for Disease Control and Prevention which presents data in percentage format rather than numerator/denominator format.

Source: CDC National Immunization Survey data from July 2008-June 2009.

The percent for 2007 should be 78.9. The percent for 2009 is entered as provisional pending verification.

**a. Last Year's Accomplishments**

Enabling Services: The New Mexico immunization program participated in the New Mexico Immunization Coalition Steering committee meetings.

Population Services: Ongoing "Got Shots? Protect Tots!" immunization days were held during two weeks 2011.

Direct Services: Supported Immunization Consultant technical assistance. Provided CHILI (Child Health Immunization Learning Initiative) trainings for Vaccines for Children (VFC) providers to improve vaccination policy, administration, and vaccine storage and handling among VFC providers. Conducted a randomized school survey of immunization levels in kindergarten and seventh grades.

Infrastructure Services: VFC visits included an evaluation of each practice's immunization "best practices" and immunization coverage levels for a majority of practices. Coverage surveys used the clinical assessment software application (CoCASA). Immunization consultants provided immunization technical assistance and training in vaccine administration, storage and handling, and immunization best practices to New Mexico VFC providers.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Done by One schedule which allows for providers and parent to get children immunized at the earliest possible opportunity.		X	X	
2. School Influenza Immunization Project.			X	X
3. "Got Shots? Protect Tots" statewide immunization events.	X		X	
4. Continue the Immunization Consultant technical assistance project.	X	X		
5. The VFC program represents an approach to improving vaccine availability nationwide by providing vaccine free of charge to VFC-eligible children through public and private providers.	X		X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Direct: "Got Shots? Protect Tots!" events during which participating providers open their doors for any child who presents for immunizations, regardless of whether he/she is a patient or whether he/she has insurance. "Got Shots? Protect Tots!" is a collaborative effort between the New Mexico Department of Health, the New Mexico Primary Care Association and the New Mexico Immunization Coalition, and managed care partners.

Enabling Services: Provide immunization presentations in English and Spanish for child caregivers. Workshops include information on immunization schedules, catch-up schedules, prevention and spread of communicable disease in the daycare settings, and myths surrounding immunizations.

CHILI (Child Health Immunization Learning Initiative) training for medical. The training covers topics such as the importance of vaccine storage and handling, interpreting children's shot records, proper documentation, preventing medication errors, and new daycare/pre-school/school immunization requirements.

Infrastructure Services: The Paso Del Norte Binational Health Council along with the US-MX Border Health Commission, U.S. CDC, the Pan American Health Organization (PAHO), and the ten border states celebrated National Infant Immunization Week (NIIW) focusing attention on the importance of immunizing and protecting children. The goal of NIIW is to unite communities in both nations to ensure all children have a healthy and safe childhood free from vaccine-preventable diseases.

**c. Plan for the Coming Year**

Continue promoting "CHILI," "Done by One," SKIP, "Got Shots? Protect Tots!" "VFC," and border area immunization collaboration.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	34.5	33	33	30	25
Annual Indicator	32.9	32.3	33.7	29.2	25.5
Numerator	1605	1597	1479	1287	1107
Denominator	48759	49375	43910	44066	43422
Data Source		NMVRHS	NNMVRHS	NNMVRHS	NMVRHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	24	24	24	22	22

**Notes - 2011**

2011 birth data not yet available

New Mexico released new population estimates in February, 2012. Correct denominators to: 2007=43666; 2008=43788; 2009=43910;

New rates:

2007 36.8  
2008 36.5  
2009 29.3

**Notes - 2010**

2010 Population Denominator data are not yet available. 2009 population is used here. Objectives for 2011-2015 will be adjusted when final 2010 data are available.

#### **Notes - 2009**

2008 natality data not yet available.

#### **a. Last Year's Accomplishments**

**Direct:** According to the 2011 FPAR, the total number of adolescents aged 15-17 seen at statewide FPP-funded clinics for comprehensive reproductive health services was 4,138; 3,832 females and 306 males. The FPP offered a broad range of contraceptive methods, including four extended use, teen friendly contraceptive methods other than IUDs (vaginal ring, patch, implant, DepoProvera).

**Enabling:** Education and outreach by Public Health Office (PHO) staff emphasized contraception and family planning services, sexually transmitted infections, and where to receive family planning services. Due to high vacancy rates there were less education and outreach activities than in previous years.

**Population-Based:** The FPP continued evidence-based education programs, with an emphasis on the Teen Outreach Program (TOP), at 19 sites in 10 counties. There were 715 participants in TOP.

TOP promotes positive youth development with service learning (volunteer work in the community) and curriculum-based activities in a program to decrease teen pregnancy and increase school success.

The goals of the Teen Outreach Program are to:

1. Promote young people's healthy behavior for successful achievement in school and attainment of their life-long goals;
2. Help young people acquire valuable life skills to develop the necessary competencies and capacities to grow into healthy, self-sustaining adults;
3. Give young people a sense of purpose through authentic opportunities that allow them to contribute in meaningful ways to their communities.

These goals are achieved through the implementation of two program components: a service learning component and a classroom-based component.

The service learning component helps young people prepare for and participate in volunteer community service. Youth have an opportunity to share their volunteer experience through discussion, research activities, writings and/or creative presentations. The classroom-based component consists primarily of small group activities and discussion on topics of special interest to young people.

**Infrastructure Building:** In May 2011, FPP in collaboration with the New Mexico Teen Pregnancy Coalition (NMTPC) introduced "Challenge 2015" to establish a State's goal of reducing teen births by 20% from 2011-2015. Challenge 2015 also provided data on both 15-17 year olds and 15-19 year olds to focus attention on birth rates for both groups in each county. Results for the first year showed that seven counties reached or exceeded the 5% reduction goal for 15-17 year olds: Bernalillo, Chaves, Cibola, Dona Ana, Eddy, Sandoval, and Valencia. Eleven counties reached or exceeded the 5% reduction goal for 15-19 year olds: Bernalillo, Chaves, Eddy, Grant, Rio Arriba, Roosevelt, Sandoval, Socorro, Taos, Torrance, and Valencia. The following five counties reach or exceeded the 5% reduction goal for both 15-17 and 15-19 year olds: Bernalillo, Chaves, Eddy, Sandoval, and Valencia.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive reproductive health clinical services will be provided to clients aged 15-17 at PHOs, health commons, SBHCs and primary care clinics.	X			
2. PHOs will provide education and outreach for teens aged 15-17 at schools, detention centers, and community centers on reproductive health topics.		X		
3. The FPP will fund and support evidence-based community education programming such as TOP and Cuídate.			X	
4. The FPP will support Raíces y Alas is a two-hour workshop for parents of teens designed to increase parents' confidence in talking with their children about sex and sexual health topics.			X	
5. The FPP will evaluate evidence-based community education programming.				X
6. The NM DOH will track county teen birth rates with the Challenge project.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

July 2010 -- June 2011

Direct: The FPP continues to fund services at statewide clinics that offer confidential family planning services and to promote family planning services in outreach locations such as school based health centers (SBHCs).

Enabling: Education and outreach activities by PHO staff in the counties with high teen birth rates include:

1. Distributing packets to 163 new students at New Mexico Junior College. The packets contained information on STDs, and pregnancy including abstinence. The packets also contained condoms.
2. A tour of the Luna PHO in Deming was conducted for 23 teenagers who are members of the Deming High School TOP. The purpose of the tour was to familiarize the students with the PHO, staff members, programs and services. The tour and public health briefing are part of an ongoing effort to reduce a high rate of teen pregnancy in Luna County. A discussion and demonstration of various birth control methods was conducted. Due to the interest and enthusiasm shown by the students, a request for future site visits was made for the benefit of new TOP members.

Population-Based: FPP continues its collaboration in delivering TOP and Cuídate in communities statewide. There are 27 TOP clubs with 25 youth in each club. Cuídate is a Hispanic, culturally-based HIV sexual risk reduction intervention used for teen pregnancy prevention; six 60-minute modules are delivered to small groups of teens at four sites.

**c. Plan for the Coming Year**

Direct: The statewide FPP-funded clinics will continue to provide confidential, comprehensive reproductive health services to teen clients aged 15-17 statewide. Clinical services include pregnancy testing, providing a contraceptive method including emergency contraceptive pills

and/or a clinical exam visit. The clinical exam visit includes: a medical history/physical, laboratory tests (including Pap smear), STI testing and counseling, family planning counseling, and a supply of a contraceptive method of choice. Services are provided at PHOs, primary care clinics & school-based health centers. A "Call to Providers" was issued in April 2012 to solicit new contract sites.

The FPP will be implementing an innovative approach to increase services to hard-to-reach populations. The chlamydia/gonorrhea screening tests funded by CDC via Infertility Prevention Project has been targeted to women 25 and younger. The FPP will expand Aptima testing in Provider Agreement clinics, particularly SBHCs, to include testing and treatment of high risk young men in the context of a reproductive health visit.

Enabling: PHO staff will continue to provide education and outreach for clients aged 15-17 at school and community-based locations. NM DOH is implementing a result-based accountability process called "Turn the Curve." The FPP is the indicator lead for teen births and will be at Regional meetings statewide with community partners. This effort will actively engage community partners who are interested in reducing teen birth rates.

Population-Based: The FPP will continue to promote four population-based strategies (service learning programs, adult-teen communication programs, comprehensive sex education and male clinical/educational services), which have worked in concert with the clinical family planning direct services to prevent teen pregnancy.

The main focus of the FPP teen pregnancy prevention program is to develop and support quality teen pregnancy prevention programming in communities throughout New Mexico in order to bring about meaningful and measurable reductions in teen births. Programming will target high risk teens (male or female/ages 18 or younger) through primary teen pregnancy prevention (preventing the first teen pregnancy).

TOP and Cuídate programming will continue at 31 sites in 10 counties statewide. Raíces y Alas (Roots and Wings) will also continue to be implemented in communities statewide. Raíces y Alas is a two-hour workshop for parents of teens designed to increase parents' confidence in talking with their children about sex and sexual health topics.

Infrastructure Building: In collaboration with Wyman, the FPP will evaluate the effectiveness of TOP and will perform an independent evaluation of Cuídate. The NM DOH will continue to track teen birth rates with the Challenge project.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	50	50	50	50	50
Annual Indicator	48	48	48	48	48
Numerator					
Denominator					
Data Source		NM Oral Health	NM Oral Health	NM Oral Health	NM Oral Health
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	50	50	50	50	50

**Notes - 2011**

NM Oral Health Program does not track this indicator.

**Notes - 2010**

Through Medicaid during FFY2010, there were 95,501 dental clients aged six to nine, 61,791 of whom received a dental service.

In FY 10 1,168 3rd graders received at least one dental sealant from the NM Department of Health.

4,894 elementary school aged children received at least a dental sealant. The data do not capture "no" response to the consent form.

9,956 children received a basic dental screening in anticipation for referrals or to participate in the dental sealant/fluoride varnish program.

The 2007 National Survey of Children's Health found that 91.6 % of children aged 6-11 had no unmet need for oral health care. 89.2% in that age group had one or more preventive care visits during the past 12 months.

**Notes - 2009**

1,783 third graders were given sealants by the NM Department of Health's Oral Health program.

The 2007 National Survey of Children's Health found that 91.6 % of children aged 6-11 had no unmet need for oral health care. 89.2% in that age group had one or more preventive care visits during the past 12 months.

**a. Last Year's Accomplishments**

New Mexico has lower coverage by dentists compared to nationally. The estimate for the number of dentists in New Mexico ranges from 32.4 to 43.7 per 100,000 population. This is well below the national rate of 63.6 per 100,000 population. The dentists in New Mexico are not evenly districted; approximately 50 -- 60% of practicing dentists in the state practice in NE Albuquerque, which is a metro area as compared to the remainder of New Mexico which is rural/frontier. Access to dental care is limited in New Mexico. This can be attributed to the lack of dentists in the state, low reimbursement by Medicaid, and low incomes resulting in large populations with out dental insurance.

During this period the number of children ages 6 -- 9 who were clients was 77,572 and 50,745 of those were recipients of dental services. 12,505 received a dental sealant or 16.1% of the EPSDT population. The number of children eligible to receive services should increase now that Medicaid re-certification will be changed from every six to 12 months. This will assist with children receiving continued coverage as well as continuity of care although there are a number of barriers to overcome.

In addition to the EPSDT population the Department of Health's dental sealant program provided 1,263 third grade children with a dental sealant. Screened for dentals sealants were 6,813 or

18.5% of the population.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. DOH promotes the application of dental sealants for 3rd grade children.			X	
2. DOH conducts a school based dental sealant program throughout the state.	X			
3. NMDOH FY10 Strategic Plan System Objective 3: Create an oral health system that provides children, low-income rural populations and people with disabilities with preventive and restorative oral health services.				X
4. dental hygienists can place dental sealants	X			X
5. Office of Oral Health provides direct services and contracts with providers to ensure the delivery of services.		X		
6. Dental case manager pilot project implemented and a number of 3rd graders participated in the project.	X		X	
7. Increased partnership with non-state program offering same services to target 3rd grade children and data collection.				X
8.				
9.				
10.				

**b. Current Activities**

The EPSDT program will continue to promote oral health prevention. Access to a dental provider is important in order to receive dental services including dental sealants. The Office of Oral Health (OOH) in addition to the NM Medicaid program promotes access to care to increase the number of children receiving preventive dental sealants and treatment services. OOH continues to support public-private partnerships with the hope of increasing dental services to lower income children.

OOH continues to use general and federal funds to support low-income children who do not qualify for Medicaid but are in need of preventive and treatment services. OOH continues to use general funds to support the ongoing dental sealant program. Both programs are providing dental sealants to children during this fiscal year.

**c. Plan for the Coming Year**

Both programs will continue to promote oral health and prevention efforts such as dental sealants to reduce the incidence of tooth decay among third graders. The Office of Oral Health continues to receive state general funds to support the dental sealant program.

The Department of Health is currently developing a strategic plan addressing nine indicators. Oral health is an indicator. The state is receiving input from current stakeholders and will be receiving input from the local community as well. This effort is an additional strategy to promote oral health. The NM Medicaid program will be represented in this process. Through this process OOH plans to promote the use of dental sealants among community clinics and private providers and provide data to the state.

Two years ago, the oral health partnership passed legislation to expand the scope of practice for dental hygienists in New Mexico. The legislation would allow for the hygienist to provide dental

sealants without the direct supervision of dentists. To date, the NM Dental Health Care Board has adopted and promulgated regulations for this expansion. It is hoped that public programs and private dentists will utilize this authorization and increase the number of sealants applied across the board.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	6.9	7.5	6	3.3	4
Annual Indicator	3.7	3.6	4.0	4.6	5.7
Numerator	15	15	17	20	24
Denominator	405808	410995	429114	430233	423624
Data Source		NMVRHS	NMVRHS	NMVRHS	NMVRHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	4	3	3	3	3

**a. Last Year's Accomplishments**

Enabling: The NM SAFE KIDS state coalition manages a network of 12 coalitions and chapters statewide. In collaboration with the nonprofit Safer New Mexico, over 100 car seat check and installation events are produced statewide on an annual basis, in addition to constant social marketing and distribution of brochure information regarding car seats, booster seats, seat belts & safe driving in every community.

Population: The Safe Kids network continued to engage in regular car and booster seat clinics, and to offer individual car seat checks and free replacement "fitting stations" for those who are unable to attend the clinics. Continued constant scheduling of press releases, brochure distribution, media interviews and promotions, and other social marketing opportunities for promoting of safe driving principals, including proper installation of car seats, importance of booster seats for even older children if they are too small for adult seat belts, always wearing a seatbelt as an example to all children, & making sure every occupant is secured in a motor vehicle at all times.

Infrastructure: We are soliciting donations & volunteers to start new SAFE KIDS chapters in Taos & Rio Arriba Counties. New Mexico offers 16 mini-conferences per year to home daycare providers so that they can comply with certification requirements.

Upon their invitation, we also expanded home safety workshops to include the Region 6 Head Start Conference for five states, the Albuquerque Area Early Head Start program, & the regional Native American Head Start programs, in addition to the first annual Home Visiting Specialists Conference for CYFD & workshops for Public Health Office employees.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand network of SAFE KIDS chapters with support from statewide coalition and collaboration with nonprofits				X
2. Strengthen relationship with Safer New Mexico Now to advocate for informed policy-making, provide education, support law enforcement, offer resources, and nurture public understanding.			X	
3. Continue to support the Regional Early Care Education Conference (RECEC) collaborates to strengthen the ties between State and community agencies dealing with the health and safety of the child care environment.		X		
4. Pursue additional funding mechanisms to finance SAFE KIDS programs statewide.			X	X
5. Continue to expand the relationships with the many nonprofits currently contracting with CYFD to provide home visitation services for new parents		X		X
6. Re-introduce legislation to prohibit texting while driving			X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

**Enabling:** In a continuing effort to encourage parents NOT to remove car seats from the secured position in the automobile to transport their children elsewhere, we will be increasing our promotion of the use of portable cribs. Eventually our SAFE KIDS goal is to make sure that every newborn leaves the hospital with both a car seat and a portable crib, as each will assist in the use of the other.

**Population:** Continued constant scheduling of press releases, brochure distribution, media interviews and promotions, and other social marketing opportunities for promoting of safe driving principals, including proper installation of car seats, importance of booster seats for even older children if they are too small for adult seat belts, always wearing a seatbelt as an example to all children, and making sure every occupant is secured in a motor vehicle at all times.

Cell phone use is now prohibited while driving in the municipalities of Albuquerque, Santa Fe and Las Cruces.

**Infrastructure:** The Safe Kids New Mexico network of 10 coalitions and chapters continues to engage in car seat and booster seat clinics, as well as assisting with the staffing of "fitting stations" where families can have their current seats checked, and if necessary, replaced. We are soliciting donations and volunteers to start new SAFE KIDS chapters in Taos and Rio Arriba counties, as well as to expand the current SAFE KIDS chapters in Gallup and Grants.

**c. Plan for the Coming Year**

**Population:** This coming year we intend to continue to contribute to driver education and awareness among youth via the Safe Kids organizations statewide by again enlisting more of their participation in media promotions, education and event production for children. Many of the charities that Safe Kids will be approaching, including Kiwanis, Rotary and Optimist, have special youth groups for the expressed purpose of community service, and we intend to greatly expand

the use of peer education and mentoring. We will also continue to engage youth for expanding education and safety awareness among their peers regarding the use of all terrain vehicles in collaboration with 4H Clubs.

