

**New Mexico Five Year Needs Assessment
for the
Maternal and Child Health
Title V Block Grant Program**



**Family Health Bureau
Public Health Division
Department of Health
State of New Mexico**

**July 15, 2010
Needs Assessment**

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I. Summary, Introduction and Overview for the New Mexico Maternal and Child Health Population 2011-2015 Title V Needs Assessment

I.A. Executive Summary

New Mexico receives federal funding every year through the Maternal and Child Health Block Grant Program. As part of its grant agreement, the State is required to conduct a comprehensive assessment of maternal and child health needs in New Mexico every five years. Through the 2011-2015 Needs Assessment process, the Family Health Bureau (FHB) has identified priorities on which to focus for the next five years.

FHB is a Bureau within the Public Health Division (PHD) that is part of the New Mexico Department of Health (DOH). The Title V Block Grant funds are administered by the Title V director who is the chief of FHB. Children's Medical Services (CMS), Maternal Health, Child Health, Family Planning and Family Food and Nutrition/WIC are housed within FHB. Title V programs that are outside of FHB are the Office of School and Adolescent Health within PHD, and the Childhood Injury Prevention program in the Epidemiology and Response Division. Both are within DOH. Additionally, FHB works closely with the Office of Oral Health, in PHD.

The Vision of FHB is that families will be physically and mentally healthy, and have access to care that is:

- Family Centered
- Comprehensive
- Community-based
- Coordinated
- Culturally Competent

FHB implements preventive services to women of reproductive age, mothers, infants, children, adolescents/youth, children and youth with special health care needs, and their families. The needs of these populations are assessed and data collected for use in policy decision making.

The services include:

- Direct safety net health care services to individuals
- Enabling services: family support, transportation, peer parent support, case management, outreach, translation, health education, food assistance, nutrition support, and referrals to other health and human services
- Population-based services: newborn screening, surveillance, SIDS education & counseling, injury and violence prevention, and marketing campaigns to increase healthy birth outcomes
- Capacity-building services: assessment, evaluation, planning, and policy development, training, monitoring, information systems, and helping to develop systems of care.

The MCH Title V program funds 103 positions statewide to support these programs and services. Ten programs, along with a Medical Director, Bureau Chief, and support staff, are in the state office.

FHB leadership and staff, along with partners and stakeholders from each of New Mexico's five public health regions began meeting in 2008 to identify maternal and child health issues that were prevalent at the local, regional and state levels. Through these meetings, 25 health issues were selected for consideration in an online priority ranking survey, and each issue was assigned a weight to ensure that selected priorities were the most appropriate for the New Mexico MCH population.

Eighty-four participants represented their communities during the regional needs assessment meetings where the initial 25 priorities were selected. Over 500 complete responses to the online survey were received and analyzed.

FHB managers and staff identified capacity in their programs and communities by examining their program data and soliciting stakeholder input during regular meetings throughout the previous Needs Assessment cycle. CMS conducted a series of Asthma Summit Meetings in order to assess the needs and capacity relating to children with special health care needs. The summits were held in each of the state's five regions, and included health care professionals, citizens' advocacy groups, families with asthma, pediatricians, family practice physicians, nurses, school principals and school nurses, Medicaid representatives, MCO directors, and tribal government leaders.

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:

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

I.B. Introduction

Since 1935, the Title V Maternal and Child Health Services Title V Block Grant has operated as a Federal-State partnership with the goal of improving the health of all mothers and children. The program is administered by the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). All US states and jurisdictions are eligible for Title V funding and their programs work to:

- Reduce infant mortality and incidence of handicapping conditions among children.
- Increase the number of children appropriately immunized against disease.
- Increase the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services.
- Provide and ensure access to comprehensive perinatal care for women; preventative and child care services; comprehensive care, including long-term care services, for children with special health care needs; and rehabilitation services for blind and disabled children under 16 years of age who are eligible for Supplemental Security Income.
- Facilitate the development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for children with special health care needs.¹

Each year, on July 15th, the Family Health Bureau (FHB) is required to submit an application and report to DHHS/HRSA/MCHB. The purpose is to monitor New Mexico's Maternal and Child Health (MCH) Services Title V Block Grant programs. Money from the grant is used to provide services to women of childbearing age (age15-44), pregnant and parenting women, children, adolescents, and children and youth with special health care needs (CYSHCN). These programs are administered by the Maternal and Child Health (MCH) Program, and Children's Medical Services (CMS), both of FHB. Title V funds also support positions in the Family Planning Program, Office of School and Adolescent Health, and in the Office of Injury Prevention.

DHHS/HRSA requires that a comprehensive statewide MCH needs assessment be conducted every five years in order to: 1) improve outcomes for MCH populations, 2) strengthen partnerships between MCH programs and federal, state and local entities, and 3) to help states make the most appropriate program and policy decisions that promote the health of women, children, adolescents, and Children and Youth with Special Health Care needs (CYSHCN) and their families.

FHB formally began its needs assessment process in 2007. The MCH program managers met to determine the best approach to capturing the most information possible given the state's capacity. Children's Medical Services (CMS) determined that a health-issue approach was best, and they focused on Asthma for this term. Asthma is the most prevalent condition for the CYSHCN population, and needs and capacity related to that condition represent needs and capacity in many other areas specific to CMS. CMS proceeded to conduct asthma summits in each of the state's five regions. They also

conducted a comprehensive assessment of data needs in 2007. The Needs Assessment report for Children and Youth with Special Health Care Needs is in section III.

FHB MCH programs engage in ongoing assessment of needs and capacity as part of their general work, and that information is integrated into program and policy decisions as appropriate. As a specific needs-assessment project, the MCH team decided to assess needs at the regional and county levels. New Mexico's Department of Health is organized into five health regions, each with its own director, clinical, administrative and professional staff. In 2008 and 2009, FHB coordinated five regional meetings and invited anyone from that region with an interest in Maternal and Child Health to attend. Using the results from those meetings, FHB created an online survey and invited anyone in New Mexico to rank 25 MCH priorities in order of importance to their communities.

Results from the regional meetings and from the online survey were analyzed by the Title V Epidemiologist. The 25 MCH priorities included in the online survey were weighted according to input from the participants in the regional needs assessment meetings, and from FHB management and staff.

FHB will report the needs assessment results to leadership at the Department of Health and Public Health Division, and to each of the regional leaders and participants in the needs assessment meetings to determine how best to approach the issues that emerged during the needs assessment process.

I.C. State of New Mexico Maternal and Child Health Overview

I.C.1. Topography and Climate

New Mexico's climate varies according to topographic regions. New Mexico's topography includes high plateaus (mesas), mountain ranges, valleys, and straight plains. The lowest point in New Mexico is 2,817 feet (Red Bluff Reservoir) and the highest point is 13,161 feet (Wheeler Peak). The weather is "mild, arid or semiarid, light precipitation totals, abundant sunshine..."

The summer temperatures often reach 100o F (below 5,000 feet), in southern New Mexico. Northern New Mexico's summer temperatures (depending on elevation) can range from 70-90o F.

Highest temperatures recorded are 116o at Orogrande on July 14, 1934, and at Artesia on June 29, 1918.¹ The coldest month is normally January and the daytime temperatures across the state range from low 20s to 50s. The mountain regions can drop to subzero temperatures. Monsoon season is July and August.²

I.C.2. Demography

In 2008, there were 431,612 women between the ages of 15 and 44. There were 26,722 infants, and 553,771 children aged one to 19. The total estimated MCH population for

that year was 1,012,105.³ The 2005-2006 National Survey of Children with Special Health Care Needs estimated that there were 59,535 special needs children aged 0-17 in New Mexico, or 12.1% of children in that age group.⁴

New Mexico also has very high levels of poverty (22.2%) and uninsured individuals (26%).⁵ 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.

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 had dropped out; 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 through high school enrollment was 332,000 children. College or graduate school enrollment was 145,000.⁶

I.C.3. Diversity

New Mexico's population is one of the most diverse in the United States, consisting of 44% Hispanic, 42% White-non-Hispanic, 10% American Indian, 2% African-American, 1.4% Asian and Pacific Islander, and 3.2% people of more than one race.

A 2007 press release from the US Census Bureau noted that New Mexico is one of four states, and the District of Columbia, that is "majority-minority" with 57% of its population being classified as "minority." There are 51.5 % Hispanic children, 13.2% American Indian-Alaska Natives children, 2.2% Black-African American children, 1.3% Asian-Pacific Islander, and Non-Hispanic White children making up only 31.7% of the population.

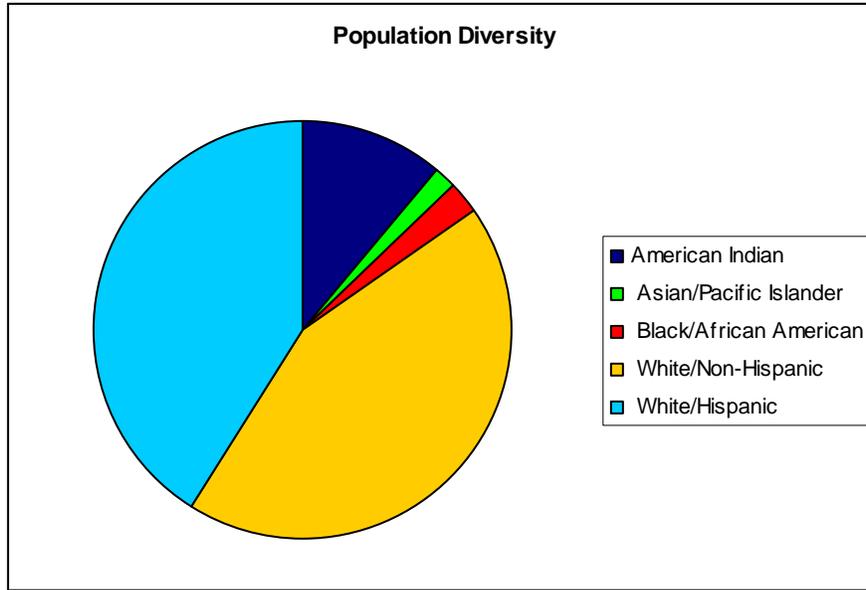
The 2007 racial and ethnic distribution of NM children, estimate is as follows:

Age 0-4 Years: 66,689 Hispanic, 38,225 Non-Hispanic White, 16,261 American Indian, 2,624 Black, and 1,782 Asian.

Age 5-9 Years: 65,667 Hispanic, 36,243 Non-Hispanic White, 14,758 American Indian, 2,760 Black, and 1,806 Asian.

Age 10-14 Years: 81,174 Hispanic, 50,158 Non-Hispanic White, 22,121 American Indian, 3,527 Black, and 2,013 Asian.

Age 15-19 Years: 81,591 Hispanic, 57,339 Non-Hispanic White, 22,546 American Indian, 3,783 Black, and 2,101 Asian.



The Census Bureau projects that the State of New Mexico will be one of the top 10 fastest growing states during the period of 2020 to 2025. The Census Bureau also projects that by 2025, New Mexico will have more American Indian residents than California. That will place New Mexico third, behind Arizona and Oklahoma, in total number of American Indian people in any US state.

I.C.4. Geography

There are 33 counties in New Mexico. Fourteen are frontier or sub-frontier with 6.8% of the population. Eighteen are rural counties with 63.5% of the population. One county is urban, with 29.7% of the population. Projections based on the 2000 census show that eight cities have more than 30,000 people: Albuquerque (528,497), Las Cruces (93,570), Rio Rancho (82,574), Santa Fe (73,720), Roswell (46,526) Farmington (43,420) Alamogordo (35,984), Clovis (32,899) and Hobbs (30,838).

County populations of children ages 0-19 range from 131 in Harding county to 167,804 in Bernalillo county. Eight counties have a population density per square mile of 20 or above. The remaining 25 have population densities of less than 14. The range is .4 persons per square mile in Harding County to 477.4 persons per square mile in Bernalillo County.

I.C.5. Economy

Federal poverty guidelines, which dictate whether a family is eligible to receive assistance such as Medicaid and Food Stamps, are tied to a formula that was created in the 1960s. It was based on what the typical family spent on groceries because that was a family's biggest expense at the time. Today, necessities like housing, childcare and health care take up a far greater share of most family incomes than groceries. Not only do the

guidelines not take these changes into account, they do not take into account regional differences in the cost of living.⁸

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.

As of 2009, the unemployment rate in New Mexico was 6.6%.⁹ In 2006-2008, 18 percent of New Mexicans were living below poverty level. 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 head-of-household had incomes below the poverty level.¹⁰

The 2009 UNM BBER reported a per capita personal income of \$32,992 placing New Mexicans 42nd in the US, and earning \$6,146 less than the US average of \$39,138.¹¹

I.C.6. Health Care Status and Access to Health Care

A significant portion of New Mexicans are at risk for lack of access to needed primary care. Only one of New Mexico's counties, Los Alamos, is designated by HRSA as neither "Medically Underserved," nor a "Health Professional Shortage Area (HPSA)." The remaining 32 counties are either entirely or partially underserved and are considered HPSAs. More than 700,000 people live in these areas. While not everyone in the HPSAs is without care, many people get less health care than they need.¹²

New Mexico has one of the highest percentages of population without health insurance. In 2007, 22% of 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. In 2007-2008, of non-elderly adults that were uninsured, 27.5% were white, and 49.7% were Hispanic.¹³ Four percent 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.¹⁴

II. Assessment of the Maternal and Child Health Population

II.A. New Mexico MCH Five Year Needs Assessment Process

The State continuously assesses needs and capacity for the MCH population and reports these results annually or biennially through a series of reports. To track the status of women and women of childbearing age in New Mexico, the New Mexico Commission of the Status of Women publishes its report annually,¹⁵ and the New Mexico PRAMS program publishes its surveillance report every two years.¹⁶

Children's health is reported annually in the New Mexico Kids Count report,¹⁷ and in the New Mexico Children's Cabinet Report Card.¹⁸ New Mexico also participates in the Youth Risk Behavior Surveillance System (known in New Mexico as the Youth Risk and Resiliency Survey) at both the middle and high-school levels, and those reports are published biennially.¹⁹

The Bureau of Vital Records and Health Statistics publishes its data on all New Mexicans annually, and reports specific to Health Disparities and to New Mexico's Native American population are published regularly.

One function of the Needs Assessment is to review these and other relevant reports to assess trends and inform the development of the State's strategic plan. The goal for this Needs Assessment cycle was to assess the strengths and challenges facing the MCH and CYSHCN populations in New Mexico and understand how to best utilize capacity to effect change and to identify areas that need to be strengthened. The objectives are as follows:

- 1) Create comprehensive "living" document that can be used as a reference by MCH advocates at all levels.
- 2) Solicit input from partners, stakeholders and the general public to ensure buy-in
- 3) Develop a plan for sharing results with partners, stakeholders and the general public in order to inform policy and programs.

II.B. Leadership

The core members of the leadership team included the Title V Director Emelda Martinez, BS, RN, Title V CSHCN director Lynn Christiansen, MSW, LISW, Title V Epidemiologist Alexis Avery, PhD, MPH, Maternal and Child Health Section Manager Carol Tyrrell, RN, BA Child Health Manager Gloria Bonner, BA, Maternal Health Manager Roberta Moore CNM, RN, and Child Injury Prevention Program Manager, John McPhee. Key support staff included Diane Denny-Frank Health Educator, MSW, LISW, HRSA Graduate Student Interns Jacob Smith, MPH and Lucy Stelzner, MA, MPH and University of New Mexico student Kimberly Brown.

The Needs Assessment was coordinated by the Title V Epidemiologist. The program managers facilitated regional meetings and solicited input from their clinical and administrative staff. Ms. Dennedy-Frank transcribed notes from the regional meetings and Ms. Stelzner assisted with logistics and produced the data book and documents used to inform the discussions at the meetings and for the online MCH priorities survey.

The CYSHCN Needs Assessment Leadership team consists of the CMS Statewide Program Manager Lynn Christiansen MSW LMSW, the CMS Medical Director Janis Gonzales MPH MD, the Newborn Screening program coordinator Susan Chacon MSW LISW, the CMS training and development specialist Elaine Abhold, and the statewide regional program managers and social work supervisors, in collaboration with parent and family organizations such as Parents Reaching Out and Family Voices. For the asthma section of the Needs Assessment, participants included the Family Health Bureau Medical Director Elizabeth Mathews MD, the Asthma Epidemiologist Brad Whorton PhD and other members of the state Asthma program. Ms. Christiansen participated in the regional meetings and assisted in the facilitation along with the regional program managers and supervisors. Dr. Gonzales, Ms. Chacon and Ms. Abhold also assisted with the solicitation of input from various stakeholders representing newborn screening and family support organizations. For the asthma section the CMS leadership team along with Drs. Mathews and Whorton participated in the facilitation of the summits in each region which included large group presentations and small break out work groups.

II.C. Methodology for Conducting the Assessment

Specific to the Needs Assessment project, the leadership team facilitated five regional meetings. During the first two regional meetings, the ten priorities from the 2005 needs assessment were presented for consideration. The participants were asked to describe any changes or new issues related to the priorities, and they were also asked to describe any new issues that were not part of previous ten priorities. The remaining three meetings asked respondents to discuss issues related to the 25 issues identified in the first two meetings, and also asked them to rank order and weigh the priorities. There were a total of 87 participants in the meetings: 14 in region one, 24 in region two, 18 in region three, 15 in region four, and 13 in region five. (A complete list of participants can be found in Appendix 1, and the invitations and agenda are in Appendix 2.)

The FHB had originally planned to visit each region twice – first to discuss the 2005 priorities and progress made toward the goals identified in the previous needs assessment, and a second time to allow participants in the other three regional more time to brainstorm emerging issues. Because of travel restrictions and budget shortages, it was not possible to visit each region more than once, many people, especially DOH employees, could only attend one meeting.

FHB compensated for this by designing an online priority ranking survey. The original survey was designed as a Q-sort pyramid as developed by HRSA. This format organizes the priorities in such a way where the first box on the lower left is the highest priority, and the last box on the lower right is the lowest priority, with the five boxes in the center

of the pyramid being of equal importance, thereby forcing a normal distribution onto the results.

During beta-testing, most respondents found the Q-sort pyramid to be counter-intuitive. They liked the drag-and drop pyramid shape, however, so the pyramid was retained, but respondents were asked to put their top priority at the top of the pyramid, then left-to-right and down so that the lowest priority was on the lower right-hand side of the pyramid. Beta-testers found this to be much easier. Screen shots of the survey can be found in Appendix 3.

The survey was announced to the media. It was promoted on several radio stations, and in regional and local news papers. Five-hundred-twelve complete responses were received, and analyzed. In addition, 298 respondents used the text box to send in their comments, many of which are included throughout this report. Appendix 4 contains the full results of the online survey.

The State continuously examines the MCH population strengths and needs, and monitors the programs designed to address them. Through regular staff meetings, the program managers examine data, monthly and annual reports, and solicit input from field staff to identify program and population strengths and needs. The Maternal and Child Health Epidemiology program examines data as soon as they become available to assess changes in the status of the population. The Family Health Bureau (FHB) management team meets every week to discuss data analysis results and program activities and challenges, and to identify opportunities for collaboration that can support positive outcomes in the MCH population. Program managers share the results of these meetings with field staff who incorporate the information into their program activities. When issues are identified, action is taken to address them. A few examples during the past five years include a helmet law for all children under age 18, legislation requiring employers to provide a place and time for breastfeeding women to pump milk, a task force and a collaborative pilot project with Human Services Department on maternal depression, a task force for home visiting, and a senate memorial working group on prenatal substance abuse. A complete list of activities that resulted from the State's ongoing assessment of the MCH population is in Appendix 5.

All of the information collected for the Title V grant application and report is relevant to the Five Year Needs Assessment, and Department and Division leadership use this information to develop priorities and strategic plans. The Public Health Division (PHD) performance measures are very closely aligned with the national and state performance measures identified in the Title V grant, and most are identical. The Department of Health (DOH) incorporates these into its annual strategic plan. In order to set the targets for state and national performance measures, FHB management and staff examine trends and program capacity and set targets that are realistic and that encourage programs to aim for improvement. Both PHD and DOH solicit input from FHB managers and staff, who are in-turn informed by their partners and stakeholders. Resources are allocated according to determined state and community priorities, state and federal mandates and determined need in programs and services where other resources are lacking.

Methodology for the assessment of Children and Youth with Special Health Care Needs

Assessment of CYSHCN population

The CMS program does not have the capacity to survey the entire New Mexico CYSHCN population, and the program is grateful for the NSSCHCN 2005-2006, sponsored by the Maternal and Child Health Bureau, which provides national and state-level information about the numbers of children and youth, 0-17 years old, who have special health care needs.

The survey asked 750 families of CYSHCN in each state about

- Access to health care and unmet needs
- CYSHCN health and functioning
- Health Care quality and satisfaction
- Impact of child's health on family activities, finances and employment
- Adequacy of health insurance to cover needed services.

CMS social workers meet with clients and families on a regular basis to obtain informal assessments of the unmet needs of the CYSHCN population, and the CMS Management Team meets monthly to set priorities and goals for the program based on feedback from the social workers and the clients and families. Advisory Board meetings occur quarterly for both the Newborn Genetic and the Newborn Hearing Screening Programs. These meetings include family members and other stakeholders who give feedback on the CMS program and how well needs of CSHCN in New Mexico are being met. The CMS Statewide Program Manager and the CMS Medical Director meet bi-annually with the CMS Advisory Board of the New Mexico Medical Society to discuss program activities, goals and priorities.

CMS receives feedback on gaps in services from various sources including the Newborn Hearing Screening Advisory Council, the Newborn Genetic Screening Advisory Council, the Pediatric Council and the CMS Advisory Board which is part of the New Mexico Medical Society. The advisory boards are comprised of various stakeholders including professionals and parents. The program meets with the Chiefs of the Pediatric Departments at UNM to negotiate the number of multidisciplinary clinics and the locations of these clinics statewide.

The CMS social workers are in close communication with their clients Medical Home and receive feedback on gaps in services in their communities. The program makes every effort to address these issues but is dependent on budget and the availability of providers especially specialists that are willing to travel to rural areas of the state to provide outreach services.

Asthma Summits

The New Mexico Pediatric Asthma Summits were conceived in 2006 by the NM Department of Health's Children's Medical Services Program and Environmental Epidemiology Program. Asthma was the main diagnosis for children on the CMS Title V CYSHCN program, and the burden of asthma was greater than what the CMS pediatric pulmonary outreach clinics could influence. That, combined with the new data from the "Burden of Asthma in New Mexico Surveillance Report 2006" on high pediatric emergency room and hospitalization use in certain counties, precipitated the formation of an asthma action group to plan the summits.

Key stakeholders in pediatric asthma care (the NM Pediatric Society, the NM branch of the American Lung Association, U. of NM Hospital's Pediatric Pulmonary Department, the Medicaid Saluds, School Health, and NM Asthma Coalition, among others) were invited to join CMS and Environmental Epidemiology in the summit planning process. The summits were to be a collaborative community process, not a DOH project alone. *The goal was to re-think and reformat pediatric asthma care* because what was being done at that time was not working, *and then move to action.* The action team decided the format and agenda of the asthma summits and that they would take place in each quadrant of the state as well as in the major city, Albuquerque. All community stakeholders would be invited, medical providers, school nurses, respiratory therapists, families of children with asthma, pharmacists, health educators, healthcare administrators, community organizations. *The goal of the summits was to engage the communities, find out region specific issues in asthma care, network with local resources, and plan for action.*

The summit day was a presentation of state and local community data, followed by the participants dividing into workgroups (aligned by topic areas: public/patient education, access to health Care, patient Issues/transition, policy/legislature, medical professional issues, pharmacy, environment) to suggest reasons for the data and solutions for it. The day's wrap up was sharing the findings, solutions, and action plans. Asthma action teams would be created in each region to follow-up on the recommendations of each summit meeting.

The summits were highly successful. Networking among community participants occurred even as the meetings were in progress. Community awareness of the issues was raised. Local initiatives were enacted even without the structure of local asthma action teams. The Secretary of Health participated in the summits, and directed DOH efforts to the region with the highest hospitalization and emergency room rates. Two follow-up "mini-summits" were done in high risk areas. The 2007 publication of the National Heart, Lung, and Blood Institute's "Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma" gave extra impetus to state and community efforts. New data and new regional information was obtained that was incorporated into the "Burden of Asthma in New Mexico Surveillance Report 2009" and the "Breathing Free, An Asthma Plan for New Mexico 2009". Asthma is now mentioned specifically in the "NM Department of Health Strategic Plan 2011" Community Health Objectives. A State

Asthma Council was created in 2010.

CMS conducted summits around the state from 2007 – 2009. We decided to focus our Needs Assessment on Asthma since this is the most prevalent CYSHCN diagnosis in NM. Stakeholders in each of the five regions were identified and brought into the planning process.

The summit meetings included a broad and diverse group of people, such as health care professionals, citizens' advocacy groups, families with asthma, pediatricians, family practice physicians, nurses, school principals and school nurses, Medicaid representatives, MCO directors, and tribal government leaders, among others. Summits were held regionally in Albuquerque, Las Cruces, Roswell, Gallup and Santa Fe due to the large geographical area in the state of New Mexico and the diverse populations and need.

Summit Process

The meetings had a uniform structure: a brief introduction to the reason for the summit, introduction of participants, presentation of state and regional asthma data, open discussion about data analysis, a networking break, four to five small groups formed around these areas of concern (Medical/Professional Issues, Environmental Health, Public/Patient Education, Access to Care, Pharmacy; Policy and Legislation) for discussions to surface issues, a working lunch, small group work continued on action plan development in each area of concern, presentation of groups' findings and action plans, summary of all groups' findings, wrap up and regional plans for action post-summit. Some local Asthma Action Groups were and many individuals committed to follow-up activities.

II.D. Methods for Assessing Three MCH Populations

II.D.1. Quantitative Methods

Maternal and Infant Health

Data on premature birth, low birth weight and infant mortality are readily available through New Mexico's Bureau of Vital Records and Health Statistics (NMVRHS). NMVRHS regularly provides birth and death files to the Title V epidemiologist. Indicators of at-risk maternal and newborn health are available through the NMVRHS and through the New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS) survey.

Child Health & Education

Child health indicators are reported annually in the Children's Cabinet Report Card. Numerous national, state and local data sources are used for this report which examines health, education, and safety of New Mexico's children and youth, as well as their

general nutritional and financial support and involvement in the community. These data are regularly accessed, analyzed and reported by various state programs, including the Title V program. High school drop out rates are available through data collected by the New Mexico Public Education Department.

Poverty and Unemployment

Poverty estimates are available through US Census data, and will be current when the 2010 Census is completed and published. The New Mexico Human Services Department publishes a monthly statistical report with benefit delivery statistics for Temporary Assistance for Needy Families (TANF) and The Supplemental Nutrition Assistance Program (SNAP). Unemployment data are collected by the US Bureau of Labor Statistics. Child maltreatment data are collected by the New Mexico Children, Youth and Families Department.

Crime, Domestic Violence, and Substance Abuse

The New Mexico Department of Public Safety publishes its Uniform Crime Reports quarterly. Domestic violence data are available through the New Mexico Interpersonal Violence Data Central Repository. Substance abuse data are collected by the NM Epidemiology and Response Division, and data on prenatal substance abuse are provided by the Health Policy Commission.

Stakeholder Input Survey

For the 2010 Needs Assessment, the Family Health Bureau conducted a two-month online survey of 25 health priorities and asked respondents to rank-order them according to which they felt were most important in their communities.

Children and Youth with Special Healthcare Needs

For the CYSHCN Needs Assessment data was used from the 2005-2006 National Survey of Children and Youth with Special Health Care Needs, data collected for the Newborn Hearing Screening program from Vital Records and child specific data from the INPHORM data collection system used by the Special Needs program. Incidence and prevalence data was collected by the Asthma Program within the Department of Health's Office of Environmental Epidemiology. This data was used to guide the Asthma needs assessment as part of the data to action process used for the asthma summits.

MCH indicators ranking at county and sub-county level

The Needs Assessment team analyzed nine indicators at county level for all 33 of New Mexico's counties. The indicators were: adolescent births, premature births, low birth weight infants, infant mortality, poverty, juvenile arrest rates, unemployment, child maltreatment, and domestic violence. Sub-county analysis was done for Bernalillo county, specifically the south valley/south central neighborhoods so that they could be

compared to the counties. The four indicators used in that analysis include: adolescent births, preterm births, low birth weight, poverty, and unemployment, as these data are available at census-tract level. Data for the other five indicators were not available at sub-county level.

Raw numbers for the indicators were entered into a spreadsheet and rates and percentages calculated. Each community was rank-ordered according to the data. For example, the community with the highest rate of domestic violence received a “1” and the community with the lowest rate received a “33.” This procedure was repeated for each community and indicator. There were insufficient data for some indicators, and these were not included in the totals. The indicator ranks for each community were added, then divided by the number of indicators included to generate an overall rank. Communities with the lowest overall ranks were determined to have the highest need.

In order to more accurately compare the counties with the sub-county communities in Albuquerque, indicators that were not available at sub-county level were eliminated. Rates and percentages for the South Valley/South Central neighborhoods and counties were averaged, the standard deviations calculated, and a z score generated for each county/community and indicator. The z scores were added to generate a total score which was sorted to indicate which communities were farthest above the average levels of the five indicators measured.

The results of the county ranks on nine indicators are in appendix 6, and the county/sub-county comparison on four indicators is in appendix 7.

II.D.2. Qualitative Methods

The Family Health Bureau informally collects qualitative data through regular meetings with management and staff. NMPRAMS encourages qualitative responses in its telephone and written survey, and these were compiled and analyzed by the PRAMS team. For the 2010 Needs Assessment, formal qualitative methods included focus groups with regional partners, staff and stakeholders, and a comment box at the end of the online MCH priorities survey which yielded over 200 comments. Formal qualitative assessment is undertaken as much as resources and staffing allow.

Children’s Medical Services receives feedback on gaps in services from various sources including the Newborn Hearing Screening Advisory Council, the Newborn Genetic Screening Advisory Council, the Pediatric Council and the CMS Advisory Board which is part of the New Mexico Medical Society. The advisory boards are comprised of various stakeholders including professionals and parents. The program meets with the Chiefs of the Pediatric Departments at UNM to negotiate the number of multidisciplinary clinics and the locations of these clinics statewide.

The CMS social workers are in close communication with their clients Medical Home and receive feedback on gaps in services in their communities. The program makes every effort to address these issues but is dependent on budget and the availability of providers

especially specialists that are willing to travel to rural areas of the state to provide outreach services.

The MCH Collaborative has undergone a reorganization and is now comprised of CMS, Family Voices, Parents Reaching Out, the Pediatric Pulmonary program at UNM, 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. The intent of the reorganization was to infuse the collaborative with program representatives who share the personal dedication and commitment to Title V. The rebirth of this collaborative has been supportive and innovative and is a mechanism for CMS to receive feedback from other MCH funded programs and parent organizations representing diverse backgrounds. The participation of Collaborative partners has enabled all represented to stay current and involved in the Health Reform process.

II.D.3. Data Limitations

Critical data reports are often delayed because of issues with IT systems changes, staffing shortages, and legal issues. All of these issues are being resolved, but had not been resolved by the time of this report. Delays in obtaining data have resulted in difficulties in accurately tracking trends and detecting important changes in a timely fashion, and limit the state's capacity for program planning. The state also has limited linkage capacity due to staff and resource limitations. County-level data is sometimes unavailable in national data sets, or suppressed in state-collected data to protect privacy or when numbers are too low to constitute statistical significance.

Many of these issues are being resolved. The State has created the New Mexico IBIS data query system which will soon provide data just a few weeks or months after the close of the previous calendar year. This system includes birth and death records, hospital inpatient discharge data, and health surveys such as the Youth Risk and Resiliency Survey (YRRS), the Behavioral Risk Factor Surveillance System (BRFSS), and the Pregnancy Risk Assessment Monitoring System (PRAMS). The State is developing a Health Information Exchange which will include emergency department data, hospital in-patient data, ambulatory medical records data, and laboratory data. See Appendix 8 for a complete list of current MCH data availability and linkage capacity.

Data limitations for CYSHCN

Children's Medical Services collects data for a variety of programs. Most datasets have basic demographic information on the individual such as name, date of birth, and address. The Newborn Screening and Birth Defects data sets which are located on a separate database called Challenger Soft are linked to Vital Records data, which can provide information such as mother's name, date of birth and education. The datasets are used for quality assurance, providing services such as early intervention (secondary prevention) and also surveillance with a goal of primary prevention. Consequently, this dataset contain very reliable data on how to find a small number of individuals. Overall the data CMS maintains are good for conducting follow up. However, several of the

datasets are accessible by only a single individual or are maintained only on paper and the electronic data set is dependent on the availability of Vital Records data which can often be up to six months past real time.

The Integrated Network for Public Health Official Records Management (INPHORM) is a database which contains records for approximately 4,000 CMS clients who are followed in the CYSHCN program. This dataset is electronic and the information is mostly entered by the social workers in the field. There is a major issue with INPHORM in that clients become hidden from view within the database. Each client must be renewed annually, and if the renewal date is missed the system hides the client. There is no way to locate these people until they try to access services and are denied. Since the system hides clients from view, this causes population and diagnosis counts to be low. INPHORM and Challenger Soft are two separate system within the CMS program that do not communicate with each other.

INPHORM is being phased out by the Department of Health and is in fact very unstable. CMS is looking to replace this system and has examined various options but due to funding issues no decision has been made yet by the Department as to what the replacement system will be.

II.E. Methods for Assessing State Capacity

Capacity was assessed in through careful examination the Title V Health System Capacity Indicators and through consideration of other capacity issues brought to the attention of the needs assessment leadership team through the regional meetings and. During the regional meetings, after identifying the top health needs in their communities, participants were asked to describe the capacity that their programs and communities had to address the issues, and the needs assessment leadership discussed administrative capacity and how it impacted programs at the local level.

These discussions are what generated the list of 25 priorities for consideration such that none of them was deemed completely beyond the capacity for the state to address. The weights applied to each priority assisted the FHB leadership team in selecting the 10 priorities on which to focus for the 2011-2015 cycle. The Department of Health's Strategic Plan is closely aligned with the priorities identified in the 2010 Needs Assessment as listed in the executive summary. All of the strategic plan's 19 objectives have a direct impact on the MCH and CYSHCN populations, encompass the 10 Needs Assessment priorities, and were considered by DOH leadership in terms of the state's capacity to accomplish them. A complete list of DOH's Strategic Plan Objectives can be found in Appendix 9.²⁰

Asthma was the main diagnosis for children on the CMS Title V CYSHCN program, and the burden of asthma was greater than what the CMS pediatric pulmonary outreach clinics could influence. That, combined with the new data from the "Burden of Asthma in New Mexico Surveillance Report 2006" on high pediatric emergency room and hospitalization use in certain counties, precipitated the formation of an asthma action

group to plan the summits.

As a response to this data, and the difficulty experienced by CMS in locating and providing adequate asthma care to children around the state, Children's Medical Services, and the FHB medical director, along with the State Asthma Program created a series of six Pediatric Asthma Summits in five locations around the state, an 18 month process, to bring this data to the regions in order to raise awareness of the issue, to seek input from the community about reasons, solutions, and what is already being done in their area, and to network with local and state resources.. Regional differences in need, triggers, resources, asthma activities, and access to care and training/education were discovered. This information helps to tailor interventions that can have the greatest chance of success in a given area, and common themes among regions were also identified. One important purpose of the Asthma Summits was to mobilize communities to be a crucial part of the solution to the problems they faced. Information and input obtained from these summits was used to revise and update the state asthma plan; "Breathing Free, An Asthma Plan For New Mexico" and "The Burden of Asthma in New Mexico" April 2009 report.

II.F. Dissemination

All Title V documents are published to the web, and hard copies are available at all regional offices and in the state library. The Title V program has its own email address and web page so that anyone with electronic access can comment on the documents at any time. The phone number is provided for those who do not use the internet. Additionally, FHB will work with the office of policy and multicultural health to determine the best way to disseminate the Needs Assessment to non-native English speakers, residents with low literacy levels, and to make the information culturally accessible to as many New Mexicans as possible. The Needs Assessment document will be sent to the regional directors and to all who participated in the regional meetings. The regional meeting participants expressed the desire to meet again to discuss the results of the assessment and to meet with FHB leadership to create strategies for addressing the issues that were identified. FHB plans to visit each region again each year during the next cycle to accomplish this as resources permit.

Asthma Summit Coalition Successes

The CMS asthma summits resulted in several positive outcomes such as the achievement of the goal of data to action and the engagement of the Secretary of Health who placed pediatric asthma on the state's strategic plan and identified the Southeastern Region as one of the Department of Health priorities.

A series of local and regional action groups were created after the summits to further asthma projects locally in conjunction with the New Mexico Department of Health, which oversees the framework.

Alliances were forged or strengthened, such as the UNM Pulmonary Department, the UNM ECHO Telemedicine/Telehealth project, NM Pediatric Society, and the Pediatric

Council which includes representatives from all the Medicaid MCOs (managed care organizations). School nurses and CMS social workers now attend more ECHO Telehealth/webinar clinics than ever before. There was enhanced collaboration with the UNM ECHO program on regional outreach to locate local asthma champions, to create a local asthma center, and boost the use of asthma educators. The ECHO pulmonary team has presented at grand rounds in the Southeast and met with hospital administrators.

Presbyterian Hospital's Pediatric Pulmonologist agreed to contract with Children's Medical Services to provide eleven additional pediatric pulmonary clinics in the Southeast improving access to care for children with asthma in that region.

The DOH has participated in the Pediatric Council of the New Mexico Pediatric Society with their negotiations with the Medicaid MCOs over asthma and formulary issues. The DOH Asthma Program presented their data to this group. As a result of that presentation the interest and attention of the Medicaid MCO's to asthma practice and prescribing patterns in their respective organizations has increased and actions have been instituted to improve asthma care. The NM Pediatric Society and the DOH Family Health Bureau coauthored a grant for a pilot project in the Southeast. The NM Pediatric Society now collaborates with the American Academy of Pediatrics for an AAP Asthma Outreach program rolling out in 2010-11

There has been increased promotion of the Asthma Allies home visiting program and asthma camp. Asthma Allies has held several training programs for asthma educators, and ECHO has provided financial support to pay the exam fee for rural participants.

A second more focused "mini-summit" was requested by the participants in the Roswell summit because of the high ER and hospitalization rates in the Southeast. This was organized in Hobbs, NM by CMS and the State Asthma Program. The Secretary of Health attended and reinforced the DOH's commitment to making the Southeast a priority area for asthma activities. From the Hobbs summit several projects in the Southeast were created, initiated, and carried out by the regional action group, CMS, FHB medical director, and the State Asthma Program, such as hospital pediatric chart reviews in Hobbs, a comparison of community hospitals, and a medical provider information gathering pilot for input from pediatricians in the Southeast. Pilot projects for asthma educators and educational detailing are in the planning phase.

The school nurses in the Southeast region have been very active in obtaining asthma action plans for each school child and collaborate with the CMS asthma clinics in the area. In one area the school nurses attend the asthma clinics. Data for the Southeastern Region, with commentary from the summit were published in the New Mexico Epidemiology newsletter in April 2009.

There has been an increased use of asthma action plans in schools in all regions, especially in the Southeastern Region and more widespread sharing of Albuquerque Public Schools' materials from their own school asthma program. Work is in progress statewide to standardize the Asthma Action Plan within DOH Asthma Program and state public schools.

The NM Asthma Program and the FHB medical director have presented asthma action updates to the Secretary of Health periodically. The Secretary invited the FHB medical director and the State Asthma Program epidemiologist to present data and information on the new national asthma guidelines to the NM Academy of Family Physicians 2009 annual meeting.

In 2010 CMS, the FHB medical director, the State Asthma Program collaborated with the UNM ECHO Program to do another focused community and individual stakeholder outreach about asthma and pediatric asthma in the Northwest. Data sharing arrangements with the Navajo Nation and the DOH have been further negotiated and now are pending.