If there is sufficient funding, the home safety program will be expanded from home day care providers to foster, adoptive, and grandparents, of which there are approximately 100,000 currently residing in New Mexico.

A new state law prohibiting texting while driving will be considered for a third time at the legislature in 2013.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	50	43	45	53	53
Annual Indicator	49.0	41.8	42.2	49	
Numerator	144				
Denominator	294				
Data Source		NIS	NIS	NIS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	53	53	55	55	57

**Notes - 2011**

2008 birth cohort not available. 2010 data reports cohort born in 2007.

**Notes - 2010**

49% is the percent of infants that were fed any breast milk to six months or beyond. This is the result from the National Immunization Survey of children born in 2007.

The percent of infants from that same cohort that were exclusively breastfed was 46.8% at three months, and 18.7% at six months.

Healthy People 2010 goals for exclusive breastfeeding are 60% at three months and 25% at six months.

[http://www.cdc.gov/breastfeeding/data/NIS\\_data/ind](http://www.cdc.gov/breastfeeding/data/NIS_data/ind)

**Notes - 2009**

42.2% is the percent of infants that were fed any breast milk to six months or beyond. This is the result from the National Immunization Survey of children born in 2006.

The percent of infants from that same cohort that were exclusively breastfed was 33.2% at three months, and 14% at six months.

Healthy People 2010 goals for exclusive breastfeeding are 60% at three months and 25% at six

months.

Source: [http://www.cdc.gov/breastfeeding/data/NIS\\_data/ind](http://www.cdc.gov/breastfeeding/data/NIS_data/ind)

**a. Last Year's Accomplishments**

Direct: UNM and Presbyterian Hospitals in Albuquerque operated free Lactation Clinics that provided postpartum breastfeeding consultations and breastfeeding classes weekly. The NM BFTF Honor Roll Project was implemented to formally recognize with a plaque, ceremony and media attention the 9 hospitals in NM that banned formula discharge bags. WIC provided group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; a choice between 4 different types of breast pumps for breastfeeding mothers; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers. WIC also provided prenatal backpacks filled with support materials to all pregnant mothers.

Enabling: WIC continued operation of the Peer Counselor Program; expanded to 55 counselors throughout 40 public health clinic sites.

Population-Based: The NM BFTF and WIC worked to increase public acceptance of breastfeeding through the development and dissemination of 6,500 "Positive Images of Breastfeeding" 2010 Calendars to families and healthcare providers statewide; created public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week, August 1-7, 2010. As a result of House Memorial 58 passed by the NM 2009 Legislature, the Governor's Women's Health Office convened a task force which made recommendations for breastfeeding accommodations in schools to a legislative committee. All WIC clinics provided a breastfeeding reference book and educational DVD to local health care providers through a WIC Physician Outreach Project.

Infrastructure Building: WIC provided breastfeeding training for staff through a statewide WIC conference which included 2 breastfeeding and 2 peer counselor program training sessions. WIC also provided 5 "Using Loving Support to Grow and Glow in WIC" staff trainings and 5 Loving Support Peer Counselor Trainings. The NM BFTF Annual Advanced Concepts in Breastfeeding Conference provided lactation education to over 300 health care professionals. The project "Using Loving Support to Build a Breastfeeding Friendly Community" developed a weekly mothers' support group in Grants, and expanded to Clovis, NM. The NM BFTF awarded 4 grants for breastfeeding promotion/support to Santo Domingo WIC, Valencia County, SW NMBF Council and the Breast Cancer resource center. Access for healthcare professionals to adequate breastfeeding research, supplies and resources continued through ongoing development of WIC's intranet and internet websites, and the BFTF website.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Breastfeeding Education and Counseling	X			
2. WIC Breastfeeding Peer Counseling		X		
3. WIC and BFTF Website Education and Activities				X
4. Breastfeeding Continuing Education/Trainings for healthcare professionals				X
5. BFTF and WIC World Breastfeeding Week Celebration			X	
6. BFTF Hospital Honor Roll Project to Ban Formula D/C Bags	X			
7. "Using Loving Support to Build a Breastfeeding Friendly Community" Model				X
8. BFTF Grants for Breastfeeding Projects Statewide.				X
9. UNM and Presbyterian Hospitals' Lactation Clinics	X			

10. NM Legislation in Support of Breastfeeding		X		
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**b. Current Activities**

Direct: UNM and Presbyterian Hospitals in Albuquerque continue to offer free lactation clinics. 14 hospitals in NM have banned the dissemination of formula gift packs to mothers upon hospital discharge. The NM BFTF has applied for funding from the Kellogg's Foundation for a 3 year project to encourage and support NM hospitals to be designated Baby Friendly. WIC continues to provide resources, aides and breastfeeding support sessions to WIC mothers.

Enabling: WIC increased number of peer counselors to 73 throughout 51 WIC clinic sites.

Population-Based: 6,500 "Positive Images of Breastfeeding" 2011 Calendars were given out statewide. WIC and NM BFTF participated in World Breastfeeding Week.

Infrastructure Building: The NM BFTF has applied and received funding from the Kellogg's Foundation for a 3 year project to build and strengthen the statewide and local NM BFTF coalitions. Breastfeeding education and training opportunities for health care professionals continue to be provided through: WIC "Using Loving Support to Grow and Glow in WIC Staff Training," newly developed computer based breastfeeding trainings, self-paced continuing education modules for IBCLE Cerps and the Loving Support Peer Counselor Trainings, as well as the NM BFTF Annual Advanced Concepts in Breastfeeding Conference. WIC is currently updating and expanding its public internet site, including a staff resource component, as well as starting to design a new management information system for WIC data.

**c. Plan for the Coming Year**

Direct: The NM BFTF will continue the NM BFTF Honor Roll Project to increase the number of and formally recognize hospitals in New Mexico that ban formula discharge bags. UNM and Presbyterian Hospitals in Albuquerque will continue operation of free Lactation Clinics, with expansion of the Presbyterian support group to the city's west side. WIC will continue to provide all prenatal clients with a backpack filled with breastfeeding education materials; group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; emphasis on exclusive breastfeeding through the WIC food package and 4 different types of breast pumps; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers. The NM BFTF will begin implementation of year 1 of the 3 year grant project funded by the Kellogg's Foundation to encourage and support NM hospitals to be designated Baby Friendly.

Enabling: WIC will continue to operate its peer counselor program, expanding to additional WIC clinics as funding allows. Expansion plans also include further program development to ensure better recruitment, training and retention of peer counselors.

Population-Based: BFTF and WIC will continue the development and dissemination of "Positive Images of Breastfeeding" Calendars annually through WIC and other health care providers statewide. Public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week will take place. The NM BFTF will begin implementation of year 1 of the 3 year grant project funded by the Kellogg's Foundation, to include a breastfeeding awareness media campaign.

Infrastructure Building: WIC will work on design and development of a new management information system to collect and report breastfeeding client data, as well as improved breastfeeding initiation and duration data. Breastfeeding education and training opportunities for health care professionals will continue to be provided through WIC "Grow and Glow" and "Breastfeeding Basics" training, computer based training, self-paced continuing education modules for IBCLE Cerps, Loving Support Peer Counselor Trainings, and the NM BFTF Annual Advanced Concepts in Breastfeeding Conference,. Access for healthcare professionals to

adequate breastfeeding research, supplies and resources will continue through on-going updates to the WIC staff's intranet site and the BFTF website. The NM BFTF will begin implementation of year 1 of the 3 year grant project funded by the Kellogg's Foundation to build and strengthen the statewide and local NM BFTF coalitions. Development of local community breastfeeding projects to increase the duration of breastfeeding will continue through NM BFTF mini-grant funds. The number of IBCLCs in New Mexico will continue to be increased through providing NM BFTF scholarships for IBCLC exam expenses, and providing WIC staff with study resources.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	96	96	96	96	97
Annual Indicator	92.3	95.0	95.0	95.0	95.0
Numerator	27625	28648	27429	25175	25888
Denominator	29918	30156	28873	26500	27251
Data Source		CMS	CMS	CMS	CMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	97	97	97	97	97

**Notes - 2011**

This is an estimate. The hearing screen field on the electronic birth certificate is not required, and many hospital personnel do not record this information, especially in larger birthing facilities.

As of 2/2012, Children's Medical Services has hired a contractor to assess issues around recording hearing screening on the birth certificates.

**Notes - 2010**

This is an estimate. 2010 Hearing Screening Data not yet available. The hearing screen field on the electronic birth certificate is not required, and many hospital personnel do not record this information, especially in larger birthing facilities.

**Notes - 2009**

This is an estimate. The hearing screen field on the electronic birth certificate is not required, and many hospital personnel do not record this information, especially in larger birthing facilities.

**a. Last Year's Accomplishments**

Enabling: The Newborn Hearing screening Program received funding from CDC to develop, maintain and enhance early hearing detection and Intervention systems and surveillance programs. The Program received Supplemental funding from HRSA to support Universal Newborn Hearing Screening and Intervention. The Program hired a Newborn Hearing Screening Program Coordinator. The Program maintained the contract with the short term follow-up

coordinator to reduce lost to follow-up rates. The Program also has a part time short term follow up coordinator for Spanish speaking families. The Program used CDC Funding to contract with a Data Manager and Needs Assessment Coordinator to evaluate and implement more accurate data collection procedures. The Program used funding from HRSA used to contract with Education of Parents of Indian Children with Special Needs (EPICS) to improve outreach and education to Native American families with children that are deaf or hard of hearing.

Population-Based: Coordinator continued to address lack of access to audiology services. The Program received supplemental funding from HRSA that was used to provide technical training to audiologists on diagnostic procedures. A conference was planned for the Fall of 2011 and an contractor that is an officer in The New Mexico Speech and Hearing Association and is a pediatric audiologist is coordinating this conference with the NMSHA Annual Meeting. A contract was established with EPIC's to develop training specific to families of children who are deaf or hard of hearing and to help establish cultural brokers in native communities to partner with the NHS Program and deliver information to improve hearing health information, outreach to families who's baby did not pass the hearing screening and follow up in the native population. Needs Assessment began with all hospitals, Indian Health Services, midwives, and from neighboring states to improve accuracy of Newborn Hearing Screening data reported to the CDC..

Infrastructure Building: The hospitals received revised referral form and DVD curriculum developed by NCHAM to assist with on-going training needs 100% of birthing hospitals continue to provide newborn hearing screening. The Program continued an Extended Partner Advisory Council with a focus on improving follow-up activities. A policy has been developed to identify and contact parents of infants with risk factors. A packet of information is sent to these families. The largest hospital in the state UNM provides an annual appointment for all babies with identified risk factors. The CYSHCN Program Manager continued to chair CDC EHDI Minority Committee, which addresses access for diverse families. The Program maintained distribution of hearing, child development, and family support materials including informational brochures and family handbooks in English and Spanish. The Program continued collaboration with the Early Intervention Programs ( Family Infant Toddler and Step Hi), Head Start to provide access to hearing screenings in the community and to continuously identify and support children who are deaf and hard of hearing in the state. The Program was invited to participate in the National Initiative for Children's Healthcare Quality Improving Hearing Screening & Intervention Systems Learning Collaborative (NICHQ). The Program joined 14 other states in this national HRSA sponsored learning initiative. The Program Coordinator and extended partners formed a team for this initiative and completed the pre-work required. The Program continued to monitor hospital and provider compliance with the Public Health reporting requirements. Medical providers reported to DOH suspected and/or confirmed hearing loss in children birth to 4 years. The program continued to work on the implementation of the telehealth audiology project in Gallup. The D/HH Task Force and Hands and Voices to remained inactive this year.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Training of all hospital staff, midwives and providers on proper reporting procedure and protocol.				X
2. Monitor compliance with reporting requirements.				X
3. Enhance current data collection system.				X
4. Implement audiology surveillance of reporting			X	X
5. Facilitate advisory council meetings				X
6. Attend Cultural Competence Committee			X	X
7. Implement audiology telehealth project				X
8.				

9.				
10.				

**b. Current Activities**

Enabling: Program improved family and medical home communication and reduced loss to follow up. HRSA and CDC funds supplement improving loss to follow up and infrastructure building. Program and partners participated in NICHQ and the EHDI annual Conference.

Population-Based: Partnered with NMSHA and provided hands on training for audiologists specific to newborn hearing screening 45 audiologists attended the training, s EPIC's held the Family Leadership Academy and fall and spring workshop series for families and providers giving preference to families of children who are deaf or hard of hearing- 300 people have participated, coordinator contracted to work with Spanish speaking families, with the CDC EHDI Minority Committee produced a pamphlet on Communication Choices in English and Spanish.

Infrastructure Building: Participated in NICHQ ISIS Learning Collaborative with extended partners, provided training and technical assistance to hospitals, midwives and CMS staff, needs assessment coordinator evaluated birthing hospitals and provided report, implemented improvements to the collection of data, enhanced surveillance software, established workgroups to address drivers learned thru NICHQ, implemented consistent policies for screening, risk factors, referral and follow up, implemented telehealth audiology pilot project, participated in the statewide MCH Collaborative, maintained board membership and established a contract with Hands and Voices for capacity building.

**c. Plan for the Coming Year**

Enabling: Continue funding with HRSA and CDC. Continue contracts with Short Term Follow- up coordinators and Data Manager using CDC Grant. Continue contract with Needs Assessment Coordinator to complete the report and recommendations begun in 2011 working with Indian Health Services, neighboring states and out of hospital birth providers to build a system for collecting EHDI data. Continue contract with Audiologist to assist with training and outreach to audiologists. Continue to support UNM/ Gallup Teleaudiology program attending committee meetings and helping to trouble shoot during the first year of program implementation.

Population Based: CMS Medical Director is AAP EHDI Chapter Champion liaison working on Early Hearing Detection and Intervention with physicians statewide. Implement PCP Roadmap in medical homes. NHS Training to be provided for any newly licensed midwife in conjunction with Newborn Genetics Program. All midwives renewing licenses will receive NHS training materials and referral forms. All educational materials will be available in Spanish and English. Audiologist consultant to assist with outreach and training with pediatric audiologists in the state. Needs Assessment Coordinator and Program Coordinator will work with Indian Health Services to identify screening sites at IHS Clinics and develop a reporting agreement with the NHS Program. Continue contract with EPICs to develop Indian parent leaders in communities as cultural brokers for newly identified families of children who are deaf or hard of hearing. Contract with a parent liaison to the NHS Program to co-chair Advisory Committee, to speak on panels at conferences and attend the EHDI National Conference. Contract with Hands and Voices to develop family to family support for parents of children that are deaf or hard of hearing.

Infrastructure Building: NHS Coordinator to hold 5 Regional informational meetings inviting Early Intervention Providers, hospital providers, parents, midwives and HIS leadership to teach about Early Hearing Detection and Intervention and to recruit statewide stakeholders for the Advisory Committee work groups. Needs assessment Contractor, Data Manager and software contractor will build a system to more accurately collect the data required for reporting for the EHDI annual survey based on findings of the needs assessment. NHS Coordinator to report to hospitals and audiologists monthly births and reported hearing loss referrals received. This information will also

be compared with Early Intervention referrals received to assure that all children identified with hearing loss are identified and referred for services. NHS Coordinator will attend the Maternal Child Health Collaborative, remains a board member for Hands and Voices, working member of the Interagency Collaboration Committee Childfind work group and Facilitate the Program Advisory Committee.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	10	10	10	10	10
Annual Indicator	11.9	11.9	11.9	11.9	11.9
Numerator	58681	58681	58681	58681	58681
Denominator	493459	493459	493459	493459	493549
Data Source		2007 NSCH	2007 NSCH	2007 NSCH	2007 NSCH
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	8	8	5	5	3

**Notes - 2011**

NM set its target at 10 for the period 2004 through 2010, and during that time it was not reasonable to set it lower. We are not yet able to determine how the Patient Protection and Affordable Care Act (PPACA) is currently affecting child insurance coverage rates, nor are we able to determine how it will affect those rates in the future. Should he act be upheld, we expect that the number of uninsured children in New Mexico will decrease.

**Notes - 2010**

Data are currently being collected for the new National Survey of Children's Health 2011-2012.

**Notes - 2009**

Source:

National Survey of Children's Health

<http://nschdata.org/Content/#>

The 2009 US Census Current Population Survey reports that 14% of children under age 18 are uninsured.

NM has reset its target to 10 for period 2004 through 2010; it is not reasonable to set it lower - the state should be able to maintain ground if present priorities remain actively pursued.

**a. Last Year's Accomplishments**

Direct: Family Health Bureau (FHB) staff participated in the EPSDT-Medicaid Advisory Committee. FHB worked with partners to identify statewide strategies to address issues of uninsured or underinsured, lead screening, and immunizations schedules and issues. Families

FIRST and CMS programs completed Presumptive Eligibility/Medicaid On-Sight Application Application (PE/MOSAA) applications for eligible pregnant women, children or youth. Medicaid continued to have a twelve-month renewal process. DOH is working collaboratively with HSD to identify community events that provide opportunities for outreach and Medicaid enrollment of eligible children. New Mexico formed the New Mexico Office of Health Care Reform which is meant to help more people obtain health insurance. The exchange would function as a way to connect uninsured residents and small businesses without insurance with companies to sell them a policy.

Enabling: Title V MCH and State General funds were used to cover services to pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of health care coverage. New Mexico won a federal grant to start the building of a health care exchange computer framework. Estimates are that as many as 250,000 of New Mexico's 430,000 uninsured would become eligible to use the exchange from 2014 to 2020.