The State met the five asthma program goals outlined in 2006: conducting asthma surveillance, increasing asthma education of health care professionals, educating patients, families, schools and communities about asthma, improving access to and delivery of asthma care, mobilizing to reduce environmental exposure to asthma triggers.

Strategies were developed in the State Asthma Plan including measurable indicators. Surveillance data will help the State evaluate the effectiveness of its own and others' interventions. A 10% reduction in asthma youth hospitalizations was established as one of the ERD's health outcome goals.

Through Asthma Summit follow-up meetings as well as meetings with DOH leadership, the Asthma Action Groups, the NM Asthma Coalition, and other key partners a continuous assessment how well the current asthma plan is meeting the needs of NM communities. These meetings will involve an exchange of ideas and input in which we anticipate existing objectives and activities will need to be refined and revised.

Future plans include: more projects in the Southeast such as educational detailing, introduction of certified asthma educators, outreach to emergency room staff, home visiting for high risk children; expand similar projects to other areas of the state; re-energize local asthma action teams in other areas besides the southeast; continued data collection and dissemination; promote the use of asthma educators and community health workers to support primary care practitioners; reduce pediatric hospitalizations and emergency room rates statewide, especially in the Southeast; work with Pediatric Council to provide education and outreach to pediatricians in NM, especially in the SE region and continue work to obtain data on Native Americans, specifically around asthma rates.

CMS Social Workers in conjunction with pulmonary specialists will continue to work to ensure that each child attending CMS asthma clinic receives an asthma action plan and that this plan is communicated back to the Medical Home and to the school nurse to improve continuity of care.

II.G. Strengths and Weaknesses of Process

New Mexico State Government enacted a hiring freeze in November of 2008. Several positions were vacant at the time, and more have become vacant since then, and most remain so. Moreover, as of 2011, the Public Health Division (in which FHB is housed) has had to cut its budget by 18%. Both situations have resulted in staff and resource shortages, and embargoes on travel. Staff who remain are often tasked with duties of vacant positions, and do not have time to participate in activities other than direct safety-net services. This is true for many who work in the private sector as well.

Specifically, because of time- and labor- intensity, formal qualitative research is not currently possible.

The Family Health Bureau is working closely with the Information Technology and Services Division (ITSD) to design better ways to make resources available to New Mexicans. The online MCH issues ranking survey was a first step toward soliciting stakeholder input specific to the Title V MCH Block Grant Program using IT.

Asthma Summit Challenges

The CMS Asthma Summit identified several challenges during the process which impeded the ability of the program to understand the needs of the population at large. Some of these challenges included: limitations of the statewide data whereby the Northwest region of the state is underrepresented as data from the Indian Health Service and Navajo Nation has not yet been made available to the Department of Health ; gaining buy-in from Pediatricians, family practice physicians and primary care providers regarding practices and interventions that may positively impact the burden of asthma in the regions; and adequate physician participation in order to establish true representation and input regarding regional differences and specific professional needs. The willingness of summit participants to share environmental concerns which could be economically connected to the employment in the region and thus the ability of group participants to feel capable of addressing an issue as large and complex and politically weighted as environmental air quality. Adequate staffing to continue a comprehensive follow-up statewide given the recent travel, hiring and funding restrictions at the DOH and other agencies also affects the program's ability to meet the needs identified.

II.H. Needs Assessment Partnership Building and Collaboration

Collaboration

Within the Family Health Bureau (FHB) are housed Children's Medical Services (CMS), which serves the population of special needs children, the Family Planning Program (FPP), Maternal Health, Child Health, and Family Food and Nutrition/WIC. They collaborated closely with the office of the bureau chief and the MCH Epidemiology program throughout the needs assessment process by contacting their stakeholders to

invite them to the regional meetings, and collecting and reporting information to be used in the Needs Assessment document.

The regional needs assessment meetings were attended by representatives from Healthy Start, Newborn Hearing Screening,

The MCH Epidemiology program has a data-sharing agreement with Vital Records and Health Statistics and receives birth and death files annually. The child injury prevention program manager and the adolescent health coordinator participated regularly in the needs assessment process. The MCH Epidemiology program has data sharing agreements with several other state agencies, and data are available to the program upon request.

CMS Partnership building and collaboration

CMS collaborates with the Maternal Child Health program, the MCH Epidemiology program, WIC and Family Planning to enhance delivery of services and avoid duplication of efforts. WIC and Medicaid are used as resources for the Newborn Screening program to assist the newborn follow up staff in tracking down the family of an affected infant identified on newborn screening. The CMS Medical Director sits on the Multi-Agency Team for Child Wellness, an advisory board to the ECCS grant administered by the Maternal Child Health Program, and on the Autism Advisory Board which has representation from UNM and many agencies both private and in state government.

The CMS Medical Director also represents CMS on the Interagency Coordinating Council, the Governor appointed advisory board to the Part C Family Infant Toddler Program housed in the Developmental and Disability Services Division of the State of NM, and attends the NM Immunization Coalition meetings to represent the CYSHCN population. CMS social workers around the state work closely with Medicaid to assist clients in eligibility determination and application for Medicaid benefits. CMS leadership participates in a monthly meeting of the MCH collaborative which includes representatives from UNM, Family Voices, PRO, and EPICS (Educating Parents of Indian Children with Special needs.)

The Newborn Hearing Screening Program holds quarterly meetings of its Advisory Board which includes representation from parents, audiologists, UNM and the School for the Deaf. The Newborn Genetic Screening Program holds quarterly meetings of its Advisory Board which includes representatives from UNM metabolic and pulmonary specialists, the CMS program, and parents of children with disorders identified on newborn screening.

CMS has struggled with budget cuts over the past two years and with a hiring freeze which has left a third of our social worker positions vacant. Our collaboration with other agencies and with the University has been a strength in getting through this difficult time while still maintaining a high level of service to the CYSHCN population. Weaknesses

include insufficient funding to do outreach, travel and training. Some sub-programs have been forced to close due to lack of funding.

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 perinatologists 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 for primary care services. 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 works 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.

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.

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. The social workers 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.

House Bill 479 was passed in the 2005 legislation required expanded screening for all newborns born in the state of New Mexico, from six diagnoses to 28. 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.

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.

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, bi-lingual transition plan that is used in all the health offices with youth once they reach the age of 14.

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.

CMS Coalition Building through Asthma Summits Statewide

An Asthma Coalition existed statewide prior to the Asthma Summit Coalition and some of the previous coalition members became part of the Summit Coalition. The initial coalition was established through the efforts of the DOH Environmental Epidemiology

Asthma Program (formerly Epidemiology and Response Division, ERD). Children's Medical Services (CMS) has been a key member of the New Mexico Asthma Coalition (AC) since 2003 and participated in the development of the original Asthma Plan for New Mexico "Breathing Free", as well as the 2009 revision. These two Department of Health entities continue to be major stakeholders and participants in the Summit Coalition.

Stakeholder Involvement

Stakeholders were invited to, and attended, the five regional meetings. Attendees represented public and private-sector health workers, families of special needs children, political representatives, and educators. The regional meeting attendees selected the 25 priorities to be considered, and weighted them with guidance from the Title V Epidemiologist. FHB developed an online survey of Maternal and Child Health priorities using the 25 identified by the regional meetings to which over 1,000 New Mexicans responded, including over 200 who provided comments through the text-box option. The survey was successful inasmuch as many more responses were received than expected. The majority of respondents were female health-care professionals over the age of 40, however all demographics were represented. The greatest weakness was in not being able to solicit input from non-native English speakers, and people with literacy levels below that of someone with a 6th grade education.

The priority needs were selected based on the survey results and on the weights applied to the issues during the regional meetings. A thorough report of those results is in Appendix 4.

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 in which FHB participates, 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: House Office of Faith-Based and Neighborhood Partnerships (weekly meetings)

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.

III. Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes

“Good access to care including the vast majority of rural health care in this state would help reduce some of those issues with medical conditions like diabetes, asthma, immunizations...The issues and problems facing our state/country need to start from both spectrums (top and bottom). Local and individual people need to become self empowered to help to make those improvements in their local area but the top officials in the state need to open that communication process to hear the voices of the people.” –Online Priority Survey Respondent

What follows are data reports on the priority needs that were selected during the regional meetings and considered for the final ten needs on which the Title V program will focus during the current needs assessment cycle.

III.A. Maternal Health

III.A.1. Birth Rates ²¹

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 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.

Of New Mexico's 33 counties, eleven had birth rates higher than the 2007 state rate of 14.9. Lea County had the highest birth rate in the state at 21.0. New Mexico's fertility rate has increased 14.5% between 2006 and 2007. The birth rate for American Indians was 17.3, for Asian/Pacific Islanders, 14.6, and for African Americans, 11.7, and for whites, 9.9.

In 2007, Hispanic mothers had the highest fertility rate (86.6), the highest percent of births (54.3), and the highest birth rate (19.6) among the state's racial/ethnic groups in New Mexico.

III.A.2. Teen Births ²²

“I think the focus always has to be on prevention first because it will save us money in the long run. Focusing on youth and finding effective ways to prevent our youth from having serious adult problems such as substance addiction, teen pregnancy, IPV or obesity is the best approach.” -Online Priority Survey Respondent

HP 2010 Goal: Reduce teen births to 43 pregnancies per 1,000.

The birth rate to 15-19 year olds in 2007 was 5.6% lower than the 2003 rate. The rate of births to 15-17 year olds decreased 25.4% between 1980 and 2007, from 44.1 births per 1,000 females ages 15-17 years to 32.9. Birth rates to 18-19 year olds decreased by 18.9% since 1980. The teen birth rate in the United States for 15-19 year olds rose 3.0% for the first time since 1991 with a rate 41.9 in 2006.¹ Although New Mexico's teen birth rate continues to be higher than the national rate, the difference in rates generally declined since 1990. The national birth rate for females ages 10-14 years was the same in 2003 and 2006. In New Mexico, the birth rate for this age group decreased 10.0% from 2003 to 2007.

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. 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.

Despite high diversity in NM teen populations, particularly Hispanic and Native American teens who generally have higher teen birth rates, the NM rate of birth (per 1,000) for teenagers aged 15-17 years continues to decline. The NM birth rate of 32.3, while still higher than the 2008 national rate of 21.7, reflects health disparities issues seen nationwide.

The 2007 teen birth rate decreased in the most populous counties (Bernalillo, Doña Ana, McKinley, Santa Fe, Sandoval and Valencia). The NM Department of Health (NM DOH) and the New Mexico Teen Pregnancy Coalition (NMTPC) have utilized five strategies since 2006. These strategies are clinical family planning services, comprehensive sex education, service learning programs, adult-teen communication programs and male involvement programs.

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 by Doña Ana County and a statewide increase in a service learning teen pregnancy prevention educational program named Teen Outreach Program (TOP) and Plain Talk.

- Four counties reached or exceeded the goal for both 15-19 and 15-17 year olds: Otero, Rio Arriba, Sandoval and Valencia.
- Three counties reached or exceeded the goal for 15-19 year olds: Colfax, Taos and Torrance.

- Two counties reached or exceeded the goal for 15-17 year olds: Bernalillo and San Miguel.
- Three other counties were very close to the goal: Dona Ana and McKinley for 15-17 year olds and Lincoln for 15-19 year olds.

III.A.3. Pregnancy Intention ²³

“I just kept missing my appointments for birth control. I got a pregnancy test yesterday, and I’m afraid I’m pregnant again.” - PRAMS mom

HP 2010 Goal: Increase the percentage of intended pregnancies to 70%.

Among New Mexico women who gave live birth in 2004-2005, 43% had an unintended pregnancy. Among moms not trying to get pregnant, 48% were not using any method of contraception to prevent pregnancy.

In New Mexico 57% of women giving live birth in 2004-2005 said they intended to get pregnant (wanted to be pregnant at that time or earlier). That means over 40% of mothers did not mean to get pregnant. Forty-one percent (41%) of women 18-19 years compared to 64% of those 25-34 and 73% of women 35 or older intended their pregnancy. Compared to all NM mothers, lower proportions of young, or Native American and Hispanic women, unmarried women, and those with less than a high school education had an intended pregnancy. From 1998-2005 pregnancy intention remained stable. Contraception: Among women not trying to get pregnant, fewer than half (48%) said they and their partners were doing something to avoid a pregnancy. The most common reasons for not utilizing contraception were: not minding a pregnancy, thinking a pregnancy could not occur when it did, or having a husband or partner who did not want to use birth control.

The 2005 Behavioral Risk Factor Surveillance System data indicated that 82% of all NM women ages 18-49 had ever heard of Emergency Contraception, but among women (all ages) giving live birth in 2004 and 2005 67% knew about ECP before their recent pregnancy. Awareness about Emergency Contraception was lowest among Native American women (43%), those with the least education (49%), and women whose pre-pregnancy healthcare coverage was with Indian Health Service (48%).

III.A.4. Prenatal Care ²⁴

“I wish there was a way to make insurance companies pay for prenatal care. I had/have health insurance but because I have an individual policy not a group policy, I couldn't get prenatal or maternity benefits. We had to pay cash for all the doctors visits, tests, hospital, etc, etc. I questioned every test and ultrasound my doctor ordered because I had to pay cash for it.” –PRAMS mom

“I work at a hospital here in New Mexico and I do see mothers who do not get prenatal services which then cause baby to have major complications once born. Many times,

these mothers to be don't have the resources I had due to lack of Insurance.” -PRAMS mom

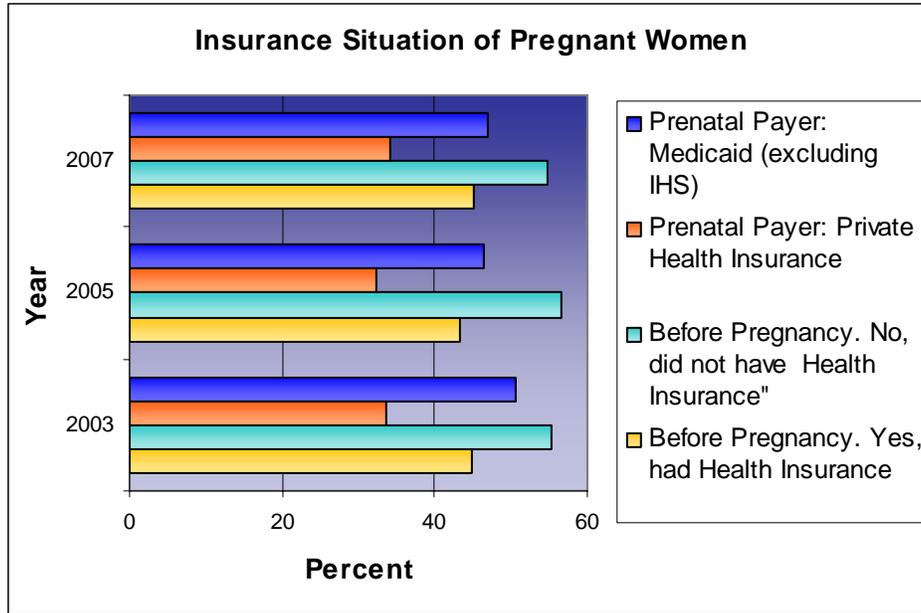
HP 2010 Goal: Increase prenatal care beginning in first trimester of pregnancy to 90%, of live births. Increase early and adequate prenatal care to 90% of live births.

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 in some pregnant women intentionally avoiding prenatal care. NM has long been one of the nation's poorest performers for prenatal care (70% of women, on average, nationally receive adequate prenatal care compared to New Mexico's 59%).

Over half (59.2%) of New Mexico births in 2007 were categorized as high-level in the Kessner Index, 24.4% as mid-level and 11.1% had a low to no prenatal care level. There were 1,626 (5.3%) births for which the level of prenatal care received was unknown. The percent of New Mexico mothers receiving no or low levels of prenatal care was highest for mothers less than 18 years old in 2007.²⁵

In 2004-2005, 63% percent of new NM mothers had adequate (or adequate plus) prenatal care (p.40). Seventy-two percent (72%) of women with more than a high school education v. 52% of women with less than a high school education had adequate prenatal care.

Only 58% of unmarried women, compared to 67% of married women, had at least adequate prenatal care. Sixty-four percent (64%) of U.S./Mexico border residing mothers had adequate prenatal care, while 57% of those living in the rest of the state had the recommended care. From 1998-2005 adequate/adequate plus prenatal care increased in NM from 56 to 63% (p.43). Twenty percent (20%) of women giving birth in 2004-2005 had inadequate prenatal care (p.41). NM women who were Native American, or had less than a high school education, or were 18-19 years old, or those without prenatal health insurance had the highest proportions of inadequate prenatal care. Among all mothers who wanted prenatal care but had problems getting it, the highest proportion (16%) said they could not get an appointment (p.42). Thirteen percent (13%) did not have enough money or insurance for prenatal care, and 11% did not have a Medicaid card.



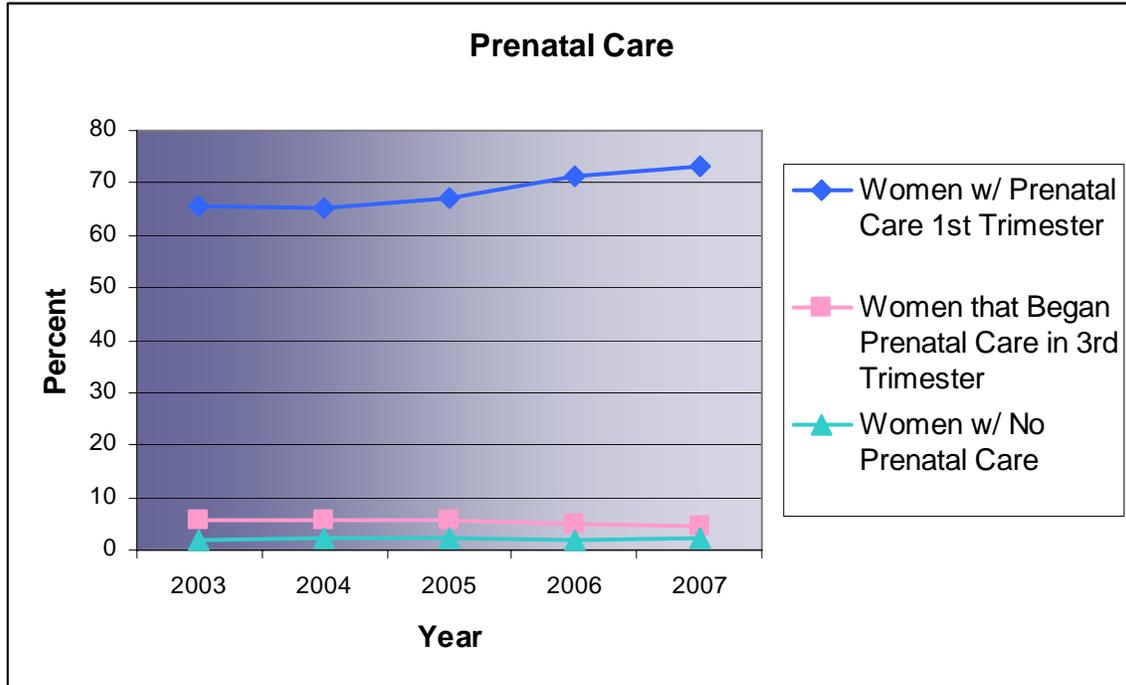
For women in New Mexico, geographical access is a barrier to prenatal care in sparsely populated areas. In eight counties within New Mexico there are no prenatal care options for women. This requires these women to travel long distances to receive the care they need. Many are not able to seek care because they cannot afford to travel, and cannot find care for their other children. The Rural and Primary Health Care Program collaborates with agencies to collect data to enhance current prenatal care practices and develops strategies for ameliorating access problems.

New Mexico is one of the nation's poorest performers for prenatal care due to the state's inadequate capacity to provide prenatal care to pregnant women. Often, 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. 11.6% of the state's 2007 births were to residents of these counties. 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.

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. A map of obstetric service availability is in Appendix 10.



III.A.5. Maternal Oral Health ²⁶

“I got cavities and my hair fell out, and the doctors said this was normal during pregnancy.” - PRAMS mom

Healthy People 2010 goal: Reduce to 15% the proportion of adults with untreated dental caries. Reduce gingivitis to 41% and destructive periodontal disease to 14% among adults, ages 35-44.

In New Mexico, 21% of mothers giving live birth in 2004-2005 had a dental problem during pregnancy (p.45). Compared to all NM mothers, higher proportions of Native American mothers, or mothers with prenatal care paid by Medicaid, or those receiving public assistance, experienced a dental problem. Thirty-seven percent (37%) of all mothers went to a dentist or dental clinic while pregnant (p.46). Among women with a prenatal dental problem from 1998-2005, fewer than half (47%) went to the dentist or dental clinic for treatment (p.48). Thirty-nine percent (39%) of NM mothers recalled discussion about the care of their teeth and gums during prenatal care visits.

III.A.6. Maternal Depression ²⁷

“I think that every woman should be questioned about depression at their six-week check-up. With my first child I had depression. But I never said anything, and the doctor I had never asked me how I felt”. - PRAMS mom

Healthy People 2010 goals: Increase the proportion of adults with recognized depression who receive treatment. Reduce postpartum complications, including postpartum depression.

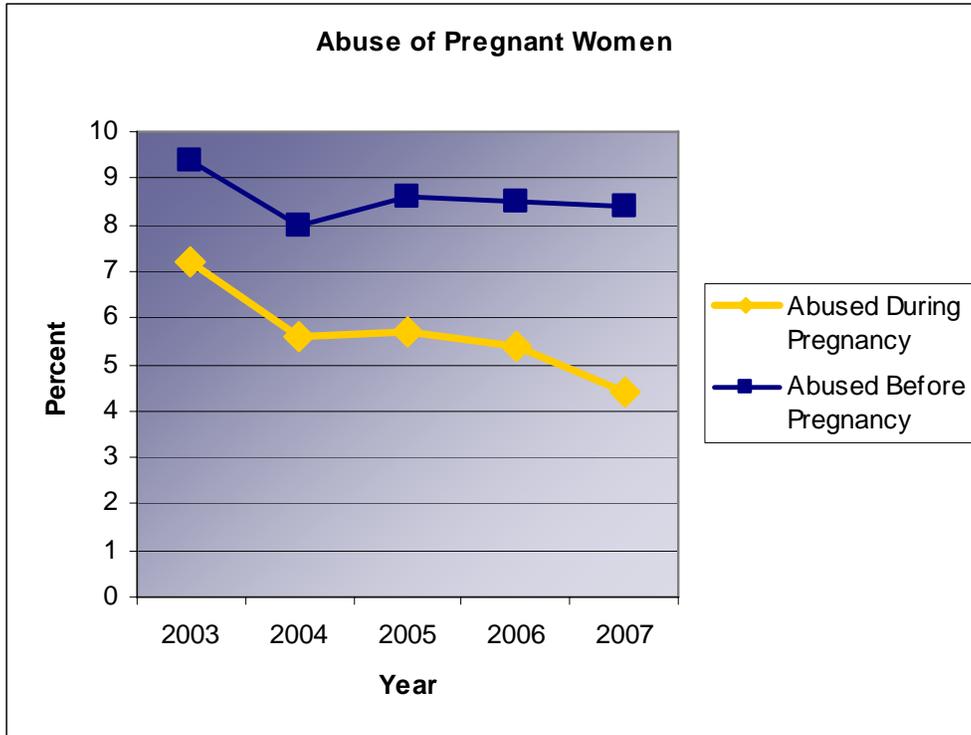
Twenty percent (20%) of all NM mothers reported feeling down, depressed or hopeless or having little interest or little pleasure in doing things since the time their baby was born. Twenty-seven (27%) of Native American mothers reported these symptoms compared to 22% of Hispanic and 15% of non-Hispanic White women. Higher proportions of younger women and unmarried women reported postpartum depressive symptoms compared to older or married women. Eighty-seven percent (87%) of new mothers said they could count on their husband or partner for help or support since their new baby was born; 84% could count on family members. Thirteen (13%) percent of new mothers could not count on anyone.

III.A.7. Physical Abuse ²⁸

“I think a very important part of a woman’s pregnancy is her mental health. It’s very hard to admit you’re being abused, if you’re even asked at all. I was abused mentally and physically during my entire pregnancy and had no one to turn to.” -PRAMS mom

Among 20 PRAMS states with data on physical abuse in 2001, only 5 states had higher rates of preconception abuse than New Mexico. New Mexico was among the four PRAMS states with the highest prevalence of prenatal physical abuse. According to the 2005 NM victimization survey, 27 per 1,000 females experienced domestic violence in New Mexico.5 Healthy People 2010 goal: Reduce physical assaults by current or former intimate partner to fewer than 3.3 per 1,000 persons, 12 years or older.

Eight percent (8%) of New Mexico women giving live birth in 2004-2005 said they were physically abused by a current or ex-husband or partner in the 12 months before pregnancy. During pregnancy, 6% were abused. Four percent (4%) of NM new mothers were abused during both time periods. From 1998-2005 prenatal violence dropped from 7% to under 6%, but preconception abuse rates remained stable. Physical abuse by an intimate partner was much more prevalent among young mothers compared to older mothers. Thirteen percent (13%) of teens 15-17 years were abused before pregnancy compared to 3% of women at least 35 years of age. Fifteen percent (15%) of American Indian women were abused before and 11% were abused during pregnancy. Eight percent (8.0) of women with Medicaid were abused during both time periods.



III.A.8. Gestational Diabetes ²⁹

“As soon as you get pregnant you need to get your baby and everything else checked. Like moms who have diabetes should go right away so their baby won't suffer like mine did because I was afraid to go.” –PRAMS mom

Healthy People 2010 goal Reduce maternal illness and complications due to pregnancy to 24 per 100 deliveries.

From 2004-2006, an estimated 6.6% of all New Mexico adult women had ever been told by a doctor that they had diabetes.³⁰

Two percent (2%) of New Mexico women giving live birth in 2004-2005 experienced high blood sugar or diabetes that started before they were pregnant. Among all new NM mothers, 8% said they developed gestational diabetes or high blood sugar. Twelve percent (12%) of Native American mothers had gestational diabetes compared to 8.4% of Hispanic and 7% of non-Hispanic white mothers. Other medical problems during pregnancy ranged from severe nausea or dehydration to needing a blood transfusion. Over 20% of NM women giving live birth said they experienced labor pains more than three weeks before their baby was due. Forty-two percent (42%) of mothers with any prenatal medical problems went to the emergency room or hospital for help, and 19% of the women reporting a medical problem stayed in the hospital 1-7 days.

III.A.9. Nutrition in Pregnancy ³¹

“To sum it up for me, Hunger will always be a #1 issue.” -Online Priority Survey Respondent.

“It is crucial for the pregnant women to take their vitamins and eat a well balanced diet.” -PRAMS mom

HP 2010 Goals: Reduce iron deficiency among young children and females of childbearing age. Reduce anemia among low-income pregnant females in their third trimester. Increase food security among U.S. households and in so doing reduce hunger.

Eighty-five percent (85%) of new mothers said their families always had enough food to eat in the twelve months before the survey. Seventy-four percent (74%) of women with no payer for delivery, compared with 97% with private insurance, reported food sufficiency. Seventy-five percent (75%) of women with less than a high school education had enough to eat versus 92% of women with more than a high school education. Food sufficiency was more prevalent among non-Hispanic White mothers (92%) compared to Hispanic (83%) or Native American mothers (76%). Twenty-two percent (22%) of all new mothers who received public assistance in the 12 months before their baby was born did not have enough to eat for their families. Among women who qualified for food stamps, 39% received them, and just 21% of those who qualified (household income at 100% poverty level), participated in Temporary Assistance for Needy Families (TANF) or Welfare to Work in the 12 months before their baby was born. Stressful social experiences just before or during pregnancy ranged from arguing more than usual with a husband or partner to being in a physical fight. Financial challenges included being homeless and losing employment just before or during pregnancy. Almost 4% (3.7%) of all NM mothers were homeless just before or during pregnancy. Six percent (6.2%) of women with less than a high school education and 6.3% of women with no insurance coverage experienced homelessness.

III.B. Infant Health

III.B.1. Preterm births and Low Birthweight ³²

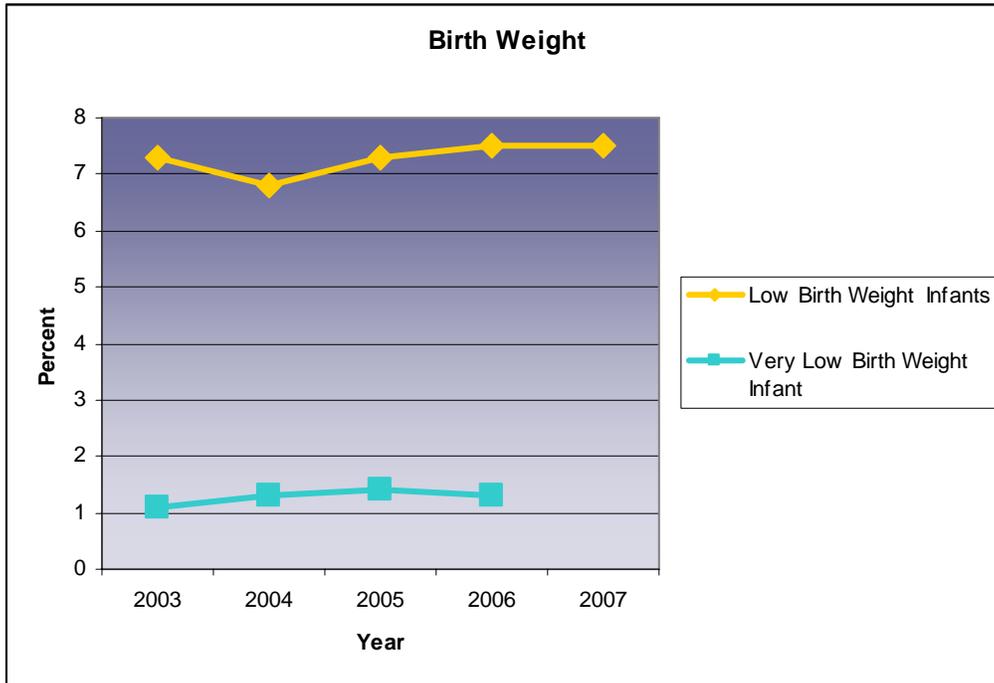
Healthy People 2010 Goals: Reduce Low birth weight (LBW) to 5.0%. Reduce preterm births to 7.6%.

In New Mexico and the United States, low birthweight increased by more than one percentage point from 1989-2005. In New Mexico, 8% of infants were premature in 2004-2005. Compared to the U.S., New Mexico is doing better but still has not reached the Healthy People 2010 goal. Disparities persist by age, race, marital status, and education. Low birthweight 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 lived in Bernalillo County. In 2004-2005, 10% of newly-delivered NM moms had an infant admitted to an intensive care unit after birth. The majority of NM infants stayed in the hospital for one or two days (64%), followed by three days (14%) and six days or more (6%).

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.

In 1996 the cesarean section rate in New Mexico was 17.2% increasing to 23.3% in 2007, representing a 35% increase during that time. In the US rates were 20.7% and 31.8% respectively, for a 58% increase. (CDC) Nationally, demographic factors associated with increased risk of low birth weight include mother’s age (17 years and younger or 35 years and older), marital status of the mother (single), and gestational age. For mothers less than 20 years of age the national figures showed a higher proportion of low birth weight births while for mothers 20 years or older New Mexico had higher proportions of low birth weight births.

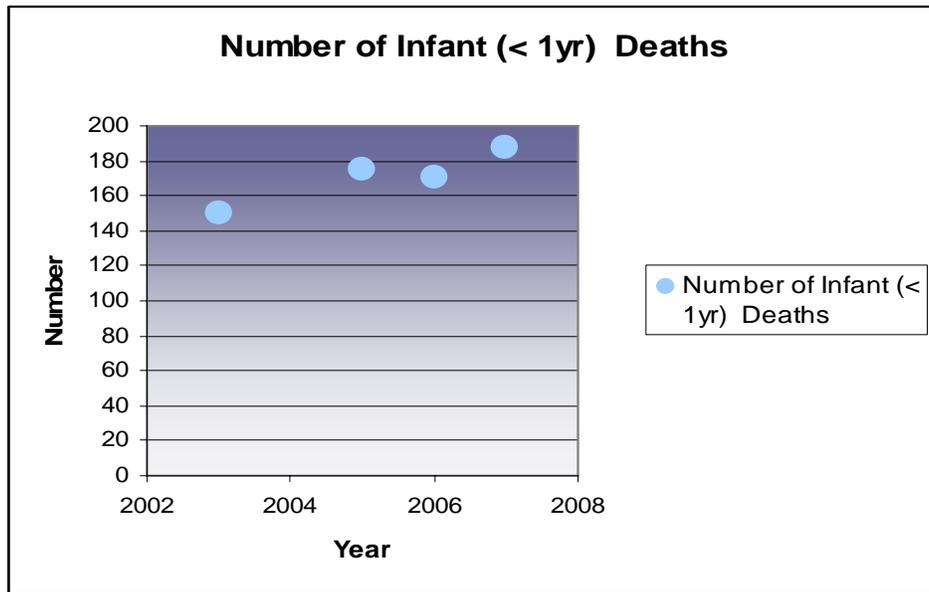


III.B.2. Infant Mortality ³³

“I had my child two weeks early and felt better just the two of us. Then he (the baby’s father) begged me back and I took him back...he shook my daughter and yelled at her. She was just a month and two weeks. He left and I almost lost my baby. Now my baby and I are doing good.” –PRAMS mom

**Healthy People 2010 Goals: Reduction in Fetal and Infant Deaths
Per 1,000 Live Births Plus Fetal Deaths: Fetal deaths at 20 or more weeks of
Gestation 4.1; Fetal and infant deaths during perinatal period (28 weeks of
gestation to 7 days or more after birth) 4.5.**

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. The three leading causes of infant deaths in New Mexico were congenital malformations (birth defects), disorders relating to short gestation and low birthweight, and sudden infant death syndrome (SIDS).



III.B.3. Breastfeeding ³⁴

“I have been pleasantly surprised by the support I’ve received in breastfeeding my baby, whether it’s acceptance in restaurants or information from doctors and midwives. I truly hope that state and federal governments continue to increase information available about the benefits of breastfeeding so that nursing moms like myself won’t have to encounter negative responses from the public.” –PRAMS mom.

“I am sorry this is a little sloppy. I filled this out while breastfeeding my baby. She kept moving around.” –PRAMS mom

Healthy People 2010 goals: Any breastfeeding: Increase the proportion of mothers who breastfeed their babies to 75%. Increase to 50% the proportion of mothers who breastfeed their babies to 6 months of age. Exclusive Breastfeeding: Increase to 60% exclusive breastfeeding through three months and to 25% through six months of age.

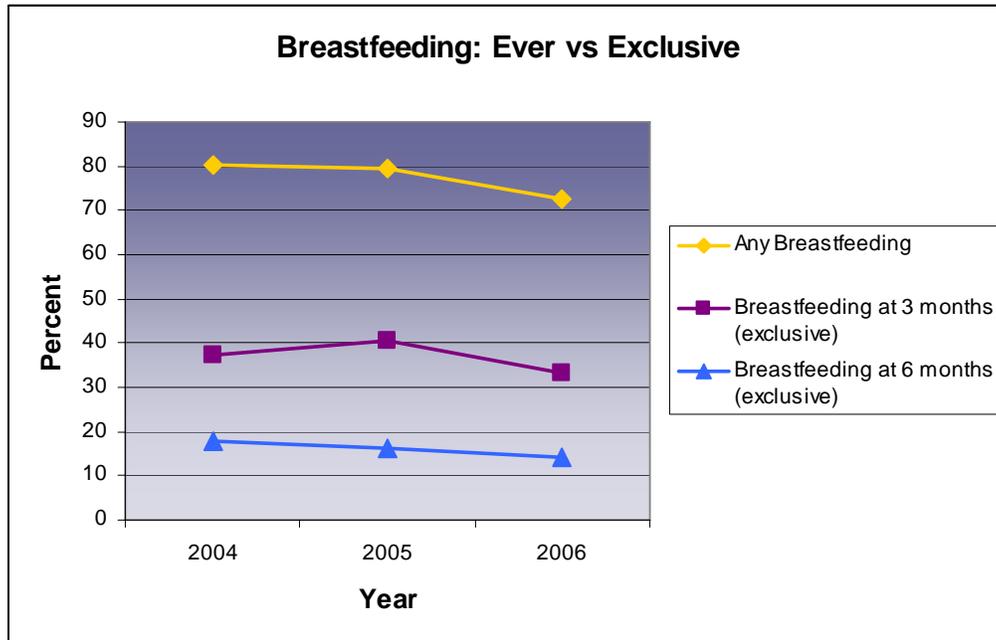
According to results from the National Immunization Survey of children born in 2006 33.2% of New Mexico mothers exclusively breastfed their babies for at least three months, and 14% exclusively breastfed for at least six months.

The 2004-2005 New Mexico PRAMS reported that: married mothers (90%) were more likely to ever nurse their babies compared to unmarried mothers (77%). Lower proportions of mothers with prenatal Medicaid coverage or public assistance breastfed (78%). Among mothers who started breastfeeding, 43% breastfed exclusively (had not introduced any liquid or food other than breast milk to their infants). Duration: While breastfeeding initiation is high in New Mexico, duration rates are poor. Fifty-seven percent (57%) of New Mexico mothers giving live birth in 2004-2005 breastfed their infant for more than two months. Among mothers who said someone suggested they not breastfeed, 35% said a mother, father or in-laws made the suggestion. Breastfeeding at work: Among non-working mothers and mothers not attending school, 62% breastfed their infants at least nine weeks compared to 51% of working mothers (p.72). Fifty-one percent (51%) of mothers who worked outside the home or attended school reported that moms could breastfeed or pump milk, but only 30% said moms could use breaktime for feeding. Twelve percent (12%) said moms were not allowed to breastfeed at all.

In New Mexico two laws protect a woman’s right to breastfeed in public.

NMSA 1978, Section 28-20-1 (1999) makes it legal for a mother to “breastfeed her child in any location, public or private, where the mother is otherwise authorized to be present.”

USE OF A BREAST PUMP IN THE WORKPLACE: NMSA 1978, Section 28-20-2 (amended 2007) requires employers to provide flexible break time, and a clean, private space, not a bathroom, in order to foster the ability of a nursing mother who is an employee to use a breast pump in the workplace.



III.B.4. Immunizations ³⁵

“Immunizations are on the bottom, not because they aren't important, but I feel we are doing a good job in that area.” –Online Priority Survey Respondent

HP 2010 Goal: Increase coverage levels of universally recommended vaccines (for children 19 to 35 months) to 80%.

Since 2005, the percent of 19-to-35-month-olds receiving a full schedule of age-appropriate immunizations against measles, mumps, rubella, polio, diphtheria, tetanus, and pertussis has remained between 76% and 79%.

III.B.5. Sleep Position ³⁶

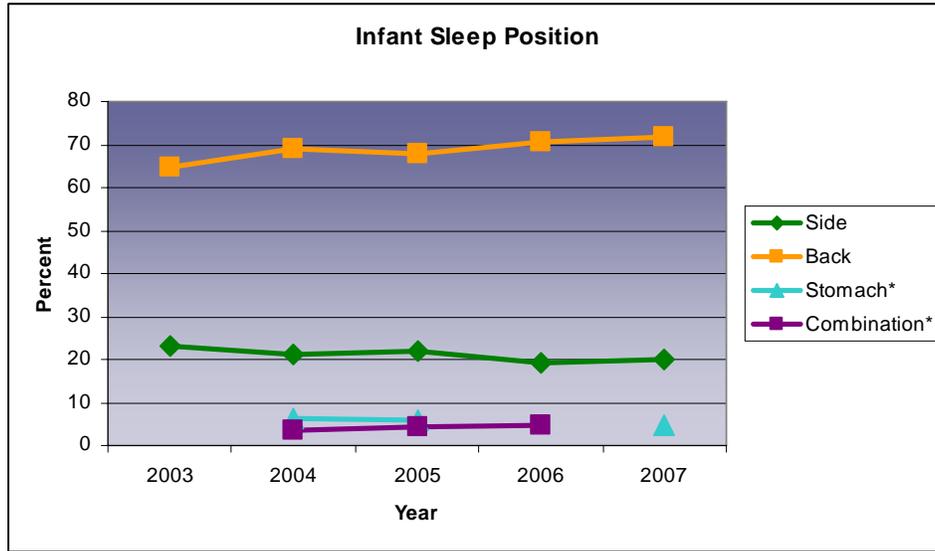
“What about child care, especially infant care? What about home visitation and family support? What about parent education?” –Online Priority Survey Respondent

Healthy People 2010 goal: Increase the percentage of healthy, full-term infants who are put down to sleep on their backs to 70%.