Infrastructure Building: About 21,000 children, 5 yrs old and under are uninsured in New Mexico. HSD continued to allow an increase in the amount of income that can be disregarded and the amounts that can be deducted from gross income, thereby increasing the number of families who qualify for Medicaid. The Medicaid 1115 waiver continued to provide family planning services. Gaps in services were monitored and identified thru the Early & Periodic Screening, Diagnosis, & Treatment (EPSDT)-Advisory Committee. DOH worked collaboratively with the Children's Cabinet to address universal coverage for children.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate in the EPSDT-Medicaid Advisory Committee	X			
2. FHB will work with partners to identify statewide strategies to address issues of uninsured or underinsured.	X			
3. Families FIRST and CMS programs will provide assessment of insurance options for clients, and complete PE/MOSAA applications for children or youth who are eligible.	X			
4. Working collaboratively to the birth certificate requirement.	X			
5. Title V MCH and State General funds are being used to cover services to pregnant women and children who have no other source of coverage.		X		
6. Continue to reach out to families to increase the number of children who enroll for Medicaid and provide information to families about the new program which will provide assistance to pay for health insurance.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Direct: Family Health Bureau (FHB) staff is a member of the EPSDT-Medicaid Advisory Committee which meets quarterly to discuss services provided to children under EPSDT. PE/MOSAA training for CMS and Families FIRST (FF) staff continues and online training is available. This increases the number of staff trained to reach out to Medicaid eligible clients. The New Mexico Office of Health Care Reform continues to prepare for the operation of a health care exchange to be operational by January 1, 2014.

Enabling: Title V MCH and State General funds are used to cover services to pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of health care coverage.

**c. Plan for the Coming Year**

Direct: DOH will continue to reach out to children and families to increase the number of children who are insured. This includes the efforts of Families FIRST and CMS staff who are actively involved in assisting families to complete the PE/MOSSA application, and the continuing efforts to prepare for the implementation of a health care exchange by January 1, 2014.

Enabling: Title V MCH and state general funds will continue to be used to cover services for pregnant women (Hi Risk Prenatal Fund) and children (Healthier Kids Fund) who have no other source of coverage.

Infrastructure Building: DOH will work collaboratively with HSD to increase the number of eligible children enrolled in Medicaid. The Children’s Cabinet continues to work with the Governor and the State Legislature to implement health care coverage for all New Mexicans, including Children. The New Mexico Office of Health Care Reform will continue to prepare for health care reform which could potentially assist 250,000 New Mexicans obtain health care insurance.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	24	21	24	24	24
Annual Indicator	26.3	25.7	25.7	25.4	37.6
Numerator	6493	7065	7065	7885	21244
Denominator	24691	27442	27442	31043	56544
Data Source		NM WIC	NM WIC	PEDNSS 2010	eWIC Client Obesity 9197 S
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	35	35	35	33	33

**Notes - 2010**

Derived from CDC PEDNSS 2010 report.  
[http://www.cdc.gov/pednss/pednss\\_tables/pdf/national\\_table6.pdf](http://www.cdc.gov/pednss/pednss_tables/pdf/national_table6.pdf)

Data from before 2010 were analyzed by the WIC program. 2010 data are from CEC PEDNSS, and should not be compared to previous years due to differing analysis strategies.

**Notes - 2009**

2009 data are incomplete, and are not reported.

**a. Last Year's Accomplishments**

Enabling: Provided referrals to Children's Medical Services (CMS), Families First, health care providers and therapists in the state who provide treatments to women, infants and children who displayed feeding issues. WIC staff provided WIC participants individual nutritional counseling and support which included the issuance of eWIC cards (food benefits) which the WIC food package was changed to align with the 2005 Dietary Guidelines for Americans and the infant practice guidelines of the American Academy of Pediatrics. WIC staff provided WIC participants group nutrition education on healthy nutrition choices and practices.

Population-Based: Continued collaboration with the "The New Mexico Plan to Promote Healthier Weight", the University of New Mexico/Project Extension for Community Healthcare Outcomes (ECHO). Shared positive healthy eating choices and physical activity information to WIC clients to expand knowledge and skills, in anticipation that the information went directly back to their communities to impact their families' health. The WIC Program provides opportunities for participants to learn how to choose what's best for their health and the health of their family.

Infrastructure Building: Collaboration with the University of New Mexico and Extension for Community Healthcare Outcomes (ECHO) provided specialized training to the New Mexico WIC nutritionists and Eligibility Interviewers on Gestational Diabetes Mellitus (GDM). The staff learned to provide assessment to first trimester pregnant mothers to identify high risk GDM criteria. Additionally, staff were trained on A1C testing, documentation, and a referral process to offer educational materials to pregnant mothers who were found to be in the blood glucose impaired range. After statewide training was completed, University of New Mexico and Project ECHO made the commitment to provide 2012 quarterly continuing education, data updates and presentations.

Direct: Planned a Value Enhanced Nutrition Assessment (VENA)/ Participant-Centered Education (PCE) matrix model to continue staff training support. This matrix model incorporated the State Agency's Support, Service Delivery Environment, WIC Region Managers/Supervisors and all WIC local clinic staff, Motivational Interviewing (MI) Competency, Cultural and Linguistic Competency and resource materials that include but are not limited to; Get Healthy Together, WIC FIT, GDM, etc. The need for observation tools to provide skill building opportunities for staff was identified. These tools will enhance the quality of service for one-on-one appointments and group nutrition education to create the focus on the participant's needs. WIC staff provided group education and individual counseling on key messages using USDA materials, "FIT KIDS = HAPPY KIDS". The key messages included physical activity, decreasing TV and computer time, drinking more water and less sweetened drinks and eating as a family. Gestational Diabetes Mellitus individual assessment and counseling as well as group education was offered to WIC pregnant moms who were found to have blood glucose in the impaired range. Specific GDM education materials were offered on walking, portion sizes, healthy weight gain, etc. In addition, a "WIC says: Activate Your Day" group education was offered to WIC participants which included offering a physical activity brochure that focused on physical activity ideas for babies, toddlers and adults.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a comprehensive plan and effectively administer the mandated USDA Value Enhanced Nutrition Assessment (VENA) statewide.	X			

2. Provide referrals to Children's Medical Services, Families First, health care providers, and therapists in the State of New Mexico who provide counseling, support and treatments to women, infants or children demonstrating feeding issues.		X		
3. Collaborate with "The New Mexico Plan to Promote Healthier Weight", UNM and ECHO partners, NM Collaboration to End Hunger by providing healthy lifestyle information and resources to WIC partners and their communities.			X	
4. Market and promote the new updated NM WIC website to the WIC staff and the public to create awareness of this tremendous resource in providing information on positive lifestyle changes and healthy nutrition choices with New Mexican flair.				X
5. Connect with additional agencies and/or organizations to create linkages of support and a broad network.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Direct: Train and mentor staff on MI to attain PCE goals in assessments and group nutrition education. Share messages from "The New Mexico Plan to Promote Healthier Weight".

Enabling: Refer to CMS, Families First, health care providers and therapists who provide counseling and treatment to women, infants and children who display feeding issues. WIC staff demonstrate MI skills to provide individual nutritional counseling and group education including issuance of eWIC cards (food benefits) at scheduled WIC appointments.

Population-Based: Continue collaboration with the "The New Mexico Plan to Promote Healthier Weight" by providing health and physical activity information to WIC participants. Partner with NM Collaboration to End Hunger to provide outreach and nutrition materials. The WIC Program website is currently under construction.

Infrastructure Building: Continuing to collaborate with UNM and ECHO partners to provide quarterly training to WIC staff. Present documentation and regular data outcomes to WIC management staff. Continue to attend NM Public Health Diabetes and Control Program meetings. Continue collaboration with the NM Department of Health Tobacco Use Prevention and Control Program. WIC participants or caregivers will be offered smoking cessation information and referrals to the 1-800-QUIT-Line. Continue to train staff on MI to perform PCE components to connect nutrition assessment and nutrition education to meet each participant's needs.

**c. Plan for the Coming Year**

Direct: Continue to train, observe, and mentor staff on MI to perform and attain USDA/VENA and PCE goals. Continue to train, observe and mentor staff to provide quality participant centered individual assessments and group nutrition education with activities and resources to engage and connect with the WIC participants. Regions will implement the PCE observation tools and provide feedback. Continue to share and heighten our messages to increase activity, reduce TV and other screen time, increase fruits and vegetables, educate on portion control, increase breastfeeding rates, and reduce sweetened beverage intake. Statewide evaluation of the PCE on-line modules will be conducted by Survey Monkey. Write policy and procedures for training and process for training "Competent Professional Authority" (CPA) and Para-professionals for the New Mexico WIC Program and submit to the State Management Team for approval. State and Regional Clinic Reviews will incorporate the VENA and PCE skills observation component and

noted deficiencies will be cited.

Infrastructure Building: Continue to train, guide, and mentor staff on PCE components to perform quality USDA Value Enhanced Nutrition Assessment (VENA) mandates. Meet and communicate with staff from UNM and ECHO partners to plan out specialized WIC staff trainings, communicate needs, and discuss data outcomes in order to share with other departments and agencies, WIC Director and Regional Managers/Supervisors. Continue to attend NM Public Health Diabetes and Control Program meetings to connect with statewide plans and activities. Continue to collaborate with the New Mexico Public Health TUPAC initiative, as well as attend Community Transformation Grant TUPAC meetings to continue to be involved with goals and activities. Connect with the members of the New Mexico Action for Healthy Kids to collaborate and exchange ideas. A Statewide WIC Training Conference is planned for June 7 & 8, 2012.

Enabling: Continue providing referrals to CMS, Families First, health care providers and therapists who provide counseling, support and treatments to women, infants or children demonstrating feeding issues. Continue the expectation for WIC staff to demonstrate MI skills to provide quality individual nutritional counseling as well as provide quality nutrition education group sessions to provide healthy nutrition choices and resources. Continue providing referrals to WIC participants who have GDM risk criteria and offer WIC TUPAC smoking cessation materials and referrals.

Population-Based: Create public awareness of positive lifestyle changes and healthy nutrition choices through the New Mexico WIC website. Continue to align New Mexico WIC information and tasks with "The 2016-2015 New Mexico Plan to Promote Healthier Weight". Correspond and connect with New Mexico Action for Healthy Kids to create a linkage of support to the organization.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	8.5	7.2	7.2	7	8
Annual Indicator	7.6	8.1	9.3	7.9	
Numerator	2129	103	2494	104	
Denominator	27936	1264	26861	1321	
Data Source		NM PRAMS	NM PRAMS	NM PRAMS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	6.5	6.5	6	6	5

**Notes - 2011**

2011 Data not yet available.

**Notes - 2010**

Unweighted data.

**a. Last Year's Accomplishments**

Direct: The Families FIRST Program (FF) offered statewide perinatal case management to pregnant women. Women were assessed for tobacco use and second hand smoke exposure. Second hand smoke was the most reported risk factor for FF pregnant clients in 2009. Case Managers (CM) educated women about the harmful effects to themselves and their babies. CMs developed plans of care, provided follow-up and monitored clients' progress. Pre-term labor and compromised respiratory ailments were discussed with their clients. Referrals were made for smoking cessation classes. Services were being documented in an electronic database and reports were generated showing the number of cases screened and the numbers of pregnant women in the FF program who were reporting the use of tobacco and or exposure to second hand smoke.

Family Planning assessed women for violence, alcohol, substance and tobacco use. Pregnant, Medicaid eligible women were referred to FF and non-Medicaid eligible women were referred to prenatal care programs. Prenatal Care programs assessed for tobacco use. WIC offered Lifelong Happiness, a preconception health education project including materials, in English & Spanish, & activities that educated women regarding the avoidance of tobacco during pregnancy.

Enabling: The DOH's Tobacco Use Prevention and Control Program (TUPAC) maintained a website and reported that nicotine replacement doubled quit rates. These actions were calculated to potentially reduce the State's future health care costs by \$395.5 million.

Population: Data published this last year show that educational programs contributed to a 20% decrease in youth smoking and a 25% decrease in youth smoking between 2003 and 2009. TUPAC provided educational materials throughout the state on smoking prevention and cessation programs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Families F.I.R.S.T. will continue to provide case management for pregnant women including screening, assessment, education, care planning, referrals to smoking cessation programs and follow-up for tobacco use.	X	X		
2. WIC will continue to utilize their standard client history that includes assessment for tobacco use. They will provide motivational interviewing and referrals as needed.	X	X		
3. Family Planning and Prenatal Care programs will continue to assess for tobacco usage and refer as appropriate.	X	X		
4. PRAMS will continue to survey for tobacco usage and report on the numbers of women who smoke in the last three months of pregnancy.	X			X
5. TUPAC will continue to offer nicotine replacement services where appropriate and support services for cessation to pregnant women		X	X	
6. The Dee Johnson Clean Indoor Air Act has eliminated smoking in stores, offices, restaurants, bars and indoor public places.		X		X
7. Tax on cigarettes discourages smoking while helping overcome state financial hardship.		X	X	X
8.				

9.				
10.				

**b. Current Activities**

Direct: Families FIRST, WIC, Family Planning, and Prenatal Care continue offering assessment; education and referral services for smoking that were previously provided to pregnant women. WIC nutritionist in one region of the state use the Lifelong Happiness: Preconception Health Education Project modules related to smoking, and other harmful behaviors, using motivational interviewing to encourage pregnant women to reduce and quit smoking during pregnancy. WIC state level is now working with TUPAC to provide a toolkit for all smokers identified as they reregister for WIC. The PRAMS survey asks women questions related to tobacco usage and provides data analysis to allow programs to be targeted to areas of greatest need. Other results produced from the Families FIRST database analysis are also being used to direct educational efforts to reduce the incidence of tobacco use specifically in pregnant women and their families.

Enabling: TUPAC increased the number of support calls for pregnant women participating in their program this year. TUPAC also continued offering free nicotine replacement (patches, lozenges and gum) to New Mexican tobacco users who enroll in the "Quit for Life" program.

**c. Plan for the Coming Year**

Direct: Families FIRST, WIC, Family Planning, and Prenatal Care will continue to offer the assessment, education and referral services for smoking that they are presently providing to pregnant women. WIC nutritionists will offer the materials developed with TUPAC on smoking cessation resources, to encourage pregnant women to reduce and quit smoking during pregnancy. PRAMS will continue to survey women related to tobacco usage. Results from PRAMS and results from the FF database analysis will be evaluated to direct future educational efforts to reduce the incidence of tobacco use in women of childbearing age.

Enabling: TUPAC will continue to offer free nicotine replacement (in the form of patches, lozenges and gum) to New Mexican tobacco users who enroll in the "Quit for Life" program.

Population: TUPAC also plans to continue public education work to reduce smoking in youth.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	13.5	21	16	13	14
Annual Indicator	18.5	19.5	15.2	18.0	16.9
Numerator	31	33	26	27	25
Denominator	167360	169498	170939	149978	147705
Data Source		NMVRHS	NMVRHS	NMVRHS	NMVRHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	15	15	15	14	14

**Notes - 2011**

2011 data not yet available.

New Mexico revised its population estimates in 2010. Denominators and rates from previous years should be corrected as follows:

2007=148606 20.18

2008=149024 22.14

2009=149443 17.4

**Notes - 2010**

Final 2010 data pending release of 2010 population estimates.

Data from: <http://ibis.health.state.nm.us/>

**Notes - 2009**

2008 and 2009 data not yet available.

**a. Last Year's Accomplishments**

Direct Health Care: Family Health in partnership with OSAH continued efforts to reduce youth suicide by implementing evidenced based tools such as the Signs of Suicide (SOS) curriculum, community coalition building, screening/early identification, referral and treatment. Targeted training was provided to schools with school-based health centers (SBHCs) on suicide crisis planning and response and a peer-to-peer program entitled "Natural Helpers" (NH) was implemented with eight schools. OSAH also supported and coordinated three statewide crisis line activities and were linked to the National Talk Line (1-800-272-TALK). OSAH continued to fund and offer technical assistance to the SAMHSA funded demonstration project that incorporated eight Universal, Selective, and Indicated strategies. The initiative served four diverse rural communities and implemented screening, assessment and treatment programs for high school youth. The peer-to-peer programs implemented in the original project was expanded to four additional sites during FY 11.

Enabling Services: Family Health and OSAH are partnered with inter-departmental workgroups, Optum Health, and the Behavioral Health Collaborative to evaluate and recommend strategies to improve statewide behavioral health infrastructures for youth at-risk for depression and suicide. The redesign of New Mexico's behavioral health system created opportunities to increase interagency collaboration, assess infrastructure issues to improve the delivery of behavioral health services, and increase community collaboration focused on reducing youth suicide.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use of NM Child Fatality Program, Youth Suicide Panel review findings about suicide for policy and program planning.				X
2. Suicide prevention training in schools and universities.			X	
3. Gatekeeper training in communities.			X	
4. Public and professional training sessions, educational and	X			

informational sessions are ongoing.				
5. NM Crisis line implemented statewide and toll free.	X			
6. Signs of Suicide peer based gatekeeper training in schools.	X			
7. Identify youth at risk and assure access to mental health services.		X		
8.				
9.				
10.				

**b. Current Activities**

Direct: Promote suicide prevention/intervention/postvention through schools & SBHCs. Technical assistance/training provided to school staff on linking school safety planning to suicide/crisis/grief planning & response. Facilitates peer-to-peer youth programs to promote awareness & resiliency. Provide Gatekeeper training for faculty and staff at several high schools, colleges and universities. A new contractor was added this year to provide training, resources and programs for suicide prevention for Gay, Lesbian, Bisexual, and Transgendered (GLBT) youth statewide, including formation/support of Gay-Straight Alliances in middle and high schools.

Enabling: Partnership with inter-departmental workgroups, Optum Health, Behavioral Health (BH) Collaborative to evaluate and recommend strategies to improve behavioral health infrastructure for youth-at-risk for depression and suicide. Support for the development of a Native American Suicide Prevention Clearinghouse website for resources and programs.

Population: Trainings on signs of suicide, Prevention, Intervention, Postvention (PIP), response and reducing stigma. Include behavioral health track at Head-to-Toe Conference. Worked with partners to provide community-based awareness & crisis response.

Infrastructure: Participate in NM Child Fatality Review. OSAH uses a health care quality initiative in SBHCs to improve infrastructure, quality of integration between primary & BH care and enhancement of SBHC administrative functions.

**c. Plan for the Coming Year**

Direct: Family Health in partnership with OSAH will continue to promote suicide prevention and intervention through schools and SBHCs. Technical assistance and training will be provided to school staff on linking school safety planning to suicide/crisis/grief planning and response. OSAH, in partnership with PED, will coordinate training and resources necessary to increase suicide reduction skills, knowledge and awareness of school personnel. OSAH will expand the availability of telehealth services that link SBHCs statewide to behavioral health specialists, including psychiatrists. OSAH will continue to NH and similar peer-to-peer programs.

Enabling: Family Health and OSAH will partner with inter-departmental workgroups, Optum Health, and the BH Collaborative to evaluate and recommend strategies to improve statewide behavioral health infrastructure for youth at risk for depression and suicide. OSAH will continue to fund the operation and marketing of three statewide crisis lines that are linked to the National Talk Line (1-800-272-TALK). OSAH will support the production of webinars that will provide targeted trainings to school and SBHC personnel around decreasing stigma surrounding BH issues, decreasing bullying, and improved screening, diagnosis and treatment of depression and related BH/MH diagnoses.

Population: Family Health with OSAH plans educational efforts engaging the public and professionals about youth depression. Trainings will focus on early recognition of the signs of suicide, intervention and referral, crisis planning and response among adolescent populations, means restriction and reducing MH stigma. OSAH will include a behavioral health focused track at the annual Head-to-Toe Conference, including workshops and presentations on Youth Suicide

Prevention and training on QPR. OSAH will partner with youth suicide prevention organizations and agencies to provide community-based activities such as gatekeeper and anti-stigma awareness and training, and crisis response planning.

Infrastructure: OSAH will participate in regular DOH cross-agency workgroup meetings to address data collection and reporting on prevention activities for all age groups. The workgroup will continue to utilize data from the NM Child Fatality Review Program, Youth Suicide Panel to monitor trends and inform policy-makers, organizations and communities, program planning and policy-making. OSAH will use a health care quality initiative in SBHCs to improve infrastructure, including increasing quality of integration between primary and behavioral health care staff; and enhancement of school-based health center administrative functions needed for sustainability (ie, successful Medicaid billing and reimbursement for services.)

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70	70	70	70	70
Annual Indicator	67.6	67.6	67.8	72.1	82.0
Numerator	286	286	240	269	246
Denominator	423	423	354	373	300
Data Source		NMVRHS	NMVRHS	NMVRHS	NMVRHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	84	84	86	86	88

**Notes - 2011**

2011 birth data not yet available.

**Notes - 2010**

2010 data for this measure are not yet available.

**Notes - 2009**

2008 and 2009 NMVRHS data not yet available.

**a. Last Year's Accomplishments**

Continued outreach and education influenced providers and facilities to implement strategies to transfer care of pregnant women and babies at risk to these facilities.

The Maternal Health Program worked at the infrastructure level in collaboration with the UNM MFM and Presbyterian Medical Group perinatologists to provide care to high risk, medically indigent women. Through the High Risk Prenatal Care Fund (HRF) these services were provided to patients free of charge. Services were provided by at the UNM Health Sciences Center in

Albuquerque, UNM outreach clinics and Presbyterian hospitals and clinics throughout the State. The clinics are staffed by perinatologists, nurses and social workers, and provide high level evaluation and consultation. UNM maintains the Physician Access Line for Service (PALS), providing statewide access to a perinatologist for telephone consultations and to arrange transport for patients requiring intensive management at the university. Additionally, UNM Telemedicine offers the High Risk Pregnancy direct patient evaluation, real-time fetal ultrasound analysis and counseling.

This network of care is designed to prevent low birth weight births through specialized care to the mother. These high risk providers are most likely to anticipate and recognize conditions where delivery at a tertiary care center is desirable and make appropriate transfers of care to them.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contract with providers of high risk and low risk prenatal care to women with no other means of access.				X
2. Partner with stakeholders to upgrade staff, capacity and systems of transport.				X
3. Analyze linked birth-death data to identify gaps or disparities.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Infrastructure Building: Support continued to UNM and Presbyterian perinatology clinics and outreach programs. The high risk fund was used to maximum effectiveness through agreements with a statewide network of high-risk prenatal care providers which obligates them to provide services for high-risk medically indigent women at no cost to the client. Clients at risk for a low birth weight infant due to growth restriction for example, have benefited from a plan for provision of care at birth in an appropriate level facility.

This has improved data on gaps and disparities in transport of appropriate women to tertiary care facilities for delivery through partnership with UNM and Presbyterian perinatologists to develop strategies for improving rates of very low birth weight infants born in tertiary care centers.

**c. Plan for the Coming Year**

Infrastructure Building: Continue to support UNM perinatology clinics and outreach programs. Continue to maximize effectiveness of the HRF, which consists of agreements with a network of high-risk prenatal care providers. The agreements give minimal reimbursement to these selected providers to provide services for high-risk medically indigent women at no cost to the client.

Continue to improve data on gaps and disparities in transport of appropriate women to tertiary care facilities for delivery and partner with UNM perinatologists to develop strategies for improving rates of very low birth weight infants born in tertiary care centers.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	71	74	75	76	68
Annual Indicator	73.0	62.0	65.9	68.7	67.6
Numerator	22354	14040	16626	17795	17302
Denominator	30605	22644	25232	25909	25603
Data Source		NMVRHS	NMVRHS	NMVRHS	NMVRHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	70	70	80	80	80

**Notes - 2011**

Denominator is not equal to total births in NM. It represents only resident births and eliminates births for which prenatal care status is unknown.

**Notes - 2010**

Denominator is not equal to total births in NM. It represents only resident births and eliminates births for which prenatal care status is unknown.

**Notes - 2009**

New Mexico changed to an electronic birth certificate system in 2007. It is not possible to compare data from before and after that year. It was discovered that many of the electronic birth certificates are missing data on month of prenatal care initiation. New Mexico VRHS is working to address this issue.

Denominator is not equal to total births in NM. It represents only resident births and eliminates births for which prenatal care status is unknown.

**a. Last Year's Accomplishments**

The Maternal Health Program administered multiple provider agreement contracts for the delivery of routine prenatal care. Provider agreements were in place for First Step Center and Memorial Hospital in Las Cruces; First Choice Community Health Clinics in Albuquerque, Los Lunas and Belen; First Nations Community Health sources in Albuquerque and Socorro; UNMs Maternal & Family Planning Clinics throughout Albuquerque; and UNM Hospital. All of these clinics and hospitals agreed to see an unlimited number of pregnant women for routine prenatal care and screening, birthing services and postpartum care. Additionally, the Program negotiated with SED laboratory and 3 ultrasound providers for reduced cost services for these clinics. These contracts totaled just over \$857,000 and provided the vast majority of prenatal care for uninsured women in New Mexico. Funding for this care came from both the Federal Maternal and Child Health Services Title V Block Grant Program with matching funds from the General Fund.

Services these different programs provided included evidence based practice protocols,

documentation compliance review, training workshops and continuing education opportunities, text and web based resources, client education materials, access to routine laboratory testing for certain patients, pharmaceuticals and medical supplies through the Public Health Division Pharmacy, and technical support.

Funding of all of the above mentioned programs was essential to the continued access for women to adequate prenatal care, birthing services and post partum care. Decreased funding on both the state and federal level has resulted in less funding for these programs. Our providers have been willing to sustain cuts to their contracts and still provide unlimited service to our prenatal, birthing service and postpartum clients.

The Birthing Workforce Retention Fund gave 6 providers (CNM's and MD's) malpractice insurance premium assistance in 2010. These awards went to providers whose insurance premium costs jeopardized their ability to continue their practices in underserved areas of New Mexico. In FY 2010 each of the 6 providers was awarded \$5,000.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide case management to Medicaid-enrolled pregnant women, including assistance with accessing prenatal care.	X	X		
2. License and regulate certified nurse-midwives and licensed direct-entry midwives, who provide prenatal care.			X	X
3. Provide support for prenatal care in local health offices to women who have no other source of care.	X			
4. text4baby MOU		X	X	X
5. Administer contractual agreements with clinics to provide prenatal care for medically indigent women.		X	X	
6. Assess access disparities, gaps and barriers to prenatal care services.				X
7. Use NM PRAMS data, Vital Records data and other information to identify key factors, gaps and disparities associated with late entry and low level of care.				X
8. Partner with state and community entities to develop and implement strategies for improving access to prenatal care.			X	X
9.				
10.				

**b. Current Activities**

The State of New Mexico Maternal Health Program (MHP) continued to administering the Birthing Workforce Retention Fund to provide malpractice insurance premium assistance for MDs and CNMs whose insurance premium costs jeopardize their ability to continue their practices in NM. The total award amount from this fund was cut by 25% for 2012. Six awards were given out this year all to Nurse Midwives.

The Maternal Health Program made a memorandum of agreement with text4baby and has encouraged providers and clients to participate in the text4baby opportunity. The service, made available through a broad partnership of community health organizations, wireless carriers, businesses, health care providers, and government health agencies, is very popular and has grown quickly. The MCH Program has promoted participation through home visiting programs, conferences, and e-mail campaigns to our participating Public Health Offices and the New Mexico Midwifery organizations.

The MHP received funding from HRSA to provide a social awareness marketing program for a First Time Motherhood/New Parents Initiative. We are awaiting approval of our contract with an advertising firm and consultant to develop a social marketing program to promote pregnancy planning, early and continued prenatal care, and healthy parenting practices in three target communities.

**c. Plan for the Coming Year**

New Mexico will set up health insurance exchanges and insure more New Mexicans under the Affordable Care Act. This should make earlier prenatal care access easier for the women of this state.

The Maternal Health Program (MHP) will continue to administer the Birthing Workforce Retention Fund to provide malpractice insurance premium assistance for MDs and CNMs whose insurance premium costs jeopardize their ability to continue their practices in NM, thus insuring that maternal health need is addressed in the rural areas of NM.

The MHP will carry through with funding from HRSA to provide a social awareness marketing program for the First Time Motherhood/New Parent Initiative. We will have contracted with an advertising firm and consultant to introduce a social marketing program to promote pregnancy planning, early and continued prenatal care, and healthy parenting practices in three target communities.

The MHP will continue to partner with our PHO's, UNM, private practitioners, the NMMA, the NM chapter of the American College of Nurse Midwives, and institutions throughout the state to form agreements to provide timely and adequate care to pregnant, birthing, and post partum women throughout the state. By working to retain providers and promoting public awareness we hope to improve the percentage of women receiving care in the 1st trimester of their pregnancy and throughout their pregnancy.

**D. State Performance Measures**

**State Performance Measure 1:** *The percent of women with a live birth who had no health care coverage for prenatal care.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					5
Annual Indicator		8.5	6.4	7.3	
Numerator		2422	1735	1880	
Denominator		28473	27263	25914	
Data Source		NM PRAMS	NM PRAMS	NM PRAMS	
Is the Data Provisional or Final?				Final	
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	6	6	2	2	2

**Notes - 2011**

2011 PRAMS data are not yet available.

**a. Last Year's Accomplishments**

In New Mexico, about 2/3 of all births were paid for by Medicaid (66.8 percent). New Mexico enables pregnant women to apply for Medicaid coverage expeditiously through the Presumptive Eligibility/ Medicaid On-Site Application Assistance (PE/MOSAA) program. Under PE/MOSAA, pregnant women do not have to visit a NMHSD eligibility office to obtain coverage, but instead can complete a required face to face interview with a PE/MOSAA Determiner (e.g. school employees, public and private providers, or physician, hospital and clinic staff), who is trained and certified by NMHSD to enroll people in Medicaid and expedite the application process.

As PE/MOSAA Determiners are located statewide, PE/MOSAA determination occurs nearly everywhere in New Mexico: from hospitals and rural clinics, to state fairs and shopping malls. The Premium Assistance for Maternity (PAM) insurance program offers coverage for uninsured pregnant women who are ineligible for Medicaid due to income or who have insurance that does not include maternity coverage. It provided pregnancy-related coverage, including pre and post-natal care. The New Mexico State Coverage Insurance (SCI) covers uninsured adults 19-65 with household income up to 200% FPL.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer High-Risk prenatal care fund.		X		X
2. Conduct outreach to women of childbearing age to educate them about insurance options for prenatal care.		X	X	
3. Continue to enable presumptive eligibility/Medicaid onsite application assistance for low income women.		X	X	
4. State to set up insurance exchanges				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The Maternal Health Program (MPH) continued reaching out to women of childbearing age in New Mexico to educate them about their health insurance options and connect them with insurance providers and services. We have worked to make known that there are no prior authorization requirements for OB/GYN care and that pregnancy can no longer be cited as a pre-existing condition for insurance eligibility.

Medicaid eligibility requirements are under review to include more poor women of childbearing age and Medicaid reimbursements to midwives and birth centers is improving. As single women up to age 26 now more often remain on their parents insurance it is expected the data will reflect higher numbers with insurance at the time of birth.

The MHP received funding from HRSA to provide a social awareness marketing program under a First Time Motherhood/New Parents Initiative. We are awaiting approval of our contract with an advertising firm and consultant to introduce a social marketing program to first time mothers to promote pregnancy planning, as well as early and continued prenatal care.

**c. Plan for the Coming Year**

As the Affordable Care Act now permits more women up to age 26 to remain on their parents insurance we anticipate more women insured at birth for 2012. Since the ACA also establishes insurance exchanges over the coming year more New Mexicans overall will become insured. As more women of child bearing age are insured before they become pregnant, the numbers of women experiencing a live birth without coverage should decrease.

**State Performance Measure 2:** *The percent of pregnant women and new mothers receiving support services through community home visiting programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	10	22	22	22	18
Annual Indicator	16.6	11.6	16.3	15.9	
Numerator	1812	3328	4306	4071	
Denominator	10893	28743	26338	25568	
Data Source		NM PRAMS	NM PRAMS	NM PRAMS	
Is the Data Provisional or Final?				Final	
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	18	18	18	20	20

**Notes - 2011**

2011 PRAMS data are not yet available.

**Notes - 2009**

Denominator is the CDC weighted sample of respondents.

Prenatal home visit only: 3.2%

Postpartum home visit only: 8.8%

Both prenatal and postpartum visits: 3.8%

**a. Last Year's Accomplishments**

**Direct Health Care:** The universal, voluntary home visiting system in New Mexico provides direct services within communities in 21 counties. The Children, Youth and Families Department (CYFD) contracts with community providers for four years and supports programs with state General Fund and ARRA funds. Families receive services from trained home visitors from prenatal to three years of age. In SFY11, the total unduplicated number of families who received a home visit was 1,417. The total unduplicated number of children who received a home visit was 1,121. The total number of pregnant women receiving home visits (prenatal services) was 508. The total number of newborns in home visiting was 491.

**Enabling Services:** Home visitors made 1,637 referrals for families to other services in SFY11. The referrals were for behavioral health services, breastfeeding support, child care, child protective services, developmental evaluation, domestic violence services, early head start, early intervention educational services, FIT, employment, family support, genetic counseling, hearing evaluation, child support, medical assistance, food assistance, legal services, nutrition, oral health, parenting, pediatric services, postpartum depression, prenatal services, preschool, public assistance, recreation, specialty care, substance abuse counseling, transportation, and WIC. All participating women are screened for post-partum depression; of the mothers identified as having symptoms of post partum depression by use of a screening tool, 42.7% agreed to be referred to professional services.

**Population Based Services:** Screening referrals found in the Enabling Services section are

ongoing. Public information and outreach continues by use of web-based teleconferences, newsletters, LISTSERV announcements and community-based information efforts.

Infrastructure Building: The 2011 Home Visiting Summit brought together community providers, families, child advocates, administrators and policy-makers for training, education, workshops and panel discussions. The CYFD home visiting data management system provided funded agencies to manage data effectively for reports, analysis and continuous quality improvement.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Services to 1600 families in high needs areas identified by DOH/CYFD collaboration. Strengthening and expansion of the data management system will continue.	X			X
2. Screening will continue for newborns, postpartum depression, along with information campaigns, public outreach and education.			X	
3. Coordination between community providers is being promoted through cross-training and information sharing. The basic enabling services will continue: transportation, outreach, family support, WIC, food assistance and Medicaid enrollment.		X		
4. The needs assessment conducted in response to the HRSA grant in 2010 identified the most-needy counties/regions in our state. The assessment will be used to guide funding decisions, resource allocations, and targeted services.				X
5. The state will continue to fund community-based home visiting programs statewide and commit resources to expanding the program.	X			
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Direct Health Care: CYFD and DOH continue to support home visiting programs through community contracts and the FamiliesFirst program.

In alignment with federal guidance, the NM home visiting system supports evidence-based programs and best practices.

Enabling Services: Home visitors continue to refer families to WIC, postpartum counseling, early intervention education services, transportation services, family support, food assistance, child care, medical services, and community programs.

Population Based Services: A summit in June 2012 will incorporate training, best practices and evidence-based program information for home visiting providers, child advocates, parents, administrators and health practitioners. The annual Home Visiting conference, held in May 2012, focused on working with domestic violence and was a collaboration involving CYFD home visiting and child protection services, the DOH Part C FIT program, Head Start/Early Head Start, and the Domestic Violence Coalition, with 400 participants.

Infrastructure Building: The formula grant is making possible the Parents as Teachers program

and the Nurse-Family Partnership to serve families in two of the most-needy regions of the state, as identified by a collaborative assessment between DOH and CYFD. The funds will also support development of a data management system, capacity-building, and community organizing around the continuum of family support services in high-need under-served communities.

**c. Plan for the Coming Year**

**Direct Health Care:** Home visiting services will continue to be offered with state CYFD funding and federal HRSA funds. In addition, the legislature allocated an additional \$900,000 for expansion of home visiting services

**Enabling Services:** Coordination between community providers in regards to home visiting and domestic violence is being promoted through cross-training and information sharing. The basic enabling services will continue, such as transportation, outreach, family support, WIC, food assistance and Medicaid enrollment.

**Population Based Services:** Screening will continue for newborns, postpartum depression, along with information campaigns, public outreach and education for immunizations, oral health, injury prevention, nutrition, child abuse, domestic violence and developmentally appropriate child care programs.

**Infrastructure Building:** The needs assessment conducted in response to the HRSA grant in 2010 identified the most-needy counties/regions in our state. This assessment identified 5 target communities for the HRSA federal home visiting programs, and contributed to emerging concepts of "Investment Zones" of high-need under-served communities. The home visiting data management system will develop a pricing packet so that any other home visiting agencies not funded via CYFD can participate in the data system. A home visit Program Registry is to be constructed and maintained, to have the total picture of NM home visiting in view. A statewide "All Home Visiting" collaborative meeting is planned for community-building and information sharing.