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.

Infant sleep: New Mexico was very close to reaching the Healthy People target with 68% of mothers most often placing their infant to sleep on their back in 2004-2005. This percentage increased from 45% in 1998. Eighty percent (80%) of Native American

mothers reported placing their infant in the supine position, while 72% of non-Hispanic White and 64% of Hispanic mothers reported doing so. Sixty percent (60%) of mothers with less than a high school education, and 62% of those receiving public assistance said they most often put their baby to sleep on their back. Well-child visits: Close to all (98%) new mothers said their infant had at least one well-child visit at 2, 4, or 6 months of age.

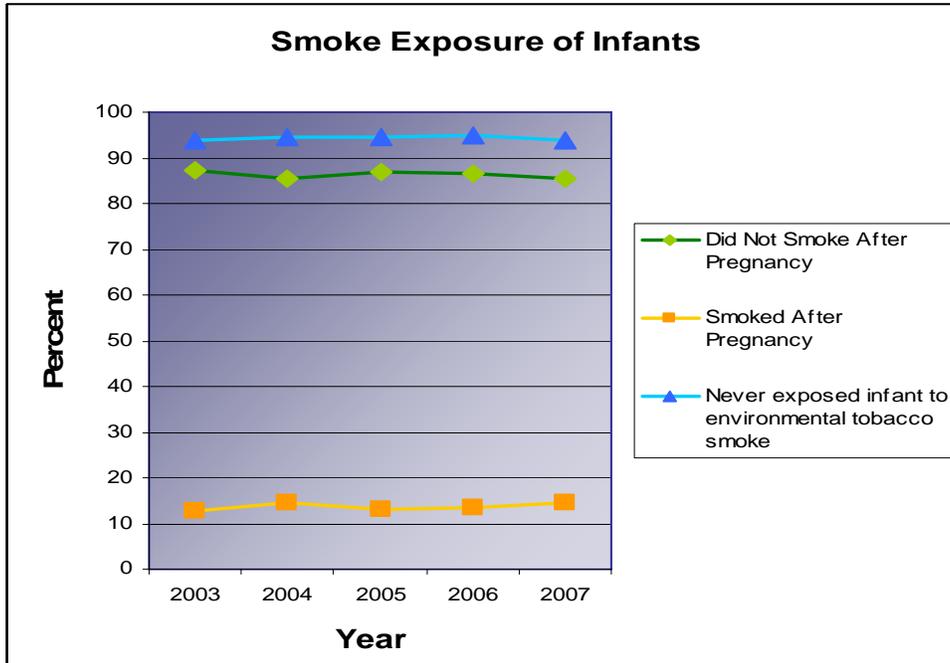


III.B.6. Exposure to Tobacco Smoke ³⁷

Healthy People 2010 goals: Lower the prevalence of smoking among pregnant women to 1%. Increase smoking cessation during pregnancy to 30%. Reduce the proportion of children who are regularly exposed to tobacco smoke at home to 10%.

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.

Almost 6% of NM moms said their infants were exposed to cigarette smoke on a daily basis. More than 9% of non-Hispanic White mothers reported that their infants were exposed to tobacco smoke compared to 3.4 and 3.7% of Hispanic and Native American mothers.



III. C. Child Health

“I am a grandmother but I care about my grandkids and the other kids who influence them.” –Online Priority Survey Respondent

III.C.1. Child Population

The University of New Mexico's Bureau of Business and Economic Research (UNM BBER) uses US Census data to create population estimates for New Mexico. UNM BBER data show that in 2008 the total population of children ages 0 to 19 in New Mexico was 580,493, representing 28% of the total population. There were 298,999 Hispanic children, and 281,494 non-Hispanic children. By race, there were 18,587 African-American children, 85,063 American Indian/Alaska Native children, and 10,202 Asian/Pacific Island children. In 2005-2006, 19% of New Mexico's children were the children of immigrants compared to 22% nationally.³⁸

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 2008 KIDS COUNT Data Book 2008.³⁹

III.C.2. Health Insurance

“We need a public health access option, even if it is only provided on a state by state basis. Corporate profit for providing basic health care cannot work forever.” -Online Priority Survey Respondent

HP 2010 Goal: Increase the proportion of children and youth (17 years and under) who have a specific source of ongoing care to 97%.

New Mexico ranks 48th out of 51 for the highest percentage of children without health insurance. In 2007-2008, 16%, or 84,200 children age 0-18 had no health insurance, compared to 10.3% in the US.⁴⁰ 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.

Medicaid provides many health services for New Mexico 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.

III.C.3. Poverty ⁴¹

“The majority of these problems would just go away if we first of all got rid of poverty.”
–Online Priority Survey Respondent

“Economic justice is the keystone for public health, without which any other endeavors are mere ‘band-aids.’” –Online Priority Survey Respondent

In 2007-2008, twenty-nine percent of children age 18 and younger lived in families with incomes below the federal poverty level, compared to 25% of children nationwide. 41% of children under the age of 18 live in families where no parent has regular, full-time employment.

III.C.4. Unintentional Injury ⁴²

“New Mexico's brain injury patients, and their caregivers, remain at high risk for severe health and economic problems. Our State lacks a well funded, specialist-staffed Neurorehabilitation center with extended inpatient capacity, specializing in brain injury exclusively. The Houston and El Paso based Mentis Neurorehab Centers are superior examples but are not within the financial or locational reach of the majority of our citizens.” –Online Priority Survey Respondent

HP 2010 Goal: To reduce hospital emergency visits caused by injuries to 126 hospital emergency visits per 1,000 persons.

III.C.5. Non-fatal Injuries

According to New Mexico Bureau of Vital Records and Health Statistics, from 2004-2007, 2,771 children under the age of 14 were hospitalized for unintentional injuries, for a crude rate of 169.2. A total of 672 hospitalizations in 2007 represented a 4% decline from the average for the previous three years, but there is no indication of a downward trend because the volume of incidence in 2007 was slightly higher than in 2006.

The NM Brain Injury Advisory Council reported that between 70% and 80% of all fatal bicycle crashes involve brain injuries. Nationally, only 41% ages 5 to 14 wear helmets when participating in wheeled activities like biking and skateboarding, and 35% of children who use helmets wear them improperly, typically not using the chin strap. Bicycle helmets reduce the risk of head injury by as much as 85% and the risk of brain injury by as much as 88% if they are properly secured.

The incidence of brain injury has been reduced by as much as 45% in some of the states and municipalities with helmet laws for minors. New Mexico enacted a non-motorized vehicle helmet law in 2007 requiring children under 18 years to wear them while riding on bicycles, skateboards, skates, scooters and tricycles on public property, including sidewalks. This law is consistent with the revised off road vehicle regulations enacted in 2006, which require training certification and helmets for all minors riding on all terrain vehicles, off road motorcycles, snowmobiles and miniature “pocket” bikes.

III.C.6. Injuries due to motor vehicle crashes

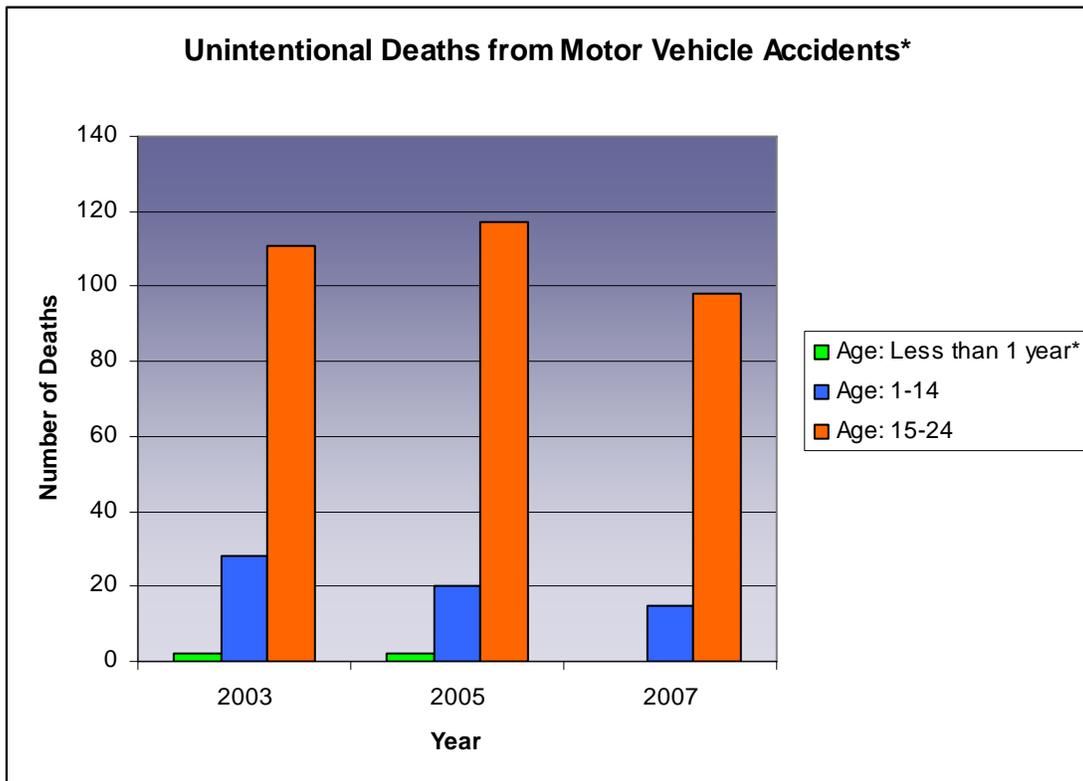
From 2004-2007, 1,039 youth ages 15 - 24 were hospitalized as a result of a motor vehicle crash. The age-adjusted rate for this period was 84.5. Fortunately, the total number of injuries in this age group in 2007 represented a 15% decrease from the average number of fatalities during the previous three years.

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.

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. Alcohol was involved in 10% of all MVCs causing injury or death in 2004. 42% 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.

For the decade of 1999 through 2008, 547 children ages 14 and under were seriously injured in motor vehicle crashes, defined as incapacitating and requiring emergency transport. The New Mexico Booster Seat Law was approved in 2005.

The New Mexico SAFE KIDS state coalition, sponsored by DOH since 1991, now manages a network of 12 coalitions and chapters statewide, with local sponsorship or active membership by the entire network of 9 trauma centers. In collaboration with the nonprofit Safer New Mexico, which manages the child car seat technician training and distribution program for the Dept. of Transportation, 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 and safe driving in every community. According to SAFE KIDS Worldwide, New Mexico now has one of the best combinations of child seat, booster seat and adult seat belt laws in the US.



Includes: Motor Vehicle Traffic Occupant Injured, Motor Vehicle Traffic Motorcyclists Injured, Motor Vehicle Traffic Pedestrian Injured, and Motor Vehicle Traffic Other and Unspecified

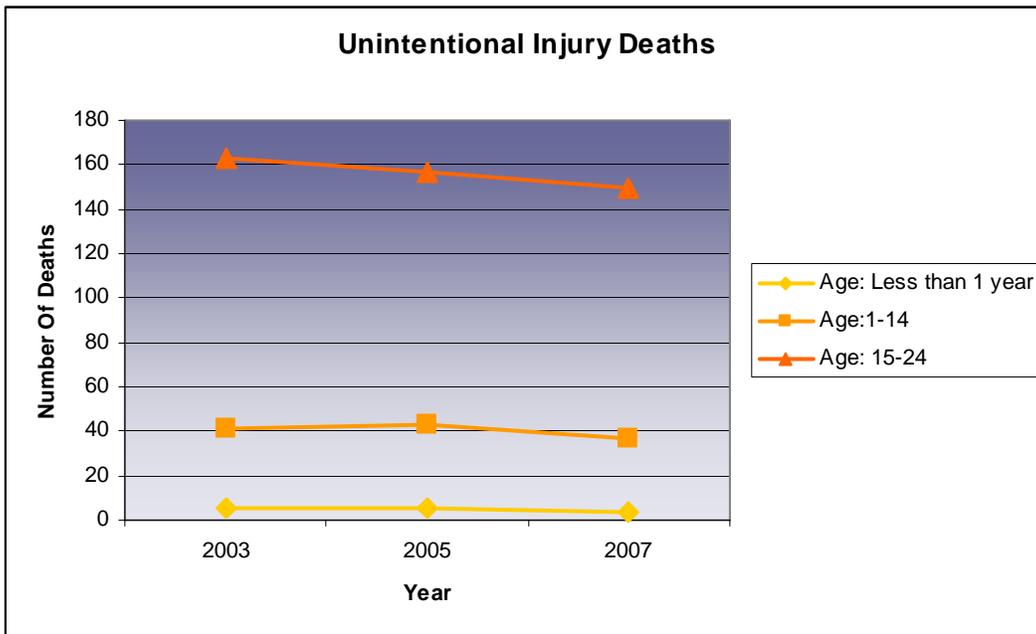
III.C.7. Injury Deaths

HP 2010 Goal: To reduce deaths from unintentional injuries to 17.5 deaths per 100,000

According to New Mexico Bureau of Vital Records and Statistics, from 2004-2007, 184 children under the age of 14 died from unintentional injuries, for a crude rate of 11.2. Forty-one fatalities in 2007 represent a 14% decrease from the previous three year average, and this was specific to the reduction in motor vehicle crash deaths, which may

be due to the increased use of booster seats for ages 5-12. The new booster seat law in New Mexico, mandatory for children ages 5 and 6, or too small for adult belts up to age 12, went into effect in 2005.

The key causes of injury 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.



III.C.8. Risk Behaviors Contributing to Unintentional Injury

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.

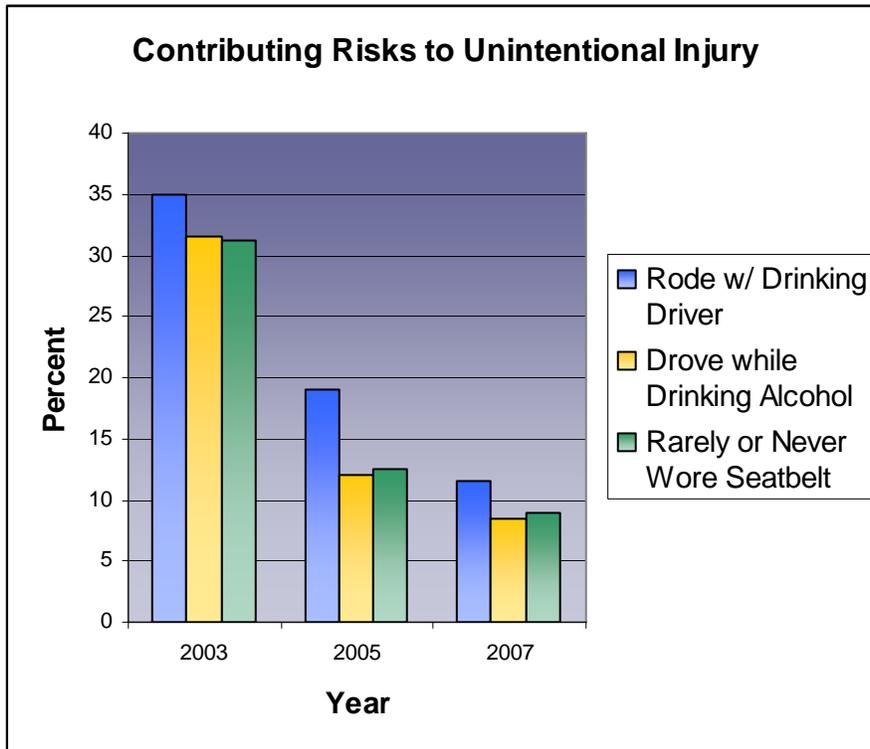
Boys (11.3%) were more likely than girls (6.3%) to rarely or never wear a seatbelt. African Americans (19.4%) were more likely than either Hispanics (8.3%) or Whites (5.8%) to rarely or never wear a seatbelt, and American Indians (11.4%) were more likely than Whites (5.8%) to report the same.

12th graders (17.7%) had a higher prevalence of drinking and driving in the past 30 days than 9th graders (8.5%). A higher percentage of both African American (22.4%) and

American Indian (16.4%) students reported drinking and driving than Hispanic (10.6%) or White (10.4%) students. There was no statistically significant difference in drinking and driving by gender.

There were no statistically significant differences by gender, grade level, or race/ethnicity for riding with a drinking driver within the past 30 days.

Of the 64.0% of students who had ridden a bicycle within the previous 12 months, 87.0% reported they rarely or never wore a helmet. Hispanics (93.5%) were more likely than Whites (78.8%) to rarely or never wear a bicycle helmet. There were no statistically significant differences by gender or grade level.



III.C.9. Weight

“More emphasis is needed on healthy diets and exercise in schools so that unnecessary obesity doesn't occur in the first place. Children are eating too many foods with sweeteners such as corn syrup and not enough fresh fruits and vegetables are provided in school food programs.” –Online Priority Survey Respondent

“The biggest problem we are facing right now is obesity and the consequences it will bring. We see younger people getting Diabetes 2.” –Online Priority Survey Respondent

Healthy People 2010 Goal: Reduce proportion of children and adolescents that are overweight or obese to 5%.