**State Performance Measure 3:** *The percent of births resulting from pregnancies that were unintended.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	42	42	41	41	41
Annual Indicator	43.7	42.0	46.2	47.4	
Numerator	12453	534	12443	12074	
Denominator	28477	1272	26938	25452	
Data Source		NM PRAMS	NM PRAMS	NM PRAMS	
Is the Data Provisional or Final?				Final	
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	45	45	43	43	43

**Notes - 2011**

2011 PRAMS data are not yet available.

**a. Last Year's Accomplishments**

Direct Health Care: According to the 2011 Family Planning Annual Report (FPAR), in calendar year 2011, statewide Title X clinics served 34,904 unduplicated clients (30,872 females and 4,032 males). The number of females represents almost 30% of the 104,760 reproductive aged women with income <250% of the Federal poverty level (FPL) (Alan Guttmacher Institute 2008).

Compared to 2010 FPAR, there was a decrease in both female (-4234/12%) and male (-490/11%) clients. The reduction in the number of female and male users is proportionate to the overall reduction. The overall decrease is a result of staff shortages in the Public Health Offices (PHOs) caused by the State required staff vacancy rate for state-funded positions and a reduction in contract service sites.

In 2011, there was a 45% increase in female users relying on long-acting reversible contraceptives (LARCs- IUDs and implant) because FPP made more LARCs available.

Enabling Services: The PHOs provided education and outreach for clients aged 15-17 at schools, detention centers, and community centers on reproductive health topics such as abstinence, decision making skills, healthy relationships, male responsibility, parent-child communication, safer sex, sexual responsibility, teen pregnancy issues and sexually transmitted infections.

Reproductive Life Plan (RLP) counseling, a CDC-recommended preconception counseling model, was added to the FPP protocol and the NM DOH Billing and Electronic Health Record (BEHR) templates. "A reproductive health plan reflects a person's intentions regarding the number and timing of pregnancies in the context of their personal values and life goals. This health plan might increase the number of planned pregnancies and encourage persons to address risk behaviors before conception, reducing the risk for adverse outcomes for both the mother and the infant" (MMWR April 21, 2006).

Population Based Services: The FPP collaborates with the NM Human Services Department (HSD) to promote over-the-counter emergency contraception for Medicaid beneficiaries through a memorandum of agreement to reimburse HSD.

Infrastructure Building: FPP continued to monitor quality of clinical services through needs assessment, client surveys, client-centered care and the electronic medical record system (BEHR).

The annual client satisfaction survey was distributed to clients seen at PHOs. In 2011, there were 2,177 PHO clients who took the survey. When the survey was conducted, 94% of respondents answered "yes" to the question asking clients if they liked the clinic hours.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase services to hard-to-reach populations	X			
2. Increase the number of service sites where possible and expand hours, with an emphasis on school based health centers.	X			
3. Provide clinical services through partnering with community-based organizations and other public health providers that work with vulnerable or at-risk populations.	X			
4. Provide education outreach through PHO staff at community sites, civic organizations, and faith based sites. Teens will receive family planning education.		X		
5. FPP will work with HSD to promote the SPA for family planning services.			X	

6. Ensure quality assurances through training, client surveys and client centered care.				X
7. Develop community networks- FPP will network with local physicians, health/MCH councils, faith-based organizations, school-related contacts, and detention centers.				X
8.				
9.				
10.				

**b. Current Activities**

Direct Health Care: Comprehensive reproductive health clinical services are provided at PHOs, health commons, school based health centers and primary care clinics. Four of the FPP-funded sites offer expanded clinic hours. There are four health commons in NM where multi-health services are provided through State Public Health, primary care clinics and University of New Mexico via telehealth.

Enabling Services: PHOs provide education and outreach through schools, community organizations, youth groups and jails/detention facilities. These outreach activities are reported and compiled in the FPP Education and Outreach Data (EOD) Report. FPP publishes a quarterly newsletter with suggestions for PHO Nurse Managers on ways to collaborate with community organizations. FPP also created and distributed community fact sheets for each NM county for local distribution.

Population Based Services: Effective July 1, 2011, under the State Plan Amendment (SPA) with HSD, family planning benefits are available for both eligible men and women of reproductive age with income <250% of the FPL. FPP will include a HSD staff as a speaker on SPA at the annual trainings.

Infrastructure Building: FPP continues to monitor quality through needs assessment, client surveys (evaluation), client-centered care and the electronic medical record system. The 2012 annual client satisfaction survey was distributed to clients seen at local PHOs in April.

**c. Plan for the Coming Year**

Direct Health Care: In an effort to reduce staff shortage, the FPP has worked with the NM DOH to issue a "Call to Providers" for clinicians. In Lea County, the contracted clinician will provide reproductive services on Friday afternoon and all day Saturday.

FPP will continue to promote LARCs to assist with decreasing unintended pregnancies.

Enabling Services: The PHOs will continue to provide outreach through partnering with community-based organizations and other public health providers that work with vulnerable or at-risk populations. The PHOs will continue to provide outreach and education at community and faith-based sites, and civic organizations. The outreach efforts will target hard-to-reach populations such as incarcerated, homeless, adolescents and males.

Population Based Services: FPP will work with HSD to promote the SPA for family planning services. Services for women include: annual reproductive health exam including a breast exam & laboratory tests (Pap smear and screening for STDs; and associated lab work); pregnancy tests; counseling services for FP including natural FP; birth control methods, medications and devices; emergency contraceptive pills; sterilization (tubal ligations), and HPV vaccine. FP benefits for men include: birth control (condoms); sterilization (vasectomy); office visits for contraceptive management and FP counseling; screening & treatment for STDs (includes associated lab work and medication).

Infrastructure Building: The FPP will continue to monitor quality through needs assessment, client surveys, evaluation, client-centered care, clinic efficiency assessment and electronic medical record system.

The FPP will continue to develop community networks and provide support to coalitions already in place for youth development programs and interventions.

**State Performance Measure 4:** *The percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					45
Annual Indicator		45.1	48.5	42.6	
Numerator		8722	4000	3209	
Denominator		19331	8239	7527	
Data Source		NM PRAMS	NM PRAMS	NM PRAMS	
Is the Data Provisional or Final?				Final	
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	40	40	38	38	36

**Notes - 2011**

2011 PRAMS data are not yet available.

**a. Last Year's Accomplishments**

Efforts in New Mexico to decrease the percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted are hampered by a provider shortage in nearly all of the state. Providers of care for poor and marginalized women are especially scarce. Maternal Health Program continued support of prenatal care in nine public health offices giving care to women who otherwise would not be able to access it. It also provides some financial support for the Maternal and Family Planning Project of the University of New Mexico, which provides such care in Albuquerque and some adjacent counties. Late and no prenatal care is associated with poor outcomes of pregnancy for both the mother and infant. Many factors affect women's ability to receive timely prenatal care. Some of these factors include logistical access to providers, insurance/financial/documentation status, and the lack of cultural relevance in care.

The Maternal Health program also licenses and regulates Certified Nurse Midwives, who disproportionately serves poor and marginalized women. They attend approximately 30% of deliveries in the state, and, presumably, provide an equivalent or larger proportion of the prenatal care.

In 2007 New Mexico was tied with Texas for the highest rate of uninsured women, aged 19-64, in the country (28%). Health care reform has the potential to greatly impact insurance eligibility for many women. In September of 2010, the Affordable Health Care for Americans Act began prohibiting prior authorization requirements for OB/GYN care. Furthermore, pregnancy can no longer be cited as a pre-existing condition for insurance eligibility.

Cultural barriers to early and appropriate prenatal care are cited in focus groups conducted within the State's Public Health Offices. Shame, apathy, and fear of being treated poorly by the medical system are themes that emerge when women in marginalized cultures talk about getting prenatal care. These women tend to start prenatal care late or not access it at all. The Maternal Health

Program has partnered with Tewa Women United and Midwives Alliance of North America (MANA) Midwives of Color to assess methods off overcoming these barriers and implementing culturally relevant programs that Native American and Hispanic women will find worthwhile.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prenatal care in public health offices for women who otherwise could not access it	X			
2. Financial support for UNM's Maternal and Family Planning Program, which provides prenatal care for women who otherwise could not access it, in Albuquerque and adjacent counties			X	X
3. License and regulate midwives who provide 30% or more of prenatal care, and disproportionately to poor and disempowered women.			X	X
4. Insurance Exchanges Established				X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

More women of childbearing age are reportedly insured as their parents may now keep them on their insurance until age 26. Wide spread news media may be aiding New Mexico in this effort. Medicaid eligibility is also changing as components of the Affordable Care Act are put in place. These changes are expected to insure more women of childbearing age before they become pregnant thereby facilitating access to early prenatal care. Efforts to begin to address disparities are in development.

Home birth and birth center birth is growing in popularity in New Mexico and this rise might entice some women that do feel comfortable with the formal medical establishment to get earlier care in pregnancy as they can access it without going into an institution. The number of public health offices offering prenatal care declined as on region was shifted over to a managed care organization. One region continues prenatal care and will continue as the provider shortage remains a challenge.

**c. Plan for the Coming Year**

The NM Department of Health is supporting the local March of Dimes as they will launch a folic acid campaign that should draw attention to early pregnancy in New Mexico. Higher numbers of women with insurance as the Affordable Care Act is implemented should allow earlier access to prenatal care. It is also anticipated as the insurance exchange is set up, that care by licensed midwives will be a more obvious option on the list of prenatal care providers as it will be covered by all Medicaid associated managed care organizations. More women will then have earlier and easier access to care.

**State Performance Measure 6:** *The percent of middle school students that report using alcohol within the past 30 days.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					15
Annual Indicator			16.2	16.2	16.2
Numerator			2114	2114	2114
Denominator			13052	13052	13052
Data Source			NM YRRS 2009	NM YRRS 2009	NM YRRS 2009
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	15	15	15	15	15

**Notes - 2010**

YRRS middle school is occurring during 2011. 2011 data are not yet available.

**a. Last Year's Accomplishments**

The Office of School and Adolescent Health uses a Positive Youth Development Approach to preven risky behaviors among adolescents.

2011 Organizing Youth Engagement (OYE): Navigating Our Worlds- youth from across NM had the opportunity to 1) expand their skills in creating positive change in their communities 2) inspire youth to increase the volume of youth engagement and 3) learn about approaches to develop innovative strategies for a better future for NM. The top 5 legislative policy priorities identified by youth were: 1) School Drop-Out Rate, 2) Substance Use, 3) Racism, 4) Poverty, and 5) Teen Pregnancy. (~120 youth)

15th Annual Head to Toe Conference PYD/YL Track & NM Envision Your Future: OSAH sponsored 5 youth groups to attend the 2 day conference from the following schools: Jemez Valley Middle School, Gallup High School, Wingate High School, Pojoaque Valley High School and Sixth Grade Academy. Dr. Patty O'Sullivan facilitated a two day Teaching 21st Century Kids train-the-trainer and development of a Teacher Support Campaign for the youth and sponsors (~50 participants).

OSAH is promoting and training on the PYD approach statewide as an overarching lens to view adolescent health. PYD is integrated into all school & adolescent health efforts.

Youth Health Link (YHL) Communications Website Update & Training- Stage II of the YHL, refining and making it more user friendly was completed. Due to a reduced budget this process is being implemented in multiple stages. Feedback from various adolescent health stakeholders continues to ensure the YHL is youth-led and youth focused.

Natural Helpers Program- was implemented in Belen, Carlsbad, Gadsden, Gallup, Jemez, Pojoaque, Capital and Santa Fe. TA was provided to Kirtland High School, Reserve High School, Navajo Prep High School, seven other middle and high schools in Santa Fe, School for the Deaf, Santa Fe Mountain Center/Gay Straight Alliance, Santa Fe Indian School, the Native American Alliance of Churches & Native American Community Academy (NACA).

OSAH also collaborated with following groups to promote PYD and adolescent health:

- AmeriCorps VISTA Cadre- OSAH assisted in placement of 3 VISTA's into the community. All focused on PYD and Native American serving communities.
- Graduation Reality And Dual-Role Skills (GRADS+)- Provided technical support for the Youth Advisory Committee meeting and GRADS+ campaign. Also presented at the GRAD Orientation
- Safe Schools Healthy Students Juvenile Justice Summit
- School-Based Health Centers- youth involvement and youth advisory/action groups
- Youth Intervention, Prevention & Education in School/Community (YIPES/C)- Presented on

PYD, adolescent health and YHL website.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SMASHED: Youth, Brains and Alcohol documentary shown to parents, educators, and students			X	
2. Organizing Youth Engagement (OYE)			X	
3. Annual Head to Toe Conference				X
4. Youth Health Link Website			X	
5. Multi-agency collaborations for adolescent health				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

PYD/Adolescent Health Request for Proposal (PYD/AH RFP)- 1st RFP in NMDOH to focus on PYD as it relates to adolescent health. Ten of seventeen applicants were approved for funding from across NM.

-16th Annual Head to Toe Conference (H2T)- Pre-conference Natural Helper Train-the-Trainer workshop.

-Natural Helper Program-Implemented in Carlsbad, Kirtland, Espanola, Gadsden, Gallup, Isshin Ryu Club, Jemez, Navajo Prep, Pojoaque, Capital and Santa Fe.

-School Based Health Centers- Contract monitor for youth engagement, PYD & health promotion efforts (~50).

-Technical Assistance and Training- Provided statewide PYD and adolescent health information for contractors and other stakeholders/partners.

-School Health Education Institute (SHEI)- NM policy now requires 0.5 credit hours to graduate. SHEI provides education and CEU's for school health educators. OSAH collaborates with PED to plan and implement SHEI.

**c. Plan for the Coming Year**

If funding permits the following activities will be planned and implemented:

-2nd year of PYD/Adolescent Health Request for Proposal (PYD/AH RFP)

-National SBHC Conference in NM (Youth Track)- promote youth engagement and attendance

-17th Annual Head to Toe Conference (H2T) and PYD/Youth Leadership Track

-Statewide Natural Helper Program-in at least 10 schools.

-School Based Health Centers- youth engagement, PYD & health promotion efforts (~50).

-PYD and adolescent health training & TA for contractors and other stakeholders/partners (i.e. Indigenous Soccer Cup & NM Youth Alliance Gathering).

-School Health Education Institute (SHEI)- collaboration with PED to plan and implement.

**State Performance Measure 7:** *The proportion of women who report being physically abused by husband or partner during pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5	5	4	4	4
Annual Indicator	4.4	4.5	3.9	4.5	
Numerator	1254	57	1062	1166	
Denominator	28217	1261	26969	25891	
Data Source		PRAMS	NM PRAMS	NM PRAMS	
Is the Data Provisional or Final?				Final	
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	4	4	3	3	3

**Notes - 2011**

2011 PRAMS data are not yet available.

**a. Last Year's Accomplishments**

Direct Health Care: The Children, Youth and Families Department (CYFD) Domestic Violence (DV) Unit does not capture specific data related to the number of women who report no longer being physically abused during pregnancy. The outcome measures related to domestic violence victims focus on support with safety planning and access to available community resources. There are various forms of abuse: physical, sexual violence, threats of physical or sexual violence, psychological/emotional violence, and economic violence.

There is national research that speaks to the increased risk for abuse during pregnancy for women who experience abuse by their intimate partner prior to the pregnancy. This data can be found at [www.endabuse.org](http://www.endabuse.org).

Most victims do not report the violence and abuse for fear of losing their children.

Enabling Services: CYFD funds domestic violence programs throughout the state. The community-based programs provide crisis intervention, advocacy, safety planning, shelter and other supportive services such as counseling.

Population Based Services: There are public information campaigns ranging from bus-boards to public information announcements on television and radio. The confidential address program through the Secretary of State's Office assists victims and their families by providing an address for mail delivery while keeping the resident address confidential.

Infrastructure Building: The Intimate Partner Violence Death Review Team is comprised of representatives from numerous local, state, community and governmental agencies. The team is a statutory body tasked with the review of the facts and circumstances surrounding domestic and sexual violence related deaths. In reviewing these deaths, the team identifies gaps in system responses to victims at both local and state levels, and recommends strategies for improving interventions. The team is a multi-disciplinary group of professionals who meet monthly with the aim of reducing the incidence of these deaths statewide. In 2010, the team reviewed 35 deaths that occurred in 15 NM counties during CY2007. There were 21 homicides and 14 suicides. Of these, 86% of victims were female, 43% of the homicides occurred in public places and the most frequent cause of death was gunshot wounds, followed by blunt force trauma.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Fund residential and non-residential community-based programs statewide.	X			
2. Expand the DV Leadership Commission to include a representative from Public Health, Department of Health.				X
3. Collaborate with higher education and the Health Sciences Center to incorporate a DV curriculum in each program for the medical, social work, and human services fields.		X		
4. Continue to collect data through CYFD, the Attorney General, and the Intimate Partner Violence Death Review Team.				X
5. Continue outreach, information and education through electronic media, radio, television, print and creative modes of communication.		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

**Direct Health Care:** CYFD funds community domestic violence programs and shelters with state General Fund, other state funds and federal funds statewide.

**Enabling Services:** These programs include community associations and provide access to shelter, transportation, counseling, safety planning, financial services, case management and linkages to community resources, such as food and medical assistance.

**Population Based Services:** The DV community provides outreach and support to private physicians, health plans, health providers, home visitors, hospitals and community social workers to screen for abuse and referrals at the local level.

**Infrastructure Building:** CYFD is planning a summit in June 2011 to facilitate collaboration between DV providers, early child care providers and home visitors. The intent is to bring together key community stakeholders and build capacity around recognizing DV and connecting families to community resources as early as possible. The summit aims to strengthen the infrastructure and build capacity within existing systems.

**c. Plan for the Coming Year**

**Direct Health Care:** New Mexico will continue to fund as many residential and non-residential programs across the state as funding allows. The commitment to community-based services is strong and the DV coalitions, advocates, and service agencies will continue to fight to preserve DV program resources.

**Enabling Services:** Collaboration with the higher education community and the state Health Sciences Center will focus on implementing a domestic violence curriculum for direct service providers, including social workers, doctors, nurses, child care providers, etc.

**Population Based Services:** The DV information campaigns and education forums are slated to continue as are collaborative training opportunities between agencies and community providers.

**Infrastructure Building:** The Domestic Violence Leadership Commission is expected to expand

and include a representative from DOH. The Attorney General's office heads the Commission and recognizes the need for public health representation.

**State Performance Measure 8:** *The proportion of women who exclusively breastfeed their babies through six months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					20
Annual Indicator		16.4	13.4	18.7	14.9
Numerator					
Denominator					
Data Source		CDC NIS	CDC NIS	CDC NIS	CDC NIS 06-08 cohort
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	16	16	16	18	18

**Notes - 2011**

CDC NIS does not provide numerators and denominators.

**Notes - 2010**

Data refer to children born in 2007.

**Notes - 2009**

.Data refer to children born in 2006.

**a. Last Year's Accomplishments**

Direct: UNM and Presbyterian Hospitals in Albuquerque operated free Lactation Clinics that provided postpartum breastfeeding consultations and breastfeeding classes weekly. The NM BFTF Honor Roll Project was implemented to formally recognize with a plaque, ceremony and media attention the 9 hospitals in NM that banned formula discharge bags. WIC provided group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; a choice between 4 different types of breast pumps for breastfeeding mothers; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers. WIC also provided prenatal backpacks filled with support materials to all pregnant mothers.

Enabling: WIC continued operation of the Peer Counselor Program; expanded to 55 counselors throughout 40 public health clinic sites.

Population Based Services: The NM BFTF and WIC worked to increase public acceptance of breastfeeding through the development and dissemination of 6,500 "Positive Images of Breastfeeding" 2010 Calendars to families and healthcare providers statewide; created public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week, August 1-7, 2010. As per House Memorial 58 passed by the NM 2009 Legislature, the Governor's Women's Health Office convened a task force which made recommendations for breastfeeding accommodations in schools to a legislative committee. All WIC clinics provided a breastfeeding reference book and educational DVD to local health care providers through a WIC Physician Outreach Project.

Infrastructure Building: WIC provided breastfeeding training for staff through a statewide WIC conference which included 2 breastfeeding and 2 peer counselor program training sessions. WIC

also provided 5 "Using Loving Support to Grow and Glow in WIC" staff trainings and 5 Loving Support Peer Counselor Trainings. The NM BFTF Annual Advanced Concepts in Breastfeeding Conference provided lactation education to over 300 health care professionals. The project "Using Loving Support to Build a Breastfeeding Friendly Community" developed a weekly mothers' support group in Grants, and expanded to Clovis, NM. The NM BFTF awarded 4 grants for breastfeeding promotion/support to Santo Domingo WIC, Valencia County, SW NMBF Council and the Breast Cancer resource center. Access for healthcare professionals to adequate breastfeeding research, supplies and resources continued through ongoing development of WIC's intranet and internet websites, and the BFTF website.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Breastfeeding Education and Counseling	X			
2. UNM and Presbyterian Hospitals' Lactation Clinics	X			
3. NM BFTF Honor Roll Hospital Project to Ban Formula D/C Bags	X			
4. WIC Breastfeeding Peer Counseling		X		
5. WIC and BFTF Website Education and Activities				X
6. Annual Breastfeeding Continuing Education/Trainings for healthcare professionals				X
7. BFTF and WIC World Breastfeeding Week Celebration			X	
8. BFTF Breastfeeding Grant Projects				X
9. "Using Loving Support to Build a Breastfeeding Friendly Community" Model				X
10.				

**b. Current Activities**

Direct: 14 hospitals in NM have banned the dissemination of formula gift packs to mothers upon hospital discharge. The NM BFTF has applied for funding from the Kellogg's Foundation for a 3 year project to encourage and support NM hospitals to be designated Baby Friendly. WIC continues to provide resources, aides and breastfeeding support sessions to WIC mothers, as well as food packages supporting exclusive breastfeeding.

Enabling: WIC increased number of peer counselors to 73 throughout 51 WIC clinic sites. Population-Based: 6,500 "Positive Images of Breastfeeding" 2011 Calendars were given out statewide. WIC and NM BFTF participated in World Breastfeeding Week.

Infrastructure Building: The NM BFTF has applied and received funding from the Kellogg's Foundation for a 3 year project to build and strengthen the statewide and local NM BFTF coalitions. Breastfeeding education and training opportunities for health care professionals continue to be provided through: WIC "Using Loving Support to Grow and Glow in WIC Staff Training," newly developed computer based breastfeeding trainings, self-paced continuing education modules for IBCLE Cerps and the Loving Support Peer Counselor Trainings, as well as the NM BFTF Annual Advanced Concepts in Breastfeeding Conference. WIC is currently updating and expanding its public internet site, including a staff resource component, as well as starting to design a new management information system for WIC data.

**c. Plan for the Coming Year**

Detailed information about breastfeeding promotion in NM is available on WIC's website: [www.nmwic](http://www.nmwic), and the NM BFTF website: [www.breastfeedingnewmexico.org](http://www.breastfeedingnewmexico.org)

**Direct:** The NM BFTF will continue the NM BFTF Honor Roll Project to increase the number of and formally recognize hospitals in New Mexico that ban formula discharge bags. UNM and Presbyterian Hospitals in Albuquerque will continue operation of free Lactation Clinics, with expansion of the Presbyterian support group to the city's west side. WIC will continue to provide all prenatal clients with a backpack filled with breastfeeding education materials; group breastfeeding support sessions and individual counseling to pregnant and breastfeeding mothers; emphasis on exclusive breastfeeding through the WIC food package and 4 different types of breast pumps; and other breastfeeding aides and devices as needed by high-risk breastfeeding mothers. The NM BFTF will begin implementation of year 1 of the 3 year grant project funded by the Kellogg's Foundation to encourage and support NM hospitals to be designated Baby Friendly.

**Enabling Services:** WIC will continue to operate its peer counselor program, expanding to additional WIC clinics as funding allows. Expansion plans also include further program development to ensure better recruitment, training and retention of peer counselors.

**Population-Based:** BFTF and WIC will continue the development and dissemination of "Positive Images of Breastfeeding" Calendars annually through WIC and other health care providers statewide. Public awareness of breastfeeding through WIC Clinic and BFTF celebrations for World Breastfeeding Week will take place. The NM BFTF will begin implementation of year 1 of the 3 year grant project funded by the Kellogg's Foundation, to include a breastfeeding awareness media campaign.

**Infrastructure Building:** WIC will work on design and development of a new management information system to collect and report breastfeeding client data, including breastfeeding exclusivity data. Breastfeeding education and training opportunities for health care professionals will continue to be provided through Access for healthcare professionals to adequate breastfeeding research, supplies and resources will continue through on-going updates to the WIC staff's intranet site and the BFTF website. The NM BFTF will begin implementation of year 1 of the 3 year grant project funded by the Kellogg's Foundation to build and strengthen the statewide and local NM BFTF coalitions. Development of local community breastfeeding projects to increase the exclusivity of breastfeeding will continue through NM BFTF mini-grant funds. The number of IBCLCs in New Mexico will continue to be increased through providing NM BFTF scholarships for IBCLC exam expenses, and providing WIC staff with study resources.

## **E. Health Status Indicators**

### **IV E Health Status Indicators**

The key issues that affect the health of the MCH population are the high rate of poverty in the state and the disproportionate burden of coping with less social advantage, particularly among minority groups who make up the majority of this population. Gaps and disparities are seen consistently among teens, parents with only a high school education or less, and single parents. These characteristics translate into greater proportions of health risk behaviors, and lower access to and use of primary preventive care or specialty care. Although the state has made progress in reducing the proportion of the population that has no health insurance, critical gaps persist. There is a significant challenge in assuring access to care for the working poor and immigrant families who come into the state -- many who pay taxes on their income. Programming throughout the Department of Health is designed with these issues in mind. Currently, due to staffing and resource shortages, much of the State's effort toward improving the status of the MCH population is focused on safety-net direct care services.

## HSI-01A & B, 02A & B --Percent of Low Birth Weight Births

Disparities in the rates of low birth weight births persist by age, race, marital status, and education. Low birth weight infants were predominant among first-time mothers and women over 34 years of age. Native American women, unmarried women and women with less than a high school education also had higher proportions of LBW infants compared to all New Mexico women. Preterm births were predominant among first-time mothers, moms over 34 years of age, Native American mothers, those with less than a high school education, and mothers who live in Bernalillo County.

Low birth weight infants born in 2010 declined in proportion to the decline in total number of births possibly in response to the economic downturn. About 450 of these low weight births in New Mexico were the product of a multiple pregnancy. Reproductive centers throughout the country are aware of the contribution multiples make to the problem of very low birth weight infants. Centers have stopped placing more than two embryos for women undergoing in-vitro fertilization.

The recent increase in births by elective and repeat cesarean section (scheduled cesarean section) contributes to the rate of late preterm births, which constitute a large proportion of low birth weight babies, as there are no perfectly accurate predictors of fetal weight or gestational age against which to plan a delivery. Similarly, increases in elective and scheduled inductions contribute to the cesarean section rate, late preterm births and low birth-weight babies.

The Maternal Health Program continues to provide support and oversight for prenatal care offered in nine of 54 local public health offices for women who cannot otherwise access prenatal care. The Program maintains financial agreements with 20 high risk prenatal care providers or groups in most counties where such providers are present, which require the providers to give care to any medically indigent woman with a high risk pregnancy who presents for care. The Program licenses and regulates all practicing certified nurse midwives and licensed direct-entry midwives, who handle approximately 30% of deliveries in NM, over half of them to medically indigent women.

Provider access continues to be a major obstacle to prenatal care, which would reduce the number of low birth weight babies. In addition to the measures listed above, the Program administers a Birthing Workforce Retention Fund, which awards between \$5,000 and \$10,000 to eligible applicants whose liability insurance rates have increased significantly for two consecutive years, to the extent its funding allows. Funding, never sufficient, continues to decrease, further limiting all the Program's efforts, except for the licensing and regulating of midwives.

In an effort to prevent preterm births, the Maternal Health Program is looking at availability of progesterone containing medications throughout the state. These medications can reduce the higher risk of a preterm birth in women with a previous preterm birth and can reduce the risk of preterm birth in women who are found to have a short uterine cervix. This approach is based on the most recent guidelines on evidence based practice. The program also continues working with WIC and the High Risk Prenatal Fund which help assure adequate screening and referral for services for pregnant women.

Almost all very low birth-rate babies are premature, though they may also be growth restricted. Efforts to decrease the percent of live births weighing less than 1,500 grams, therefore, focus on prevention of premature births.

## HSI-03A, B, and HSI 04 A, B -- Unintentional injuries and deaths, including those from motor vehicle crashes, to children aged 14 years and younger

The key causes of injury death differ by age. Birth defects and complications remain consistently the leading cause under the age of one month. Suffocation is the leading cause up to the age of

1 year, and has driven a major expansion in the "Safe Sleep" campaign, including the growing incorporation of "Cribs for Kids", which promotes the universal use of portable cribs for every environment where a permanent crib is not available. Focusing on the importance of the use of portable cribs has the primary purpose of providing a safe sleep environment for infants, discouraging bed-sharing with parents and siblings, as well as the inappropriate use of car seats, couches, chairs, tables or beds in other homes for sleeping babies.

Motor vehicle crashes are the most frequent cause of death for every age group from the age of 1 to 24, with "backovers", or pedestrian fatalities caused by automobiles in driveways and parking lots, now the leading cause of death for ages 1-4. Drowning, fires and burns are also primary causes of injury death for children 9 years and younger. Other means of transport, including all terrain vehicles and bicycles, remain major causes for children ages 5-14 as well.

The five year (2006 -- 2010) overview from the New Mexico Bureau of Vital Records and Health Statistics data continues to give the promising indication of a permanent reduction in child fatalities due to a growing incorporation of booster seats for ages 5 and 6, which is mandatory, and for ages 7 to 11, depending on size, as well as the continued use of car seats for ages 0-4. Both the overall average and yearly variance in the number of fatalities in New Mexico remain small enough to make it difficult to gauge improvement, however, a demonstrated reduction of about one fatality every six weeks over a span of four years is significant for such a small population, and it is primarily attributable to the reduction in motor vehicle crash fatalities among this age group.

The Safe Kids New Mexico network of 10 coalitions and chapters continues to engage in car seat and booster seat clinics, as well as assisting with the staffing of "fitting stations" where families can have their current seats checked, and if necessary, replaced. The lack of funding from all public and private sources to purchase car and booster seats for free distribution has been a significant problem during the last few years, however, in FY12 the funding contributions have slightly improved, and FY13 looks more promising.

#### Non-fatal injuries requiring hospitalization

The Office of Injury Prevention (OIP) of the Dept. of Health takes the lead on all aspects of unintentional childhood injury and has had a contract with SAFE KIDS Worldwide to be the sponsor for NM SAFE KIDS Coalition since 1991. OIP and its partners provide car seat clinics, including free car seat checks and/or seat replacement, bicycle rodeos, including free helmet fitting checks and/or distribution, and health fair displays, including free smoke and carbon monoxide detector, as well as gun lock, distribution.

OIP also has collaborated with the Children, Youth and Families Dept. (CYFD) since 2001 to provide home safety training for the 4,000 home daycare providers, and has begun expanding the program to include Head Start, Early Head Start, and Tribal Head Start daycare programs, as well as home visitation specialists who now work with expecting, new and otherwise "at risk" parents in 17 counties, also under the management of CYFD.

Plans are now formulating to expand the home safety program to foster, adoptive and grandparents during FY13 or FY14, and the first introductory workshops will be provided at the Foster Care Conference in September, 2012. The CDC Core Grant allocation for FY12-FY17 also includes and formalizes support for the component of developing a permanent infrastructure for providing home safety workshops statewide, in addition to trainer certification in home safety for providing the same. Subsequently, CYFD and DOH are currently beginning collaboration to expand 14 annual half day Regional Early Care Educational Conferences for home daycare providers to also accommodate the very similar safety education requirements that will be established for the many designated home visitors offering support and counseling services for expecting and new parents.

The funding for the childhood injury prevention position in OIP also includes responsibility as the Consumer Product Safety Commission Designee for the state of New Mexico. This includes tracking and the media promotion of product recalls, as some 7 million cribs were recalled nationwide for manufacturing defects in 2009 alone. Many other products are also being recalled for lead, cadmium, and other trace metal content, or plastics with toxic coatings. This is an integral part of the home safety program for home daycare providers and home visiting specialists, as well as Head Start, Early Head Start and Tribal Head Start teachers.

In 2007, New Mexico became the first state to require that all children under the age of 18 to wear a helmet on all non-motorized vehicles, including bicycles, skateboards, scooters, skates and tricycles. The Child Helmet Safety Act applies to riding on all public property, including home day care environments where the tricycles may be used on sidewalks, as well as a significant number of commercial daycares located on public school properties. Many private daycares on private property have also voluntarily decided to comply with the new law, despite the lack of jurisdiction on their properties, generally taking the legal perspective that not adhering to the law could increase their liability, regardless of their private category and location.

As of 2006, the Safe Kids New Mexico has already successfully collaborated with the Brain Injury Advisory Council and the Brain Injury Association to pass the expanded Off Road Vehicle Regulations, requiring helmet use, safety training, adult supervision and other constraints on all minors riding on all terrain vehicles, off road motorcycles, snowmobiles and miniature "pocket bike" motorcycles. The only exemptions from adult supervision for minors are for either a 13 year old teen who has acquired a motorcycle license, or a 15 year old teen who has acquired a provisional driver's license. Consequently, between the passing of two laws in two subsequent years, New Mexico became the only state that requires all minors under the age of 18 to wear a helmet on every motorized or non-motorized vehicle, unless that vehicle has a seat belt.

As federal funds for injury prevention continue to diminish, OIP is seeking funds from other sources, including charities and new sources of state funds. Safety training for home visitation programs will continue to expand. Given budget constraints, it is unknown how many additional programs and counties will be added in the coming fiscal year. The Safe Kids New Mexico network statewide has also now established a partnership with the network of ten designated trauma centers, receiving funding and administrative report from each of them as part of their requirement of establishing and maintaining an injury prevention program, mandated by state law. The Safe Kids New Mexico state coalition also offers educational, event development, fundraising and media promotional support to the entire network of coalitions and chapters to assist in organization growth. The CDC Core Injury Grant funds also provided \$20,000 for the purchase of 3,000 multi-sport helmets in FY12, which have been delivered and will be distributed for use at safety events statewide in approximately 15 communities during FY13.

HSI-03 C and HSI 04 C -- Unintentional injuries and deaths, including those from motor vehicle crashes, among youth aged 15-24

After considerable variances in fatal crashes reported from 1999 through 2002, data originating from the New Mexico Bureau of Vital Records and Health Statistics demonstrated a leveling out or plateau in the incidence of fatalities among this age group from 2002 through 2005. Even far more encouraging of better driving habits for teens and young adults was the steady decrease in incidence for 2007 through 2010. In the year 2006, New Mexico experienced 104 fatalities, at a rate of 36.9 per 100,000, and for the year 2007, this decreased to 98 fatalities and a rate of 30.8. The span of 2008-2010 was even more promising, with a drop to an average of 75 fatalities and a rate of 24.2, and 2010 may have confirmed a trend to better driving habits among this age group, with an all time low of 71 deaths and a rate of 22.7.

The Traffic Safety Bureau of the New Mexico Department of Transportation would like to interpret the encouraging improvements in data as an indication of the growing understanding by both parents and teens about the purpose of the Graduated Driver License law, approved by the state

legislature in the year 1999, with minor amendments since then. The overall intent of these regulations, aside from requiring more comprehensive education and skill development, is to minimize the miles driven by teens without adult supervision and guidance. This is in addition to also purposely minimizing the distractions of teen drivers, given their lack of experience, including the increased risk of only driving with peers, as well as at night.

This recent positive development in motor vehicle crash data among this age group in New Mexico parallels improvements nationwide. Driver education and regulation in the United States is beginning to emulate programs in many countries in Europe, encouraging youth and their parents to better understand the very significant complexities and hazards of driving. The growth in affluence in the United States from 1950 until 2000, which most commonly manifested itself in motor vehicle ownership, availability of inexpensive fuel and per capita miles driven, unfortunately has resulted in excessive fatalities, and particularly among youth. By contrast, in Europe the much greater cost of fuel, in combination with a much greater availability of public transport and more stringent licensing requirements, has kept the expectations of European youth for driving a private automobile on a regular basis much lower, which in turn has lowered the incidence of crash fatalities in this age group throughout Europe as well.