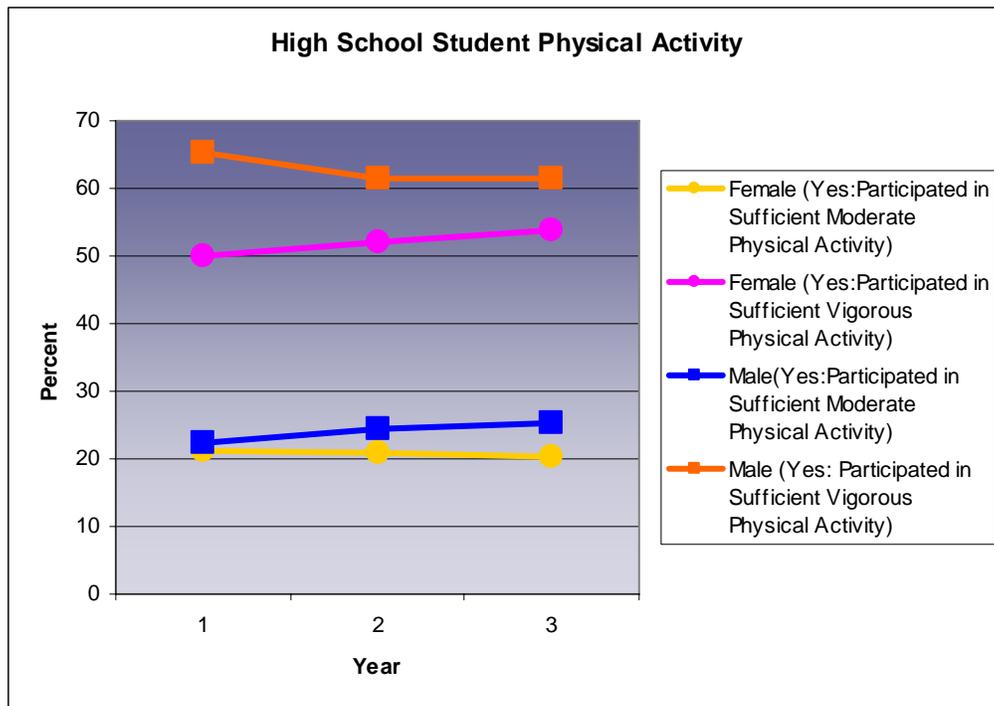
Data from two National Health and Nutrition Examination Surveys (NHANES) show that during the past 30 years, prevalence of overweight for US children aged 2-5 has increased from 5.0% to 13.9%. For those aged 6-11, prevalence increased from 6.5% to 18.8%.⁴³

In 2007, 10.7% 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.⁴⁴

The percentage of New Mexico high school students watching television for 3 or more hours daily has decreased from 37.7% in 2001 to 28.6% in 2005 and 27.9% in 2007. There has been no other statistically significant change in measures of physical activity, nutrition, and body weight.⁴⁵

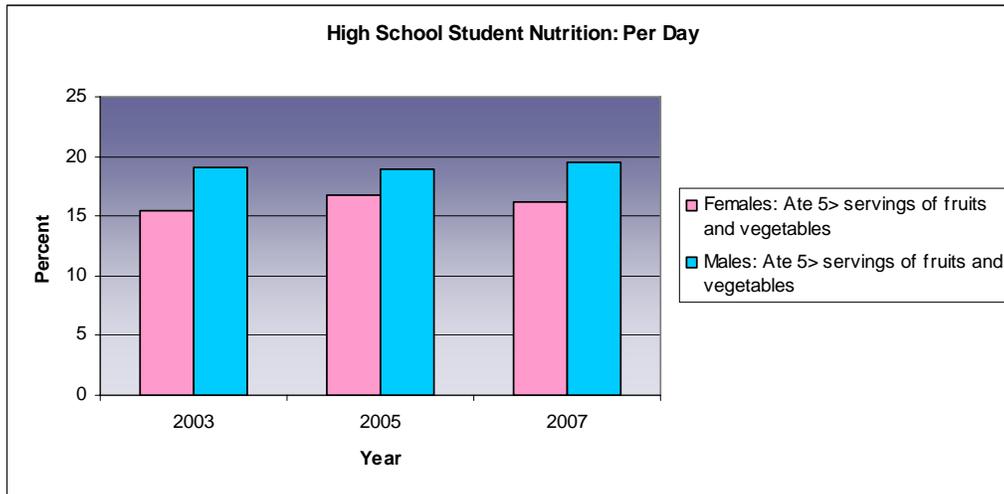
New Mexico high school students (17.2%) had a lower rate of sedentary behavior (no days with at least 1 hour of physical activity) than the rest of the nation (24.9%). Girls (20.4%) were more likely than boys (14.0%) to report sedentary behavior.



The prevalence of watching 3 or more hours of television daily was lower in New Mexico than in the rest of the US (27.9% vs. 35.4%), as it was for using a computer for 3 or more hours daily for non-school related purposes (18.7% vs. 24.9%). While there was no statistically significant difference by gender for TV viewing, boys (23.3%) were more likely than girls (14.2%) to spend more than 3 hours daily at the computer. Hispanics (31.7%) were more likely than Whites* (20.7%) to watch 3 or more hours of TV every day.⁴⁶

While New Mexico appeared to have lower rates than the rest of the nation for obesity (10.9% vs. 13.0%) and overweight (13.5% vs. 15.8%), these differences were not statistically significant. Boys were more than 2.5 times more likely than girls to be obese (15.5% vs. 6.0%), while there was no detectable difference in overweight by gender. American Indians (15.2%) were more likely to be obese than Whites (7.3%).⁴⁷

Only 17.9% of New Mexico high school students consumed the recommended 5 or more daily servings of fruits and/or vegetables, and only 11.2% drank the recommended 3 glasses of milk daily. Boys (14.5%) were more likely than girls (7.7%) to drink at least 3 glasses of milk daily. 10.5% of students reported that their families sometimes or often did not have enough food to eat. This was more common among African American students (17.9%) than among Hispanics (9.0%) or Whites (8.1%), and was more common among American Indians (15.6%) than among Whites (8.1%).⁴⁸



III.C.10. Oral Health ⁴⁹

“It is just too expensive in this state to get routine dental care let alone advanced treatment. Open a UNM Dental School and change the laws if necessary to have dental assistants perform more advanced procedures in underserved and rural areas. Children (and adults) will not even smile if they are self-conscious about their teeth. It is just too sad and impacts one’s overall mental health and outlook.” –Online Priority Survey Respondent

GP 2010 Goals: To increase the proportion of the U.S. population served by community water systems with optimally fluoridated water to 75%. To reduce the proportion of children with dental caries experience in their primary and permanent teeth to 42%.

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. In 2007, 1,100 New Mexico 3rd grade children received a dental sealant. 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.

III.D. Youth⁵⁰

“As an elementary school educator I am alarmed at the number of ‘damaged’ children coming through the school system... Dysfunctional families contribute to the rise of gangs and use of drugs. These contribute to the rise of violence towards the youngest members of our state. With the financial crunch, services and facilities have either been reduced or disappeared. These children come to school from homes who no longer value education and either do not know how to support their children or do not want to. Laws implemented to help hold parents accountable have been watered down...Our future is in our youth. However, this generation is lost.” -Online Priority Survey Respondent

Alcohol and Drug Use

GP 2010 Goal: Increase the age of first time drug users from 13.7 to 17.4. Increase the age of first time alcohol users from 13.1 to 16.1. Increase the percentage of high school seniors who have never had alcoholic beverages from 19% to 29% and never used illicit drugs from 46% to 56%.

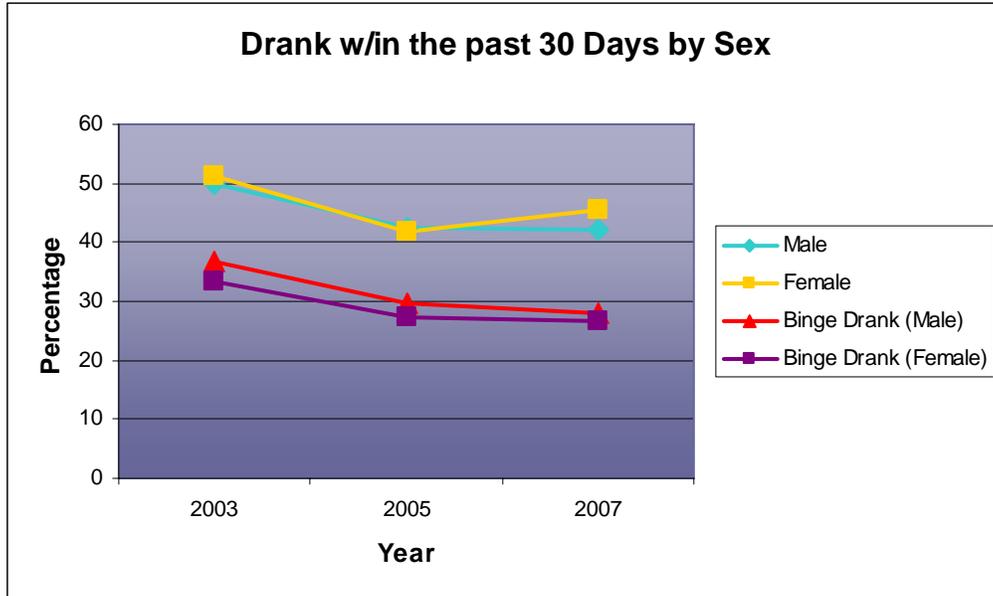
III.D.1. Alcohol

“Alcohol is killing our kids.” –Online Priority Survey Respondent

The prevalence of several important drinking behaviors has decreased since 2003. Current drinking (alcohol use within the past 30 days) decreased from 50.7% in 2003 to 43.2% in 2007, binge drinking (5 or more drinks in a row or within a couple of hours within the past 30 days) dropped from 35.4% in 2003 to 27.4% in 2007, and first drink of alcohol before age 13 decreased from 35.8% in 2003 to 30.7% in 2007. For each of these measures, the significant decrease occurred between 2003 and 2005, while the 2007 rate remained similar to the 2005 rate.

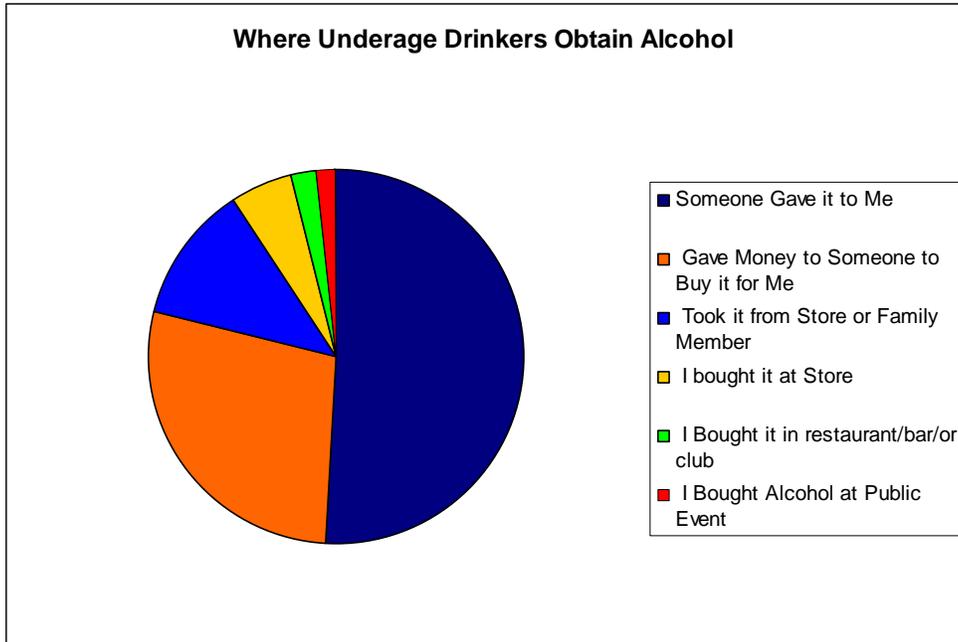
Boys (44.2%) and girls (42.0%) had similar rates of current drinking. 12th graders (49.0%) were more likely to be current drinkers than 9th graders (38.4%).

New Mexico had a higher rate of drinking before age 13 than any other state participating in the YRBS (30.7%). The difference between girls (27.8%) and boys (33.2%) was not statistically significant.



Binge drinking was reported by 27.4% of students. 9th graders (21.3%) were less likely to report binge drinking than 10th (27.7%), 11th (31.1%), and 12th (31.4%) graders. Binge drinking was common among current drinkers. Of the 43.2% of students who were current drinkers, 65.7% were binge drinkers, while only 34.3% did not binge drink. Among current drinkers, 46.8% had their first drink of alcohol before age 13. The most commonly consumed type of alcohol among current drinkers was liquor (such as vodka, rum, scotch, bourbon, or whiskey) (38.9%), followed by beer (24.9%), malt beverages (such as Smirnoff Ice, Bacardi Silver, and Hard Lemonade) (14.5%) and “no usual type” (12.5%). Fewer than 4% of current drinkers reported that wine, wine coolers, or “other” were their usual drink.

The most common usual drinking locations among current drinkers were another person’s home (54.2%) and “at my own home” (26.1%), followed by a public place such as a park, beach, or parking lot (8.3%), in a car (5.3%), on school property (4.0%), a public event (1.5%), and in a restaurant, bar or club (0.6%). 20.9% of current drinkers drank alcohol on school property at least once in the past 30 days. The most frequently reported method of obtaining alcohol by current drinkers was “Someone gave it to me” (38.4%). 21.2% reported “I gave someone else money to buy it,” 9.0% reported “I took it from a store or family member,” 3.9% said “I bought it in a store,” and 1.7% “bought it in a restaurant, bar or club.” Only 0.1% bought alcohol at a public event. Over one-quarter (25.6%) reported “Other” as their usual method of obtaining alcohol.

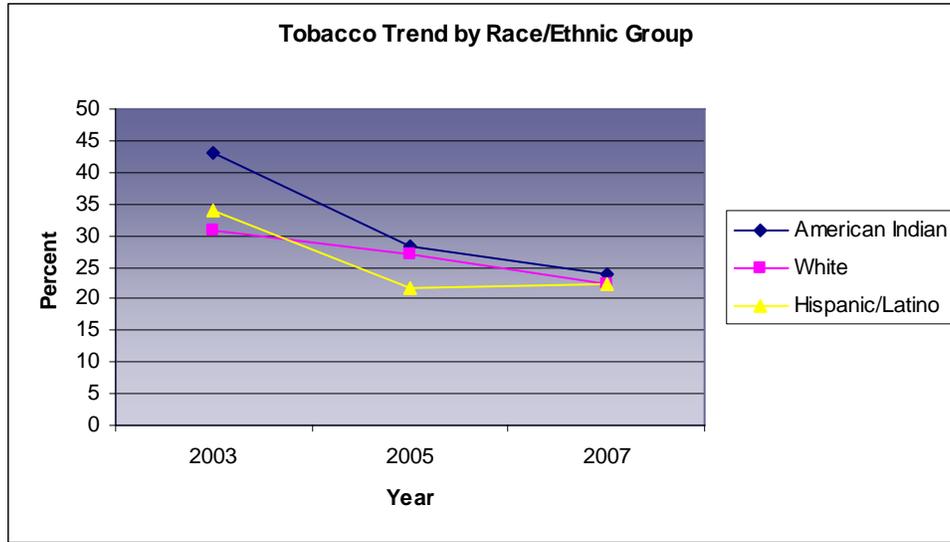


III.D.2. Tobacco

“Tobacco prevention is a great priority because tobacco addiction causes so much illness and death, and public health care costs and loss in the workplace too.” –Online Priority Survey Respondent

Current cigarette smoking among New Mexico high school students decreased significantly from 30.2% in 2003 to 24.2% in 2007. The prevalence of smoking before age 13 also decreased significantly during this time period, from 24.7% in 2003 to 18.0% in 2007. However, the percentage of youth using smokeless tobacco (chewing tobacco, snuff, or dip) has increased (8.8% in 2003; 8.5% in 2005; 11.8% in 2007).

Current smoking, or having smoked cigarettes within the previous 30 days, was reported by 24.2% of New Mexico high school students. American Indians (33.9%) were more likely than Hispanics (21.8%) or Whites (22.4%) to be current smokers. Of the 24.2% who were current smokers, 27.7% were frequent smokers (smoked on 20 of the past 30 days). Among current smokers, Whites (31.3%) were more likely to be frequent smokers than were American Indians (20.9%). Among current smokers under age 18, 11.2% usually bought their cigarettes in a store. This was more common among boys (16.4%) than girls (6.1%). Over half (51.6%) of current smokers tried to quit within the past 12 months.



18% of New Mexico high school students first smoked a whole cigarette before age 13. A higher percentage of American Indians (25.3%) and African Americans (27.0%) first smoked before age 13 than Whites (12.0%).

Smoking cigarettes on school property was reported by 7.5% of students. This did not vary significantly by gender, grade level, or race/ethnicity. 11.8% of students had used smokeless tobacco (chew, snuff or dip tobacco) within the past 30 days. Boys (17.4%) were three times more likely than girls (5.7%) to use smokeless tobacco. Past 30-day use of cigars, cigarillos, or little cigars was reported by 18.9%, the highest rate among YRBS states. Boys (23.5%) were more likely to smoke cigars than girls (14.1%). 30.2% of students used any form of tobacco within the past 30 days.

III.D.3. Drugs

“The school system in which I work has an unbelievable number of students who are depressed, possessing poor communication/ problem-solving skills, either use themselves drugs & alcohol or have immediate relatives who do, experience a lot of loss through deaths of grandparents who have ended up being the students' psychological parents, etc. The School Based Health Center is moving forward on providing Natural Helpers Program and Project Venture program as well as providing mental health services to students and/or staff.” –Online Priority Survey Respondent

Since 2003, New Mexico has seen a significant decrease in current use of cocaine (8.9% in 2003; 7.9% in 2005; 5.4% in 2007) and methamphetamine (7.3% in 2003; 4.6% in 2005; 4.4% in 2007). There has been no statistically significant change in current use of any other drug over these years.

Marijuana was the most commonly used illicit drug within the past 30 days. New Mexico had the second highest rate (25.0%) of current marijuana use among the YRBS states. The difference between boys (26.2%) and girls (23.8%) for current marijuana use was not

statistically significant. 18.2% of New Mexico high school students reported marijuana use before age 13, the highest rate of all YRBS states and more than twice the national rate (8.3%). New Mexico high school students had the highest rate in the nation for current marijuana use on school property (7.9%).

Nearly twelve percent of New Mexico high school students reported past 30-day use of narcotic pain killers such as Vicodin, OxyContin or Percocet to get high. Girls (10.8%) and boys (12.2%) had similar rates of this behavior.

7.8% of New Mexico high school students used inhalants (sniffing or inhaling glue, paint or the contents of aerosol spray cans) in the past 30 days. Current inhalant use was more common among 9th graders (12.0%) than among 11th graders (7.0%) or 12th graders (3.6%).

The percentage of students who had ever used cocaine was 11.6% (third highest among YRBS states); 5.4% (second highest rate, shared with Texas) currently used cocaine. American Indian students (7.7%) had a higher prevalence of current cocaine use than White students (2.6%).

Lifetime methamphetamine use was reported by 7.7% of New Mexico high school students (third highest among YRBS states), and 4.4% were current methamphetamine users.

The prevalence of lifetime ecstasy use was 8.4% (fourth highest among YRBS states). 5.1% were current ecstasy users. Boys (7.1%) were more likely to be current ecstasy users than girls (2.9%).

Lifetime heroin use was reported by 5.0% of New Mexico high school students (fourth highest among YRBS states). Past 30-day heroin use was reported by 3.9%. 3.6% of New Mexico high school students had ever injected an illegal drug (third highest among YRBS states, shared with Wyoming and Kentucky). Lifetime injection drug use was more common among American Indian (6.4%) and African American students (8.9%) than among Hispanic (2.9%) and White students (1.8%).

Nearly one-third (31.3%) of students reported that they had been offered, sold, or given an illegal drug on school property within the past 12 months. This was a significant decrease since 2003, when 41.2% of students reported the same. Boys (35.2%) were more likely than girls (27.3%) to report being offered, sold, or given drugs on school property.

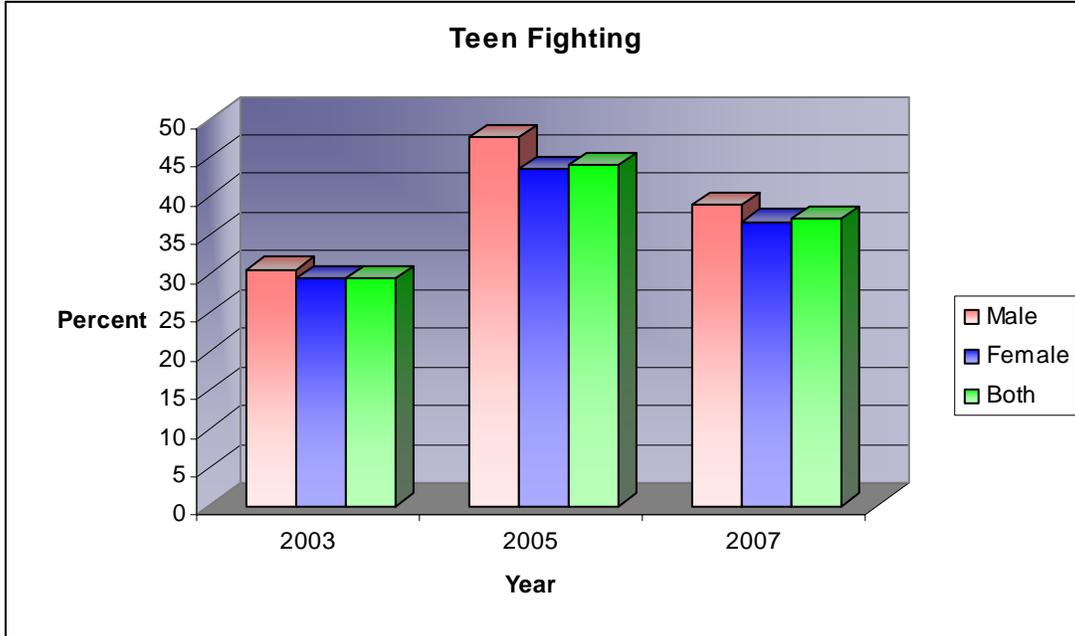
III.D.4. Youth Violence

HP 2010 Goal: Reduce physical fighting among adolescents to 32%. Reduce weapon carrying by adolescents on school property to 4.9 %.