This coming year we intend to continue to contribute to driver education and awareness among youth via the Safe Kids organizations statewide by again enlisting more of their participation in media promotions, education and event production for children. Many of the charities that Safe Kids will be approaching, including Kiwanis, Rotary and Optimist, have special youth groups for the expressed purpose of community service, and we intend to greatly expand the use of peer education and mentoring. We will also continue to engage youth for expanding education and safety awareness among their peers regarding the use of all terrain vehicles in collaboration with 4H Clubs.

According to the New Mexico Bureau of Vital Records and Health Statistics, from 2004-2007, 439 youth ages 15 - 24 died as a result of a motor vehicle crash. The age-adjusted rate for this period was 35.7. Fortunately, the total number of fatalities in this age group in 2007 represented a 13% decrease from the average number of fatalities during the previous three years. Hopefully this trend will continue.

In 2005, 15% percent of all drivers in crashes were young adult drivers, although young adults comprised only 9% of drivers here in New Mexico. 28% of crashes involving young adult drivers occurred at night, while only 26% of all crashes occurred at night. (Source: Division of Government Research, UNM, Traffic Safety Bureau)

Overall, New Mexico ranked 10th highest among states in seatbelt use in 2005 with 89.5% of front seat occupants wearing seatbelts. From 1983 to 1995, New Mexico seatbelt use increased dramatically and then continued a gradual increase to nearly 90% usage. Crash deaths decreased 30% during this same time period, and having both "primary" and "all positions, all the time" seat belt laws have been significant contributing factors.

MVC death rates and alcohol involved MVC death rates have decreased by 35% and 59%, respectively, from 1982 to 2004. Alcohol was involved in 10% of all MVCs causing injury or death in 2004. Forty-two percent of motor vehicle injury deaths in 2004 occurred in alcohol-involved crashes. A more recent key intervention has been the adoption of ignition interlock laws, and New Mexico now has the most comprehensive interlock law in the nation, as well as worldwide. Compliance with this penalty has been mediocre and slow to increase, but various court mechanisms of enforcement are improving. Otherwise, the judges are far less reluctant to impose the sanction of interlock to ensure driving while sober than to revoke licenses, as of course a loss of license and all driving privileges in most cases jeopardizes current and future employment due to insufficient options for public transportation.

According to the 2007 New Mexico Youth Risk and Resiliency Survey, 90% of high school

students reported seatbelt use most or all the time. However, more than 30% of both male and female students reported that, in the past 30 days, they had ridden with a driver who had been drinking. A more recent emerging hazard of concern for youth particularly has been the use of cell phones while driving, and especially for the purpose of texting, as of course in addition to the distraction of phone conversation, requires visual attention as well. Cell phone use is now prohibited while driving in the municipalities of Albuquerque, Santa Fe and Las Cruces, and a new state law prohibiting texting while driving will be considered for a third time at the legislature in 2013.

HSI-05A & 05B The rate per 1,000 women aged 15 through 19, and 20 through 44 years with a reported case of Chlamydia:

In 2009, there were 9,458 reported Chlamydia morbidities in New Mexico, 73.2% of them among females. In females, 72% of all the morbidities were in those aged 24 and under, and the 15-19 age group was second highest with 33.8% of the total for females. Clearly, this is a high-risk group. The total number of cases has remained flat for the past 5 years, indicating that perhaps the spread has been checked at least in part due to widespread testing, treatment and prevention efforts.

According to the YRRS (Youth Risk and Resiliency Survey) 2007, 45.7% of New Mexico high school students had "ever" had sexual intercourse, while almost one third of students (31.5%) reported being currently sexually active. 44.8% did not use condom the last time they had sexual intercourse. This indicates high numbers of young women at risk for Chlamydia in a state with high morbidity rates.

The Chlamydia testing in the FPP-funded clinics is part of the statewide infertility prevention project funded by Center for Disease Control and Prevention (CDC). The annualized (based on actual data from 3 quarters) number of tests performed in both STD and Family Planning clinics for 2009 was 35,623, with 11.0% positivity. Among females aged 15-19, the rate of positivity was 11.9%. This age group of females made up 20% of all those tested (5,224 individuals). The Family Planning and STD Programs are working hard to more effectively target screening towards the high-risk groups and especially females age 25 and under in accordance with national guidelines.

The New Mexico Department of Health prioritizes screening of all females age 25 and under to prevent PID, infertility, ectopic pregnancy and other complications. It does this statewide both internally and also working with private providers, where 70% of the STD morbidities within the state are identified and treated. Looking at this big picture, the Department has direct control over part of the health care system and only indirect influence over another part.

NM Department of Health (DOH) changed clinical protocols, aiming to stay within budget and increase the proportion of tests allocated to women aged =25 years to 75%. Title X FP limited screening to women aged =25 years and pre-IUD insertion. The STD Program recommended prioritizing women aged =25 years, and older women with risk factors. STD and FP Program staff met with clinic administrators statewide and each clinic was allotted a fixed number of tests based on 2009 test volume, screening history, and CT/GC positivity. Thus, clinics testing more women =25 years and finding more infections received fewer cuts. Quarterly performance reports were provided to clinics.

From 2009 to 2011, the Family Planning Program increased the proportion of tests provided to women aged =25 from 68% to 77%. Comparing three quarters of 2009 to 2010 and 2011 NM data, NM DOH had a decline in number of tests (12,985 vs. 12,766 vs. 12,047 tests, respectively), and found more CT infections (7.7%, 9.2% and 9.1%, respectively) and more GC infections (0.4%, 0.3% and 0.5%, respectively). Using a combination of clinical protocol changes and site-based testing caps, NM successfully increased screening of young women while reducing overall test volume, resulting in a substantial increase in GC case detection and only

slight decrease in CT case detection.

Programs stayed within budget and still improved screening efficiency. Inter-agency collaboration, straightforward guidelines, regular feedback and follow-up are critical. The following strategies are being used to improve screening and treatment for women under age 25:

- >Maintain provider agreements with selected school based health centers to support testing efforts.
- >Monitor data to target at least 75% of screening paid for by DOH is used on females under age 25.
- >Work with New Mexico Medical Society on Clinical Preventive Initiative aimed at increasing the percentage of providers who perform routine annual screening on all females under 25 statewide.
- >Promote the use of Expedited Partner Therapy (patient delivered partner therapy) to reduce the incidence of re-infection after treatment.
- >The Office of Adolescent Health is launching a study of social marketing targeting adolescents with the idea of creating effective messages to encourage screening.
- >Screening is taking place in several youth corrections facilities, and very high positivity rates are resulting compared to the general population.

HSI-07A & 07B Live births to women (of all ages) enumerated by maternal age, race and ethnicity.

There were 30,605 births to New Mexico resident mothers in 2007, translating to a birth rate of 14.9 births per 1,000 population. New Mexico's birth rate has declined from a rate of 19.1 in 1985.

Strategies to decrease teen birth rate and births to single mothers in NM have met with mixed success. The NM Prenatal Care Utilization task force and the NM Young Fathers Project aim to promote public awareness by sending messages to delay parenthood until education has been completed and employment has been established. Ten NM Public Health Offices and 3 school based clinics offer family planning services including low cost and no cost contraception options.

Abstinence only education is slowly being replaced by evidenced based sexual education including accurate information about contraception and condom use. Focused needs assessment involving Native American and Hispanic youth indicate a need for increased access to comprehensive pregnancy prevention education, community-based programs and contraceptives.

Five strategies to decrease the teen birth rate that are currently being used are:

Family Planning Services offer access to confidential reproductive health services at low or no cost. Services are provided at all local public health offices, & some community health centers and school-based health centers.

The Teen Outreach Program (TOP), a service learning program designed to decrease teen pregnancy and increase school success combines curriculum-guided experiential activities & discussion plus community service work throughout the school year. Programming includes 17 TOP sites in ten counties.

Adult-teen communication programs give adults information and skills to communicate effectively with young people about reducing risky sexual behavior. Parents influence teen decisions about sex more than their friends, the media, or their siblings. Examples include Plain Talk in the South Valley, Albuquerque and Doña Ana County.

Comprehensive sex education teaches about abstinence as the best method for avoiding sexually transmitted infections and unintended pregnancy, and about the use of condoms and contraception. It teaches interpersonal & communication skills to help young people explore their

own values, goals, and options, to make responsible decisions.

Male involvement programs for prevention efforts specifically target boys & young men. There are male involvement activities in the South Valley in Albuquerque, Hobbs and Taos.

### Births to Hispanic Mothers

Women identified as Hispanic or self-identifying as Hispanic are by far the largest population of childbearing women in New Mexico. Efforts to provide culturally relevant care for these women are multifaceted. Women may not be motivated to seek care, especially for unintended pregnancies. Societal and maternal reasons cited for poor motivation include fear of medical procedures or disclosing pregnancy to others, depression, and a belief that prenatal care is unnecessary. Structural barriers include long wait times, the location and hours of clinics, language and attitude of the clinic staff, cost of services and a lack of child-friendly facilities.

The Maternal Health Program (MH) focuses cultural competency in prenatal care (PNC) on meeting the needs of Hispanic and Native American women. The ten Public Health Offices providing PNC each have Spanish-speaking clinical staff or expert translation available for clients.

A Nurse Practitioner and Physician both originally from Mexico serve three of these ten clinics. Maternal Health contractors provide Spanish-speaking clinical staff and/or expert translation for Spanish speaking clients and other non-English speaking clients. Printed client education resource materials provided by MH are made available in both English and Spanish.

Focus groups of Hispanic and Navajo women, young and old, urban and rural, have guided PNC promotion. MH actively promotes the model of Centering Pregnancy, a facilitated group PNC approach, designed to improve cultural relevance for all women. This model has been proven to increase satisfaction with and attendance at PNC, as well as self-care and breastfeeding. MH assisted six clinics develop Centering groups for Spanish-speaking women. Two agencies in Albuquerque provide Centering care exclusively for teen mothers, their partners and support persons. MH, Public Health Offices, and community partners continually collaborate to identify cultural barriers to PNC, and to eliminate them.

### Maternal Deaths

The NM Maternal Mortality Review has been re-established after a gap of several years, through collaboration between MCH epidemiologists, UNM School of Medicine & the New Mexico Office of the Medical Investigator. Each case of maternal mortality is being reviewed. In previous years, the Maternal Mortality Review Board identified lack of seatbelt use by pregnant women as the commonest factor associated with mortality.

New Mexico continues to promote the model of Centering Pregnancy, which is used to improve cultural relevance for all women. Six prenatal clinics have Centering groups for Spanish speaking women. The Public Health Offices of the New Mexico Department of Health and their community partners work together to identify cultural barriers to prenatal care for the Hispanic population. Printed client information for pregnancy is provided at our prenatal care clinics in both English and Spanish.

HSI-08A & 08B Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.

Infant deaths are a critical indicator of a state's wellbeing. The Healthy People 2020 goal is to reduce the infant mortality rate (IMR) to 6/1,000 live births. The NM infant mortality rate (IMR), as well as the neonatal and post-neonatal mortality rates, have been at or lower than the national rates since 1980 with the exception of 1994.

Efforts continue to assure preconception and prenatal care for women in New Mexico.

The key causes of death differ by age. Birth defects and complications are the leading cause under the age of one month. Suffocation is the leading cause up to the age of 1 year. Motor vehicle crashes are the most frequent cause for every age group from the age of 1 to 24. Drowning, fires and burns are leading causes of injury death for children 9 years and younger. Other means of transport, including all terrain vehicles and bicycles, remain major causes for children ages 5-14 as well.

In the 2007 YRRS, The percentage of youth reporting three important risk behaviors that contribute to unintentional injury has decreased since 2003: rarely or never wearing a seatbelt while riding in a car driven by someone else (11.5% in 2003 vs. 8.9% in 2007), riding with a drinking driver in the past 30 days (34.9% in 2003 vs. 31.2% in 2007), and drinking and driving in the past 30 days (19.1% in 2003 vs. 12.5% in 2007). For each of these measures, the decrease in the rate occurred largely between 2003 and 2005, while the 2007 rate remains similar to the 2005 rate.

The Child Health Program, through Project LAUNCH, provided a Child Care Health Consultant (CCHC) Coordinator to train others to perform the CCHC services of working with Child Care providers to improve the early childhood environments and the health of children in those settings. Child care environments present incredible opportunities to improve health outcomes for large numbers of children at a time, the primary goal for population based public health. Child care environments serve as ideal settings to teach children about healthy behaviors such as hand-washing, preventing obesity, preventing injuries, & healthy eating that will help them lead healthier lives. CCHCs also help providers and families recognize a child's targeted developmental stages & how to address possible developmental delays.

The NM Dept. of Health Strategic Plan for 2011 has added an Objective Strategy to create policies that reduce injuries & change attitudes that may lead to them. Injuries are the leading cause of death in NM among people ages 1 to 44. Community Health Objective 4 would investigate child deaths to identify & promote changes in systems, policies & programs that reduce preventable child injuries & deaths.

HSI 10: Geographic living area for all resident children aged 0 through 19 years

Fourteen of New Mexico's 33 counties are considered "Frontier" or "Sub-Frontier." Eighteen counties are "Rural" and one is "Urban." US Census Bureau Data Set: 2008 Population Estimates show county populations of children ages 0-19 ranging from 101 in Harding county to 174,674 in Bernalillo county.

Six counties have a population density per square mile of 10 or above. The remaining 27 have population densities of 9.2 or less. The range is <0.1 children aged 0 through 19 years per square mile in Harding County to 149.4 children per square mile in Bernalillo County.

Geographic distance has long been recognized as a barrier to health care access for New Mexicans.

HSI 11 & HSI 12: Percent of the State population at various levels of the federal poverty level

The poverty measure, created in the 1950s, is inadequate for assessing a sufficient standard of living for families. In addition to food, child care is a major expense for working families, as well as housing, transportation, and health care, all of which families need to survive, though they are not calculated in the measure. Neither does the poverty measure take into account geographical location or family configuration. The FPL is the same for a family in the inner-city where costs are high and for a family living in a rural area with relatively lower costs. All of these factors make it

very difficult for families to provide the basic necessities for their children, let alone improve their situations, even when they live at 200 percent -- or double -- the official FPL.

The New Mexico Voices for Children report highlights the discrepancies between those that are considered living under the poverty level and those that are technically above it but still struggling to get by. The percentage of children that are considered to be "living below poverty" may not accurately reflect just how many children live in families that are struggling to meet their basic needs. While the official poverty measure, commonly referred to as the federal poverty level (FPL), is supposed to indicate how much it costs a family to live at a bare minimum, by many accounts the actual costs are roughly twice the FPL. People who fall below the official poverty level are deemed "poor." This leaves open the assumption that anyone making more than the FPL are "not poor."

The Basic Family Budget gives a more realistic measure of how much it costs to support a family. Seven expenditures are included in this budget: housing, food, child care, transportation, health care, other necessities, and taxes. Basic Family Budgets are calculated for communities all across the U.S. for six family types--one- and two-parent families with one, two, and three children. In New Mexico, budgets are available for Albuquerque, Las Cruces, Santa Fe, and Farmington. Source:

[http://www.nmvoices.org/attachments/nm\\_kc\\_08\\_essay.pdf//2010//](http://www.nmvoices.org/attachments/nm_kc_08_essay.pdf//2010//)

In many parts of New Mexico, it costs more than twice the FPL for families to provide the basics for their children. Over the years, wages have not kept up with inflation, and hence, paychecks have not stretched as far to pay for the rising cost of necessities. Families that were struggling before the current economic slump are likely to feel the pressure on their budgets even more acutely now.

## **F. Other Program Activities**

### **IV. F. 1. Maternal and Child Health**

NM Title V Program and MCH staff are working to develop a comprehensive state-level multi-agency service system, which reaches to the community-level and will support families in fostering the healthy development of their children. The Early Childhood Comprehensive Systems (ECCS) grant and Project LAUNCH provide opportunities to supplement the systems development work of the State Title V Program. Through the ECCS grant, a state-level Early Childhood Coordinator was hired to align and coordinate all state-level early childhood programs and services to create an effective and efficient structural, functional, and operational system to offer early childhood services for children, birth through eight, and their families. The ECCS grant funded the 6th annual Family Leadership Conference (FLAN) in April, with an attendance of approximately 200. Through Project LAUNCH, the MCH Health Educator has received training as a certified Child Care Health Consultant (CCHC) Trainer and will contribute time to build the CCHC system in NM and train others as consultants. Other new collaborative efforts include the Maternal Depression Working Group (MDWG) pilot project to identify women at risk for perinatal depression, and REEL Fathers, which uses the power of cinema and reflective activities to honor and celebrate involved fathers, and to heal, renew, and deepen the lifelong connections between fathers and their children -- supporting stronger, more stable family relationships. Additionally, by linking with public/private partners and other early childhood collaborative efforts, the First Five Years Fund video "Change the First Five Years and You Change Everything" was edited to be specific for a NM audience. A link to the video can be found at [www.earlychildhoodnm.com](http://www.earlychildhoodnm.com). Working with Kiwanis, the previously mentioned website will be revamped to be interactive and expand the scope of the site. Another exciting new state-wide collaboration includes the NM Alliance for Fathers and Families, which is helping to plan a White House Community Roundtable

and Town Hall Meeting on Responsible Fatherhood and Healthy Families, co-sponsored by the White House Office of Faith-based and Neighborhood Partnerships and USDA Rural Development.

Families FIRST received funding from the Human Services Dept. to pilot a program on Perinatal Depression Screening. Working in conjunction with the WIC Program in the Santa Fe and Las Vegas Public Health Offices, we are screening pregnant and post-partum women with the Edinburgh Screening Tool. This will highlight the % of perinatal depression and will provide a referral resource list for women experiencing maternal depression.

Senate Memorial 28: Adolescent Birth Rate Reduction Task Force, passed in 2010, is to enhance collaboration for teen pregnancy prevention activities and continue strategic targeting of resources towards evidence-based programming. The task force met in April 2010. The consensus was that teen pregnancy prevention groups in NM should continue to follow the five strategies for teen pregnancy prevention (family planning clinical services, comprehensive sex education, service learning programs, adult-teen communication programs and male involvement programs).

***//2013/Medical home and health literacy are priorities for both ECCS and Project LAUNCH grant initiatives. These initiatives are collaborating with CMS, Center for Development and Disability (CDD), other state agency programs, and private partners. A Medical Home/Health Literacy on-line training for home visitors and child care providers is currently being developed. Additionally, information for a medical home portal which will provide resources in English and Spanish for primary care providers and parents is under development.//2013//***

#### IV. F. 2. Children's Medical Services (CMS)

The Medical Director for CMS, the Title V Program for Children and Youth with Special Health Care Needs, serves on the Multi-Agency Team Council on Young Child Wellness, which is part of the ECCS project. The Title V Special Needs Director and the CMS Medical Director serve on the LEND Advisory Committee. The CMS Medical Director also serves on the Autism Advisory Board of the Center for Development and Disability (CDD) at the University of New Mexico.

A team consisting of the acting CMS Statewide Program Manager, the CMS Medical Director, and some of the regional Program Managers and Supervisors has been working on a white paper which will explain why the program is structured as it is, describe the work of medical social work and care coordination, and detail the value of care coordination in containing health care costs and improving patient care and family satisfaction with services they receive. We are planning to present the white paper to the division leadership and hopefully publish it as well.

CMS is also in the planning stages of developing two research projects to evaluate the quality of services provided to CYSHCN. Both projects will involve reviewing client records. The first project will look at a randomized sampling of Medicaid clients from each region, for whom CMS social workers provide care coordination services, to see whether they are obtaining the required EPSDT services such as hearing and vision screening. A recent report from the Office of the Inspector General at HHS showed that 76% of Medicaid clients do not get the recommended EPSDT services. This triggered interest in evaluating how our CMS clients are doing with these screenings.

The second project will focus on children with cleft lip and/or palate to determine from record review whether they are receiving surgeries and other services at the recommended times according to national standards published by the American Cleft Palate and Craniofacial Association. We will start by reviewing records of CMS clients with cleft lip and/or palate who were born between Jan. 1, 1995 and Jan. 1, 2009. If possible we will expand to evaluate non-CMS clients in NM as well. This project will be very time intensive and feasibility will depend on

staff availability as there is no funding available at this time to pay an abstractor or contractor. ***/2013/The Newborn Hearing program has been participating in the NICHQ Learning Collaborative as part of quality improvement activity around follow-up. A major initiative was implemented around communication with PCP's.***

***The MCH Collaborative is applying for a Kellogg grant to perform a needs assessment of state family leadership and better align family leadership programs. CMS is working with Medicaid on a pilot project to improve pediatric asthma outcomes as part of Medicaid redesign. CMS increased collaboration with the CDD around transition, youth leadership and medical home training.//2013//***

#### Toll-Free Nurse Advice Hotline

In 2007, New Mexico launched a 24-hour Nurse Advice Line for all New Mexicans. The number is 877-725-2552. Nurse Advice was the first public-private, health advice line in the nation. Thirty-eight nurses, totaling 15 full-time-equivalent positions, staff the line, answering healthcare questions and directing callers to local community resources. The New Mexico Department of Health provided \$500,000 in startup funding, which was supported by the New Mexico Legislature. Supporting organizations are University of New Mexico, Presbyterian Health Plan, Coordinated Systems of Care, Community Access Program, Lovelace Health Plan, Primary Care Association, Bernalillo County and New Mexico Hospital and Health Systems Association.

#### **G. Technical Assistance**

***/2012/New Mexico needs technical assistance to enhance its data linkage and geospatial analysis capabilities. The State is also requesting assistance in brokering data sharing agreements between agencies. Finally, New Mexico has requested a forum for Regions IV and VI to come together to reduce infant mortality, which is highest in these two regions.//2012//***

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> <i>(Line1, Form 2)</i>	4331887	4286183	4359436		4359436	
<b>2. Unobligated Balance</b> <i>(Line2, Form 2)</i>	0	0	0		0	
<b>3. State Funds</b> <i>(Line3, Form 2)</i>	3248916	2048070	2023983		3579742	
<b>4. Local MCH Funds</b> <i>(Line4, Form 2)</i>	0	0	0		0	
<b>5. Other Funds</b> <i>(Line5, Form 2)</i>	0	0	0		6523648	
<b>6. Program Income</b> <i>(Line6, Form 2)</i>	0	0	6821100		3200400	
<b>7. Subtotal</b>	7580803	6334253	13204519		17663226	
<b>8. Other Federal Funds</b> <i>(Line10, Form 2)</i>	54285700	74910268	71935900		74910268	
<b>9. Total</b> <i>(Line11, Form 2)</i>	61866503	81244521	85140419		92573494	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	1574580	1073966	377662		3709277	
<b>b. Infants &lt; 1 year old</b>	291200	254694	1806209		706529	
<b>c. Children 1 to 22 years old</b>	3013732	2717618	6026171		6888658	
<b>d. Children with</b>	2339246	2102703	4769472		5475601	

<b>Special Healthcare Needs</b>						
<b>e. Others</b>	0	0	0		0	
<b>f. Administration</b>	362045	185272	225005		883161	
<b>g. SUBTOTAL</b>	7580803	6334253	13204519		17663226	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	0		0		0	
<b>b. SSDI</b>	84600		84600		84500	
<b>c. CISS</b>	140000		132100		118390	
<b>d. Abstinence Education</b>	0		0		0	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	53940600		62194200		64771800	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	120500		120900		121000	
<b>j. Education</b>	0		0		0	
<b>k. Home Visiting</b>	0		0		0	
<b>k. Other</b>						
<b>Misc</b>	0		0		2120695	
<b>Program Revenue</b>	0		3303000		3200400	
<b>Title X</b>	0		4118500		4493483	
<b>Miscellaneous</b>	0		1982600		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	2650298	1761812	4423513		6182129	
<b>II. Enabling Services</b>	2337438	1902604	5228991		5475600	
<b>III. Population-Based Services</b>	140028	57514	382931		353264	
<b>IV. Infrastructure Building Services</b>	2453039	2612323	3169084		5652233	
<b>V. Federal-State Title V Block Grant Partnership Total</b>	7580803	6334253	13204519		17663226	

**A. Expenditures**

Significant Year to Year Expenditure Variations:

In the fiscal year 2009, the expenditures for services for children and adolescents as well as children with special health care needs were higher than the required percentages, similar to other states. The amount expended toward services to children and adolescents represents approximately 43 percent of the total MCH federal budget. The amount allocated toward children with special health care needs represents 31 percent of the federal budget. Overall, the amount allocated toward children and adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget

is 30 percent. The amount spent on mothers represents 22 percent of the entire budget. 20 percent of the total was spent on women out of the federal budget.

/2012/Expenditures for services for children and adolescents and children with special health care needs continues to remain higher than the required percentages. The amount expended toward services to children and adolescents represents approximately 48 percent of the total MCH federal budget. The amount allocated toward children with special health care needs represents 32 percent of the federal budget. Overall, the amount allocated toward children and adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 36 percent. The amount spent on mothers represents 24 percent of the entire budget. 17 percent of the total was spent on women out of the federal budget//2012//

The State of New Mexico converted over to a new financial system known as SHARE. This system now tracks budgets via a Department code, fund codes and project ID's, depending on the funding source. We are just entering the second year of this system and have worked through many of the issues that plagued the system upon its introduction. In past years the state match amount was considerably greater than the required three state dollars to four federal dollars. However, in this economic climate the Department of Health general fund allocation to the Title V Block Grant is at the required amount with very little state dollars to overmatch the federal dollars.

There is a significant variation in expenditures this year due to decreased state funds. Additional state matching funds previously appropriated towards Children with Special Healthcare Needs was reduced considerably, some programs were eliminated completely. Safety net services which include MCH services such as High Risk Prenatal Care Fund, Maternal Health, and Children with Special Health Care Needs continue to be funded however; many programs also pull in a minimal amount of revenues. It is evident through analysis of expenditures, that the grant continues to be spent more and more on direct services due to several factors. First, there is a great influx of undocumented immigrants coming to the State. Hospital costs continue to increase. The CSHCN Program has made a concerted effort to transition the highest cost patients to the New Mexico Medical Insurance Pool (NMMIP). The state has not offset the federal reduction in funding, thus direct services are depleting funds for some infrastructure and population based services. This year the State had to decrease the amount it is spending for contracting services out of our General Funds. This will significantly impact access to care for services. Costs are still escalating for serving children with special health care needs. The flat budget for the CMS Program over the last few years resulted in increased pressure from the hospitals to increase per diem rates for hospitalized children and youth. The Healthier Kids Fund Program funded by state appropriation has been eliminated due to budget shortfalls. The cost to serve children under this program was less than \$300.00 per child per year. The Bureau continues to try to proactively address factors impacting birth outcomes such as obesity, preconception, prenatal care utilization, alcohol, substance abuse, tobacco, mental health, unintended pregnancy, and eliminating disparities between documented and undocumented pregnant women in access to services. While evidence-based interventions are increasingly requested, there are few resources to evaluate the impact of programs. A hiring freeze which went into affect approximately 9 months ago has impacted our MCH Epidemiology program; with vacancies and retirements, the program is functioning with only 43 percent staff.

The Family Planning Program continues to receive funding via Title X, Teen Outreach program (TOP) and Teen Pregnancy Prevention (TPP). The Male Involvement grant in Luna Co. has expired and the program will apply for another Male Involvement grant in another county.

/2012/The Family Planning Program (FPP) applied for and received a Personal Responsibility Education Program (PREP) grant *Cúidate!* and Teen Outreach Program curricula in New Mexico (NM), focusing on the counties with the highest teen birth rates, to reduce sexual risk-taking behaviors in NM teens, ages 13-18, using the Personal Responsibility Education Program (PREP) funding. *Cúidate!* is a culturally-based sexual risk reduction intervention, targeting

Hispanic youth ages 13-18.//2012//

The WIC Program expanded the EBT project statewide and continues to apply for additional funding through ARRA. The need for safety net programs has not diminished in the face of Medicaid budget deficits and increased immigration. The High Risk Prenatal Care fund which uses state funds to serve undocumented immigrants has far outstripped current resources. The Bureau is applying for state expansion funds in this area, but due to many budget challenges, the state may not prioritize this need.

For Children's Medical Services (CMS) Children and Youth with Special Health Care Needs Program (CYSHCN), Governor Richardson proposed an increase in multidisciplinary pediatric outreach clinics in outlying areas. Governor Richardson became aware that there were not enough clinics to meet the expressed need for pediatric specialty services for children in rural areas. He proposed a 1 million dollar expansion for CMS. The Legislature appropriated \$500,000.00 for a combination of CMS issues. \$100,000 was given for the deaf and hard of hearing community, \$100,000 went to the blind and visually impaired community and \$300,000 was given to CMS for orthopedic patients and will be used for addressing an unmet need for outpatient orthopedic services for existing CMS clients.

The need for services continues to increase in New Mexico, however in this economic climate the funding and resources continues to decline. Those at risk are held to receiving services and funding however, many other services have been reduced.

/2012/At this time the general funds have been cut and the costs for our aviation services has increased. Due to these issues CMS will have to reduce the number of specialty clinics provided to clients.//2012//**2013/ State general funds have remainder flat and aviation costs did not increase, therefore leaving the number of clinics solvent. //2013//**

/2012/Many of the same conditions continue with regards to state general funds beyond the required Title V match, many of our programs are diligently finding ways to work with our Title XIX Medicaid system to enroll more children that are found to be eligible for Medicaid thus increasing revenues to programs. We are aware that we cannot provide services under Title V and obtain Title XIX revenues; program staff is taking every measure to check eligibility for each client. The Bureau has been working with hospitals to obtain reimbursement for the Newborn Genetic Screening kits. This program obtains funding through state appropriation. In addition expenditures are being monitored closely to detect overbilling to our programs.//2012//

## **B. Budget**

The Federal support received from the MCH Block grant complements the State's total efforts to optimize services to the MCH population. In the 2007 federal grant budget, the amounts allocated to services for children and adolescents as well as children with special health care needs were higher than the required percentages and slightly higher than FY2006. The amount allocated toward children with special health care needs represents 31 percent of the federal budget. The remaining amount allocated for women, represents 20 percent of the federal budget. 4% of the federal budget is expended on administration. Overall, the amount allocated toward Children and Adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 30 percent. The amount spent on mothers represents 22 percent of the entire budget.

/2012/Budget allocation for services for children and adolescents and children with special health care needs continues to remain higher than the required percentages. The amount budgeted toward services to children and adolescents represents approximately 48 percent of the total MCH federal budget. The amount allocated toward children with special health care needs

represents 32 percent of the federal budget. Overall, the amount allocated toward children and adolescents, including the state funding equals 45 percent of the entire budget, and for children with special health care needs the percentage of the entire budget is 36 percent. The amount allocated on mothers represents 24 percent of the entire budget. 17 percent of the total was allocated on women out of the federal budget//2012//

Resources previously spent for prenatal care media campaigns were shifted to the High Risk Prenatal Care Fund. In addition, other resources are being sought to fill this need. The year has been spent analyzing current budgets across Title V programs. A review of the final FY2009 budget as compared to the initial budget for SFY2006 (state year), With the initial low budgeting of the program by the Public Health Division and budget adjustments during the year to meet costs of safety net operations, seldom can the Title V Program operate within 10 percent of the original state year budget as required.

The State of New Mexico converted over to a new financial system known as SHARE. This system now tracks budgets via a Department code, fund codes and project ID's, depending on the funding source. We are just entering the second year of this system and have worked through many of the issues that plagued the system upon its introduction. In past years the state match amount was considerably greater than the required three state dollars to four federal dollars. However, in this economic climate the Department of Health general fund allocation to the Title V Block Grant is at the required amount with very little state dollars to overmatch the federal dollars.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal percent of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant. Because New Mexico has high rates of birth defects, low levels of early prenatal care and oral health care, Department of Health Secretary Alfredo Vigil included this as one of the priorities in the revised Strategic Plan. Preconception health care: Birth defects and low birth weight are both associated with short and long term expensive medical costs and reduced lifelong productivity. Within public health clinics clients receive very limited screening and education to promote healthy behaviors related to pre-pregnancy health risks of family Violence, Alcohol, Substance abuse and Tobacco (VAST). Prenatal care has been shown to prevent poor birth outcomes. Oral Health care before and during pregnancy is increasingly seen as a way to prevent premature birth and low birth weight. The other request that is in the top five is preventing teen pregnancy, suicide and gambling. Suicide, pregnancy and gambling are three major health issues among teens in New Mexico. Suicide among youth aged 15-24 is a major health crisis in New Mexico. In 2006, the national youth suicide rate was 64 per 100,000 while New Mexico's rate was 84 per 100,000. Nationally, suicide is the third leading cause of death for 15-25 year olds. In New Mexico it is the second leading cause of death. /2012/New Mexico has just undergone a change in Executive administration. Department of Health Secretary, Catherine D. Torres, is working with leadership staff to revise the Department of health Strategic Plan. However, the need for early prenatal care continues to prevail in NM.//2012//

The budget request in 2009 for allocations towards the MCH initiative did not pass, therefore the MCH initiative was left flat funded for the majority of 2009 with the exception of budget cuts beginning in November of 2009. Due to the economy any monies from our general fund that was not being paid out or encumbered was disencumbered back to the Department to cover existing expenses. Currently contracts have been cut by 18 percent. Vacant positions not currently 100 percent federally funded or positions not providing direct clinical services have been placed on a freeze. **/2013/ The hiring freeze was lifted and any position that becomes vacant we are allowed to fill with existing funds. The family health bureau has very few State General Fund positions that are not already within the existing budget. Programs have moved forward in allocating salaries across the board to incorporate all funding streams and allocate at a percentage for each position. //2013//**

The New Mexico Legislative Finance Committee (LFC) performed a cross agency audit of all

early childhood programs to determine efficiency and duplicative efforts for services. The LFC determined the DOH was performing in the best interests of early childhood as noted by the data provided by the Department. LFC recommended the DOH consider implementing a pilot project of the Family Nurse Partnership and requesting legislative financing for such an endeavor. This would assist with many of the early childhood indicators. ***/2013/ the LFC recently performed an evaluation of the Department. //2013//***

Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component, paid totally out of state funds is comprised of the Family Health Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintenance, strategic planning, and advocacy.

The budget meets the target percentages for Preventive and Primary Care for Children, Children with Special Health Care Needs, and Administration.

The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail.

The block grant award received in 2009 decreased by approximately \$88,000. Program budgets were adjusted for the cut accordingly. Services were affected either by the cut to services, the number of people served or the number of staff available to provide the services. ***/2013/ The block grant award for 2012 was decreased by \$ 60,090, again program budgets were adjusted for the cut accordingly. The programs most affected by the cuts were Title V Family Planning and the Medical Director's office. The remainder of the programs took minimal cuts. //2013//***

The summary budgets are an aggregation of all of the Project Identification Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Project Identification Codes are program specific: e.g., Maternal Health, Title V, Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Project I.D. is allocated funding showing the federal/state distribution. The state match amount is the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of \$3,087,900.

The state match is almost entirely from appropriations from the state general funds; a very small amount is from third party payments. The federal percent of the budget is based upon the level of funding in New Mexico's share of the MCH Block Grant.

Due to the economic status budget allocations decreased this year for services not associated to the federal match to the Block Grant.

*/2012/*This fiscal year many of our programs have worked with Human Services Department to provide outreach and enroll clients eligible for Title XIX Medicaid services. This has been successful however, slow due to the lack of manpower and resources. We will continue in these efforts to increase revenues from other funding streams as well as provide quality assurance to monitor services, i.e. overutilization/overbilling. The Maternal Health program provides licensure to Licensed Midwives and Certified Nurse Midwives, the program receives funding from this as well. The programs will continue to brainstorm and find ways to continue providing the much needed services without interruption or reduction.*//2012//*

***/2013/ the CMS and Families FIRST case management programs have approached the Human Services State Medicaid program as well as the contracted Managed Care Organizations (MCO's) to discuss an increase in reimbursement for services.***

***Reimbursement for this service has not increased in 5-6 years and the costs have far exceeded the reimbursement. These services cover Medicaid eligible clients and is billing is kept separate from the Title V funding clients. However, the more clients that can be determined Medicaid eligible the more it benefits the Title V population. //2013//***

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.