According to the 2007 Youth Risk and Resiliency Survey (YRRS), 37.1% of New Mexico youth in grades 9-12 who participated reported being in a physical fight in the last year, which was a higher percentage than any other state that participated in the survey.²⁰ New Mexico youth were also the highest among other participating states of youth reporting missing school for fear of their safety (9.0 versus 5.5%). Additionally, New Mexico youth were significantly more likely than the U.S. average to carry a weapon (27.5% vs. 18%) or carry a gun (11.7% vs. 5.2%).²⁰

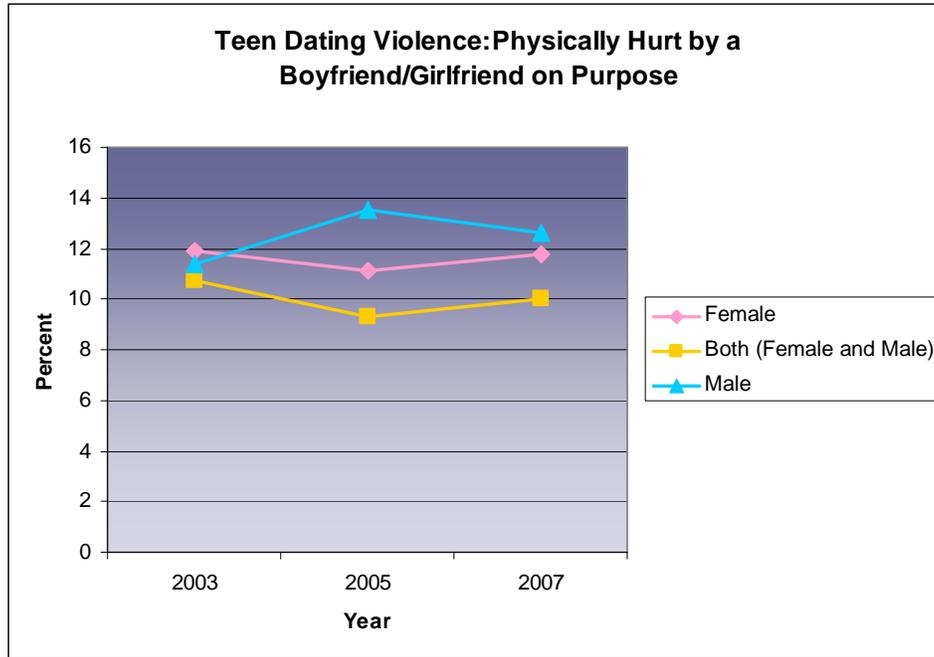
There were no statistically significant changes in the prevalence of the major behaviors associated with violence over the years of the YRRS. 27.5% of New Mexico high school students reported carrying a weapon, such as a gun, knife, or club in the past 30 days; 11.7% carried a gun within the past 30 days; and 9.3% carried a weapon on school property within the past 30 days. Each of these behaviors was more common among boys than girls (carrying a weapon: 40.4% vs. 14.4%; carrying a gun: 17.9% vs. 5.3%; carrying a weapon on school property: 13.5% vs. 4.7%). African Americans (40.0%) were more likely to report carrying a weapon than any other race/ethnicity (American Indians: 27.7%; Whites: 28.0%; Hispanics: 24.2%). African Americans were more likely than Hispanics to carry a gun (21.0% vs. 9.4%) and to carry a weapon at school (14.3% vs. 7.2%).

Compared to other YRBS participating states, New Mexico had the highest rate of two measures addressing physical fights. 37.1% of students reported being in a physical fight in the past 12 months, and 16.9% reported being in a physical fight on school property in the past 12 months. Both of these behaviors were more common among boys than girls (fight: 44.0% vs. 29.4%; fight on school property: 21.5% vs. 11.8%).



New Mexico (9.0%) had the highest rate among YRBS participating states of students skipping school at least once in the past 12 months because of feeling unsafe at school or on the way to or from school. Hispanics (10.1%), American Indians (9.5%), and African Americans (15.3%) were all more likely to skip school because of safety issues than Whites (4.8%). Having been threatened or injured with a weapon on school property in the past 12 months was reported by 10.1% of students. Boys (12.2%) were more likely than girls (7.3%) to be threatened or injured with a weapon on school property.

Teen dating violence (having been hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend) was reported by 12.6% of New Mexico high school students. 9.2% reported ever being physically forced to have sexual intercourse. Girls (11.6%) were more likely to have been forced to have sex than boys (6.9%). African Americans (15.9%) were more likely to report being forced to have sex than Hispanics (9.7%) or Whites (7.2%).



III.D.5. Adolescent Sexuality

“Teenagers seem to be having a very difficult time being young... Maybe, teaching more parental skills to adults is what is lacking in society. Maybe this would have a positive effect on many of the issues dealing with domestic violence, teenagers becoming sexually active so young, child sexual and physical abuse...” –Online Priority Survey Respondent

HP 2010 Goal: Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

For most indicators of sexual activity, there has been no significant change since 2003. This includes the percentage of students who ever had sexual intercourse, who were currently sexually active (had sexual intercourse in the past 3 months), and who, if sexually active, used condoms. However, since 2003, there has been a decrease in the use of alcohol or drugs before last sexual intercourse among currently sexually active students (31.7% in 2003; 26.3% in 2005; 23.7% in 2007).

45.7% of New Mexico high school students had sexual intercourse in their lifetimes. This increased with grade level, from 31.1% of 9th graders, to 44.1% of 10th graders, 54.7% of 11th graders, and 58.3% of 12th graders. Girls (43.5%) and boys (47.6%) had similar rates of ever having sexual intercourse. American Indian (53.2%) and African American students (58.3%) were more likely to have ever had sexual intercourse than White students (37.3%).

Sexual intercourse before age 13 was reported by 7.7% of New Mexico high school students. Boys (11.2%) were more likely than girls (4.2%) to have had sexual intercourse before age 13.

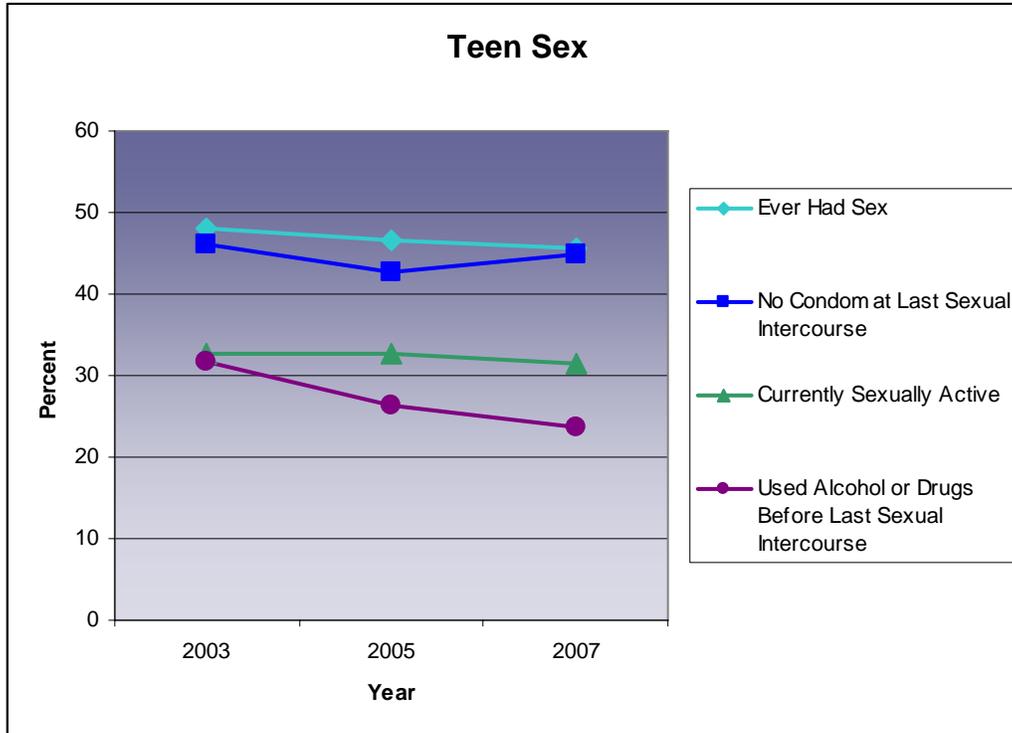
Almost one third (31.5%) of New Mexico high school students were currently sexually active (had sexual intercourse within the previous 3 months). Girls (32.9%) and boys (29.8%) had similar rates of being currently sexually active. The percentage of students who were currently sexually active increased with grade level (19.6% of 9th graders; 28.6% of 10th graders; 38.5% of 11th graders; 44.7% of 12th graders). There were no statistically significant differences by race/ethnicity.

13.8% of students reported having 4 or more lifetime partners for sexual intercourse. 12th graders (22.4%) were more likely than 9th (8.0%) or 10th graders (12.3%) to have had sexual intercourse with 4 or more people in their lifetimes.

Among the 31.5% of students who were currently sexually active, 44.8% did not use a condom when they last had sexual intercourse. This was the second highest rate among the participating YRBS states. Girls (51.4%) were more likely than boys (36.8%) to report not using a condom.

Condoms (43.9%) were the most commonly mentioned contraceptive method when students were asked the “one method” to prevent pregnancy at their last sexual intercourse. Condoms were followed by birth control pills (19.0%), no method (17.0%), withdrawal (9.9%), other (3.5%), and Depo-Provera (injectable birth control) (2.9%). 3.8% of students were not sure what birth control method was used. While boys (50.9%) were more likely than girls (38.3%) to report that condoms were the “one method” used, there were no other differences by gender in the other methods used.

Almost one quarter (23.7%) of students used alcohol or drugs before the last time they had sexual intercourse. There was no statistical difference between boys (28.7%) and girls (19.8%) in alcohol or drug use before sex.



III.D.6. Youth Mental Health

“We must place priority on children and youth health issues - physical, mental, emotional, and spiritual. We are losing youth in many ways.” -Online Priority Survey Respondent

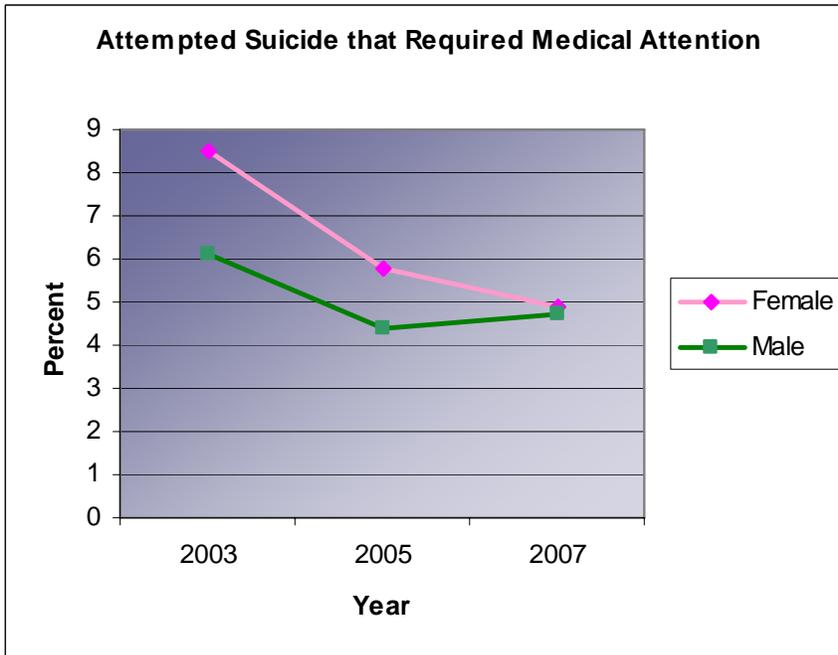
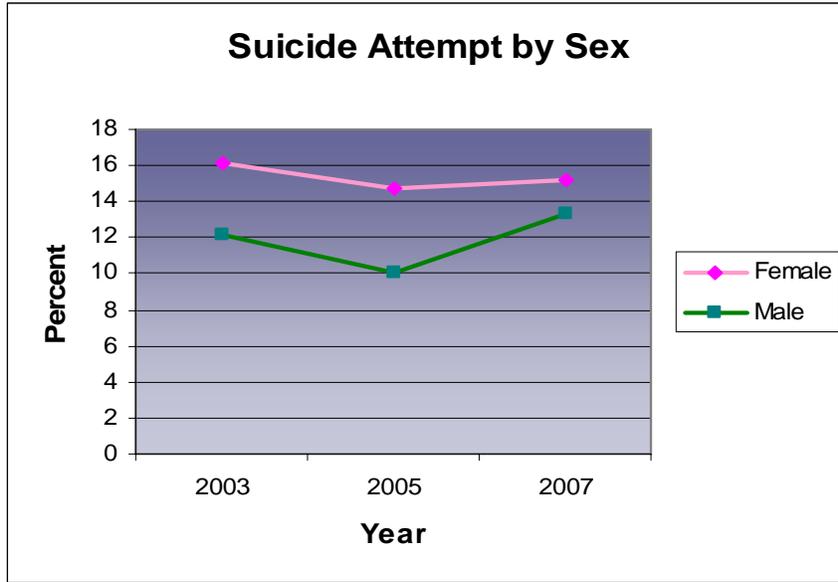
HP 2010: Reduce the suicide rate, and Reduce the rate of suicide attempts by adolescents.

The prevalence of suicide attempts resulting in an injury that had to be treated by a doctor or a nurse decreased from 7.5% in 2003 to 5.1% in 2005 and to 4.8% in 2007. The decline in this measure from 2005 to 2007 was not statistically significant.

Among states participating in the YRBS, New Mexico had the highest rate of students seriously considering suicide in the past 12 months (19.3%), attempting suicide in the past 12 months (14.3%), and making a suicide attempt that resulted in an injury that had to be treated by a doctor or nurse in the past 12 months (4.8%).

Persistent feelings of sadness and hopelessness were reported by 30.8% of students. A higher percentage of girls (39.7%) than boys (21.8%) reported feelings of sadness and hopelessness. 19.3% of students reported seriously considering suicide within the past 12 months. Considering suicide was more common among girls (23.0%) than boys (15.4%). 15.1% of students made a suicide plan within the past 12 months. Girls (17.0%) were more likely than boys (13.%) to have made a suicide plan.

A suicide attempt within the past 12 months was reported by 14.3% of New Mexico high school students. American Indians (20.4%) were more likely than Whites (10.4%) to make a suicide attempt. 4.8% reported a suicide attempt resulting in an injury that had to be treated by a doctor or a nurse. There were no statistically significant differences by gender or race/ethnicity for suicide attempts resulting in injury.



III.D.7. County and sub-county level ranks on MCH indicators

The county level analysis revealed that Quay, Albuquerque's South Valley/South Central Community, Grant, Guadalupe, Lea, Luna, Cibola, and McKinley counties were the top eight communities demonstrating highest risks in that order (Lea and Luna counties were tied at number five.) The sub-county z score method resulted in the top seven communities being Luna, Grant, McKinley, Sandoval and Mora, Lea and the South Valley/South Central community in Albuquerque. See appendices 6 and 7 for complete results.

III.E. Children and Youth with Special Health Care Needs

CYSHCN and their families experience many barriers to successful transition, including difficulty with transportation, inadequate collaboration of transition efforts between care providers, complex immigration and citizenship issues, overextended transition services, and a dearth of specialty adult care providers. Families experience difficulty in understanding the caregivers' role during and after transition, and the changing role of the youth as he or she moves into adulthood. Specifically, youth with special health care needs in NM encounter the following barriers and difficulties:

- Transportation issues in rural areas of NM, including transportation to health care as well as to employment or job training. This problem is clearly exacerbated by physical challenges for some of the youth, including those with non-ambulatory medical conditions.
- Limited collaboration between schools, agencies and non-profits who serve youth in transition.
- Complex barriers faced by non-citizen immigrant youth who are ineligible for Vocational Rehabilitation Services, SSI, SSDI, Ticket-to-Work and other employment incentive programs that are federally and state funded. Immigrants are also ineligible for Medicaid/SCHIP, and with economic hardship often cannot afford to carry private insurance
- Available transition services, which are over-extended and understaffed. At this time, CMS social work positions are frozen from hiring until July 2010, with few, if any, exceptions allowed, and high vacancy rates exist in four of the five regions.
- The CMS program has been able to provide transition services in some areas, but there still exists a limitation in practice statewide. CMS has sought funds for transition in the past, and while funding is quite competitive and CMS did not receive the funding, the program has continued its transition efforts.
- There is a dearth of adult primary and specialty care providers who are experienced in the transition of YSHCN from pediatric to adult care.

NM has improved in several of the CYSHCN Core Outcome measures according to the National Survey of CSHCN; specifically, those CSHCN who feel community based services are organized so families can use them easily increased from 66.5% to 85.7%; and families of CSHCN who partner in decision making at all levels and are satisfied with the services they receive increased from 46% to 53.2%.

Compared to the U.S. in general, New Mexico has a higher proportion of CSHCN who report that their condition affects their activities a great deal and that they missed 11 or more days of school due to illness. The NM rate has actually increased slightly, from 16.2% in 2001 to 17.3% in 2006. It is unclear why this rate is increasing, although it may have to do with worsening of the chronic conditions due to lack of access to care, which is an ongoing problem in NM and the number one problem cited by participants in the FHB Needs Assessment survey. This lack of access is partly due to New Mexico's high rate of uninsured and partly due to the chronic shortage of health care providers in NM, including dental providers.

On the 2006 survey 14% of CSHCN in New Mexico went without insurance at some point in the previous year, which was approximately the same percentage as in 2001 when it was 14.7%. This is significantly higher than the national rate of 8.8%. Those currently insured who report their insurance to be inadequate also remains slightly higher than the national rate. NM is a poor state, with a high population of immigrants, both documented and undocumented. Employment is often seasonal and sporadic, and in rural areas of the state there is a high percentage of self-employed, such as farmers and ranchers. Even with the availability of relatively low cost insurance through the state High Risk Pool, many New Mexicans find health insurance to be unaffordable.

Compared to national rates, a high proportion of CSHCN in NM report having unmet needs in the areas of health care services, family support services, and referrals, and 7.5% of CSHCN were without any personal doctor or nurse, compared to 6.5% nationally. This speaks again to the shortage of all types of health care providers in NM. In many areas it is difficult to find primary care, as practices are already full; and for CSHCN who need to see multiple specialists, these services are generally only available in Albuquerque or out of state in El Paso, Phoenix and Denver. Traveling for specialty appointments is difficult and places a huge burden on families who are already stretched thin.

The percentage of CSHCN who pay \$1000 or more out of pocket in medical expenses per year for their child has increased significantly, from 8.7% in 2001 to 19.9% in 2006 (comparable with the National rate of 20%). This is most likely a reflection of the rapidly increasing cost of medical care which has been seen across the country over the past decade.

III.E.1. Table of CYSHCN indicators as measured by the National Survey of Children and Youth with Special Health Care Needs

New Mexico Title V Maternal and Child Health Block Grant 2010 Needs Assessment

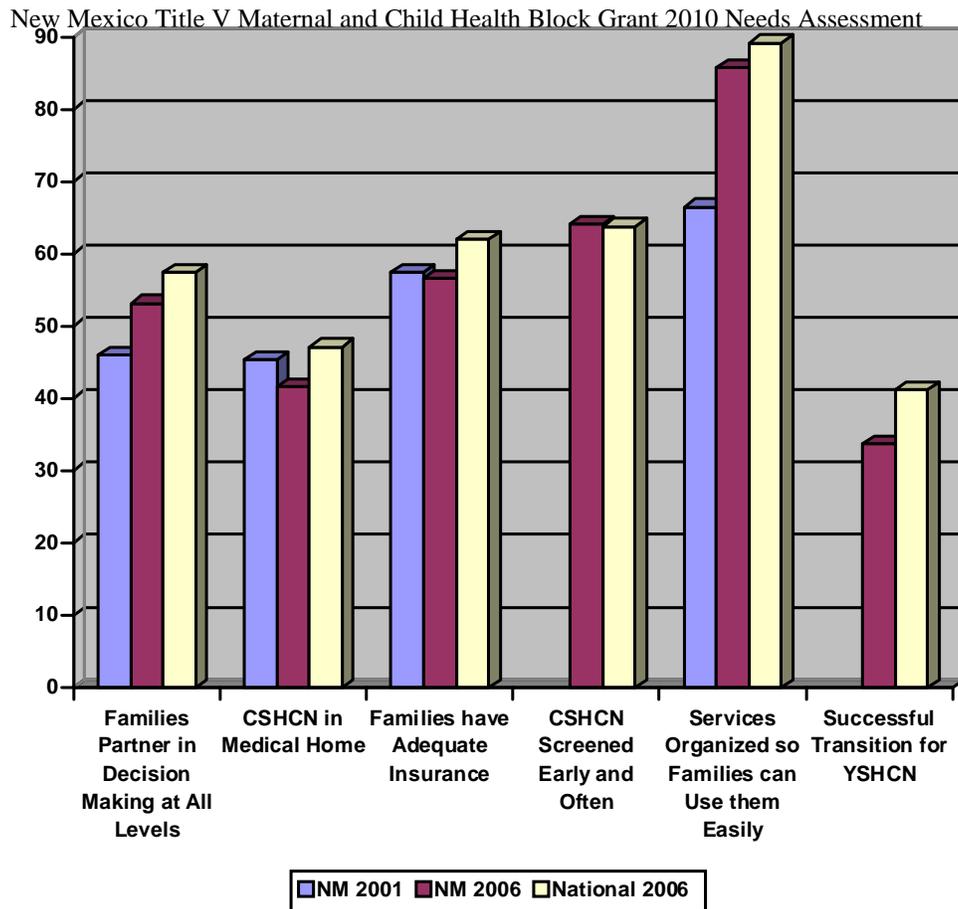
Indicator	NM % 2001	NM % 2006	National % 2006
Child Health			
CSHCN whose conditions affect their activities usually, always, or a great deal	26.8	25.8	24.0
CSHCN with 11 or more days of school absences due to illness	16.2	17.3	14.3
Health Insurance Coverage			
CSHCN without insurance at some point in the past year	14.7	14.0	8.8
CSHCN without insurance at time of survey	8.8	5.5	3.5
Currently insured CSHCN whose insurance is inadequate	35.5	35.7	33.1
Access to Care			
CSHCN with any unmet need for specific health care services	23.9	21.4	16.1
CSHCN with any unmet need for family support services	4.9	6.9	4.9
CSHCN needing a referral who have difficulty getting it	33.5	25.9	21.1
CSHCN without a usual source of care when sick (or who rely on the emergency room)	8.0	4.7	5.7
CSHCN without any personal doctor or nurse	13.0	7.5	6.5
Family-Centered Care			
CSHCN without family-centered care	42.7	38.5	34.5
Impact on Family			
CSHCN whose families pay \$1,000 or more out of pocket in medical expenses per year for the child	8.7	19.9	20.0
CSHCN whose conditions cause financial problems for the family	22.0	20.4	18.1
CSHCN whose families spend 11 or more hours per week providing or coordinating the child's health care	18.9	13.0	9.7
CSHCN whose conditions cause family members to cut back or stop working	34.1	25.1	23.8

New Mexico Title V Maternal and Child Health Block Grant 2010 Needs Assessment

Core Outcome	% of CSHCN Achieving Outcome in NM 2001	% of CSHCN Achieving Outcome in NM 2006	% of CSHCN Achieving Outcome in the Nation 2006
Families of children and youth with special health care needs partner in decision making at all levels and are satisfied with the services they receive	46	53.2	57.4
Children and youth with special health care needs receive coordinated ongoing comprehensive care within a medical home	45.4	41.6	47.1
Families of CSHCN have adequate private and/or public insurance to pay for the services they need	57.4	56.6	62
Children are screened early and continuously for special health care needs	*	64.1	63.8
Community-based services for children and youth with special health care needs are organized so families can use them easily	66.5	85.7	89.1
Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence	*	33.7	41.2

* outcome not measured

Core Outcomes



III.E.2. Asthma Incidence and Prevalence:

CMS chose to do a focused study of asthma since this is the most frequent diagnosis among CYSHCN on our program, and has shown increasing prevalence in recent years, both in NM and in the U.S. as a whole. Asthma, a chronic inflammatory disease of the airways that impacts children and adults is one of the major illnesses affecting New Mexicans. Asthma can be controlled through appropriate management of the disease by correct use of medications and avoidance of triggers that exacerbate asthma. Management of asthma in New Mexico is complicated by the state’s high poverty rate, high numbers of uninsured, low population density and large size. Immigrant communities along the border and elsewhere in the state create additional challenges to the delivery of care and asthma self-management education.

According to the 2007 BRFSS survey, approximately 8.7% of New Mexico adults report they currently have asthma (the U.S. rate was 8.3%). The 2007 child prevalence rate was 8.6%, and asthma hospitalization rates are highest in the under 5 age group. While New Mexico’s current asthma prevalence rate is similar to the national average, analysis of surveillance data has uncovered significant regional and racial/ethnic variation, such as significantly higher hospitalization and emergency room rates in southeast New Mexico. The 2004-2006 age-adjusted first-listed asthma hospitalization rate was 10.2 per 10,000 standard population. The rate in the southeast region (21.0) was more than double the state rate. All other geographic regions had rates ranging from 7.7 to 9.2.

When hospitalization rates for those under age 15 are examined, this geographical disparity is even more striking. The state asthma hospitalization rate for this age group is 21.7. The Southeastern NM rate for the under 15 age group is 58.0—167.3% higher than the state rate. Similar patterns are found when asthma emergency department rates are examined. These data were published in the New Mexico Epidemiology newsletter in April 2009. One limitation of the statewide data is that the Northwest region of the state is underrepresented as data from the Indian Health Service and Navajo Nation has not yet been made available to the Department of Health (DOH). Data sharing arrangements are pending.

For more information see:

State Strategic Plan.

<http://nmhealth.org/plans/NMDOHFY11StrategicPlan.pdf>

“Breathing Free” An Asthma Plan for New Mexico” March 2009

<http://nmhealth.org/eheb/documents/Asthma/State%20Asthma%20Plan.pdf>

“The Burden of Asthma in New Mexico” April 2009 report.

<http://nmhealth.org/eheb/documents/09burdennew.pdf>

Regional Disparities in the Southeast are presented in:

<https://www.health.state.nm.us/ERD/HealthData/pdf/ER%20Asthma%20041009.pdf>

Link to PowerPoint presentations of all pediatric asthma summits:

http://www.health.state.nm.us/eheb/asthma_meetings.shtml

Media around Summits

<http://www.kwes.com/global/story.asp?s=9308028>

<http://nmhealth.org/eheb/documents/HNS11-9-08.pdf> (page 1) and

<http://nmhealth.org/eheb/documents/HNSpage211-9-08.pdf> (page 2)

IV. MCH Program Capacity by Pyramid Levels

IV.A. Community-Based Primary Care and the MCH Population

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

IV.B. Maternal Health

Direct Health Care Services

The Maternal Health Program provides logistical and program support for the delivery of prenatal care in 10 Public Health Offices (PHOs) throughout the State. These PHOs, located in Regions 4 and 5; Lea, Eddy, Lincoln, Sierra, Socorro, Luna and Torrance

Counties, serve at least 700 low-risk women per year who would not otherwise have access to prenatal care. 90% of these women are uninsured, poor, and not eligible for Medicaid coverage for prenatal care. 10% of these women are Medicaid-covered but lack transportation to other prenatal care providers. Services the Program provides include 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 patients through the Program's contracts with SED Medical Lab, pharmaceuticals and medical supplies through the Public Health Division Pharmacy, and technical support.

In 2008, 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, 3 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. 11.6% of the state's 2007 births were to residents of these counties. Increasing liability insurance premiums and low reimbursement rates have driven some providers to leave the state or discontinue obstetric services.

Families FIRST is a case management program of the New Mexico Department of Health, Public Health Division and it is funded by Medicaid to provide perinatal case management to Medicaid eligible pregnant women and children 0-3 years old. The purpose of perinatal case management services is to provide a voluntary home visit to eligible clients, to establish a medical home, and to assist clients in gaining access to needed medical, social and educational services that are necessary to foster positive pregnancy outcomes and promote healthy infants and children in New Mexico.

The Families FIRST program's goals are to:

- Provide voluntary home visits
- Establish a medical home
- Strengthen the social support network, including family, friends and other informal resources in the community
- Improve pregnancy outcomes
- Empower families to actively participation in pregnancy, prenatal care and birth
- Improve immunization rates
- Reduce the incidence of acute and chronic illness, accidents, and injuries
- Strengthen interactions between parents and children
- Increase levels of prenatal care and participation in EPSDT

Enabling Services

Recognizing that some women seek late or no prenatal care due to lack of cultural and personal relevance, the Maternal Health Program is partnering with Tewa Women United, the Midwives Alliance of North America (MANA) Midwives of Color, the New Mexico Midwives Association (NMMA) and the New Mexico chapter of the American

College of Nurse Midwives (NMACNM) to coordinate efforts influencing changes in care delivery systems. Exploring alternatives in how women receive care through prenatal groups, community based healthcare workers (promotoras), home visiting programs and the promotion of the midwifery model of care, MCH strives to affect positive change in prenatal practices that are detrimental to pregnancy outcomes.

Through its partner Text4baby, MCH promotes social marketing strategies designed to reach all sectors of the NM population. Exploring avenues to promote healthy pregnancies and healthy parenting, MCH collaborates with county health councils, the Young Fathers Project, R.E.E.L. fathers, Taos M.E.N. and other community organizations to enhance the State's efforts to promote meaningful care and outcomes.

Population Based Services

The Maternal Health Program collaborates with the University of New Mexico (UNM) Maternal-Fetal Medicine (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 are provided to patients free of charge. Services are provided by at the UNM Health Sciences Center in Albuquerque, UNM outreach clinics and Presbyterian hospitals and clinics throughout the State. UNM MFM holds clinics in Albuquerque and in ten outreach clinics located in Alamogordo, Farmington, Truth or Consequences, Socorro, Gallup, Roswell, Las Cruces and Indian Health Service areas. The clinics are staffed by University perinatologists, nurses and social workers, and provided high level evaluation and consultation. UNM maintains the Physician Access Line for Service (PALS), providing statewide access to a perinatologist 24/7 for telephone consultations and to arrange transport for patients requiring intensive management at the university, including women in preterm labor. Additionally, UNM Telemedicine offers the [High Risk Pregnancy direct patient evaluation](#), real-time fetal ultrasound analysis and counseling whereby remotely practicing physicians can access specialty services for patients.

Maternal Health administers multiple provider agreement contracts for the delivery of low-risk prenatal care. Many of the referrals to the high risk prenatal providers are identified from these programs. There are provider agreements 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 agree to see an unlimited number of pregnant women for routine prenatal care and screening, birthing services and postpartum care. Additionally, the Program negotiates with SED laboratory and 3 ultrasound providers for reduced cost services for these clinics. These contracts total just over \$857,000 and provide the vast majority of prenatal care for uninsured women in New Mexico. Funding for this care comes from both the Federal Maternal and Child Health Services Title V Block Grant Program with matching funds from the NM General Fund.

Infrastructure-Building Services

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.

The Maternal Health Program provides logistical and program support for the delivery of prenatal care in 10 Public Health Offices (PHOs) throughout the State. These PHOs, located in Regions 4 and 5; Lea, Eddy, Lincoln, Sierra, Socorro, Luna and Torrance Counties, serve at least 700 low-risk women per year who would not otherwise have access to prenatal care. 90% of these women are uninsured, poor, and not eligible for Medicaid coverage for prenatal care. 10% of these women are Medicaid-covered but lack transportation to other prenatal care providers. Services the Program provides include 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 patients through the Program's contracts with SED Medical Lab, pharmaceuticals and medical supplies through the Public Health Division Pharmacy, and technical support.

IV.B.1. Family Planning

The FPP serves women of reproductive age (13-44), and men, with priority for services to individuals from low-income families. The FPP promotes and provides comprehensive family planning services, including clinic-based services and community education and outreach, to promote health and reproductive responsibility.

The FPP promotes and provides comprehensive family planning services, including clinic-based services and community education and outreach, to promote health and reproductive responsibility. These family planning services aid individuals and families in making choices regarding the spacing and number of their children. Family Planning is an integral component of the NM DOH's efforts to reduce teen pregnancy, prevent unintended pregnancies and sexually transmitted infections, reduce infant mortality and morbidity, and improve the health of women and men of all ages.

According to the study conducted by the Alan Guttmacher Institute, in 2006, there were 125,780 New Mexico women in need of publicly supported contraceptive services because they have incomes below 250% the federal poverty guidelines (92,320) or they are sexually active teens (33,460). In 2009, the statewide FPP funded clinics served 45,693 unduplicated clients (37,683 females and 8,010 males). This represents

approximately 30% of New Mexico women who are in need of publicly supported contraceptive services.

Funding, recruiting and/or retaining qualified staff (especially clinicians), limited administrative infrastructure: electronic health records determine the pace of the clinic, cultural: acceptance of teen pregnancy and attitude towards use of ECP, geographic: travel to clinics and lack of public transportation

There were vacancies in the last two years due to hiring freeze, but positions are now being filled.

Direct Health Care Services

The family planning clinical exam visit includes a medical history, physical examination, laboratory tests (including Pap smear), testing and counseling for sexually transmitted infections, family planning counseling, pregnancy testing (if needed), a supply of a contraceptive method of choice, a comprehensive health screening with mental health and drug abuse risk assessment may be provided. These services are provided at approximately 120 PHOs, Primary Care Clinics and School-Based Health Centers statewide. In 2009, the statewide FPP funded clinics served 45,693 unduplicated clients (37,683 females and 8,010 males).

Enabling Services

The FPP receives part of its funding through the Title X Family Planning funds, which requires that the Program complies with Title VI of the Civil Rights Act of 1964 “Prohibition against National Origin Discrimination as It Affects Persons with Limited English Proficiency (LEP),” by providing language assistance (verbal and written) necessary to ensure access to FP services, at no cost to the person at every clinic.

NM DOH has a full time Spanish translator on staff. She is available for Spanish translation of written materials as well as assessing reading levels. The NM DOH Office of Health Equity in the Division of Policy and Performance is preparing standard signage in Spanish to help clinics inform clients of the availability of translation services, and currently providing live as well as telephone translation services to DOH programs. In April 2010, the 2010 FPP Protocol added the U.S. Census “ISpeakCards2004” and emphasized in the protocol the clinic’s legal responsibility to provide fundamental language assistance to clients with limited English proficiency.

Emerging issues and linkages

Local 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. This education and outreach activities help familiarizing target

populations, particularly teens, with the local PHO providers.

The FPP continues expanded services in over 20 Family Planning funded sites that offer expanded clinic hours beyond 8 a.m. to 5 p.m.

Population Based Services

The FPP collaborates with community based organizations, the New Mexico Teen Pregnancy Coalition and Elev8, a statewide initiative of the NM Community Foundation, in the implementation of the Teen Outreach Program (TOP). TOP is a service learning program designed to prevent teen pregnancy and academic failure combines curriculum-guided experiential activities and discussion plus community service work. Page 53 In 2009, 715 teens participated in evidence-based adolescent pregnancy prevention programming. The majority (653) were in TOP, the main focus for educational services.

Plain Talk in Albuquerque is supported by collaboration between the NMTPC, NM DOH Family Planning Program (FPP) and NM DOH Region 3 Health Promotion. Plain Talk is a neighborhood-based initiative to help adults, parents and community leaders to communicate effectively with young people about reducing adolescent sexual risk-taking. FPP also partners with the NMTPC in the development and promotion of the Challenge 2010 project, to reduce teen births in New Mexico for teens ages 15-19 by 15% from 2006-2010. The results of the Challenge 2010 were promising, with several counties meeting the goal of the average birth rate (2006-2008) at least 15% lower than the baseline birth rate (the average birth rate from 2001 to 2003).

In order to reach clients statewide, the FPP contracts with various Primary Health Care organizations in New Mexico. The FPP supports family planning services in the contracted Primary Health Care clinics by monetary compensation in the form of fee for family planning services and by providing contraceptives, medications to treat sexually transmitted diseases, prenatal vitamins, and some laboratory testing such as Pap, syphilis, chlamydia and gonorrhea testing. The Primary Health Care clinics are obligated to provide low/no cost family planning services, which include some preventive and counseling services, that comply with the Title X philosophy. This collaboration is crucial to clients' access to family planning services in the rural state like New Mexico where clients may have to travel over 30 miles to the nearest Public Health Office (PHO).

In 2008, in order to gauge their awareness and understanding of the ECP-Plan B, the FPP, in collaboration with NM Medicaid Family Planning Waiver Program, funded Cooney, Watson & Associates, Inc. to conduct a survey of 21 Hispanic females between the ages of 15 and 35 who were WIC clients. Roughly two-thirds of the focus group participants were Spanish-speaking (i.e., Spanish was their first language). The purpose of the survey and subsequent focus groups was to 1) assess awareness of Plan B among this group; 2) assess the group's understanding of Plan B – i.e. what it is, how it works, who is eligible to get it and where is it available; and 3) identify specific messages and visual triggers that participants responded to for use in future development of public awareness materials

designed to target this particular group.

The survey findings were used to develop media messages in the two forms of participants' favorable media types, radio spots and the ECP Pharmacist Card; both are available in English and Spanish. These media materials were tested with subsequent focus groups and edited in 2009. The ECP media campaign was launched in 2010. The FPP plans to evaluate the campaign impact by a change in the number of phone calls from NM to 1-888-NOT-2-LATE, which was included as a main campaign message.

The main focus of the FPP teen pregnancy prevention program is implementing evidence-based programs that are culturally and developmentally appropriate for teens. The FPP will continue to partner with community-based organizations and other State agencies to apply for more federal funding in order to expand population-based programming. The FPP collaborates with community based organizations, the New Mexico Teen Pregnancy Coalition and Elev8, a statewide initiative of the NM Community Foundation, in the implementation of the Teen Outreach Program (TOP). TOP is a service learning program designed to prevent teen pregnancy and academic failure combines curriculum-guided experiential activities and discussion plus community service work.

The FPP has a collaborative relationship within the New Mexico Department of Health (NM DOH) Sexually Transmitted Disease Intervention and Treatment Program regarding the management of the Centers for Disease Control and Regional Infertility Prevention Project. The two programs clearly understand the goals and objectives of the project and are working closely to constantly monitor and improve the compliance and performance. In addition, the two programs commit to the following:

- Representatives from the two programs and the State Laboratory Division meet on a quarterly basis to manage the project funds.
- At least 50% of the grant funds are to be used to identify and treat Chlamydia among Family Planning women.
- Both programs attend the twice annual regional IPP meetings, and encourage our laboratory partners to also attend.
- Both programs work with contractors and Public Health Offices to increase the percentage of testing sites that meet the criteria of a minimum of 3% positivity and 70% females under age 26.
- In the current grant cycle, targeted gonorrhea screening is implemented by screening female inmates at the Bernalillo County Juvenile Detention Center.

The FPP has worked with the New Mexico Human Services Department Medical Assistance Division (NM HSD MAD). The NM HSD MAD oversees the NM Family Planning Waiver Program. An example of a joint project is the Emergency Contraception Pill (ECP) Public Media Campaign. ECP is the only tool available to women to prevent unintended pregnancy after an unprotected sexual intercourse.

Infrastructure Building

The FPP performs needs assessment every three years as part of the Title X competitive year grant application. The needs assessment is performed at the county level and analyzes the proportion of women in needs of publicly supported contraceptives who are not served through Title X family planning clinics, Medicaid or primary care clinics. It helps guiding the FPP of where to fund additional family planning clinical sites as well as assisting the Program to apply for additional funds.

The FPP performs quality monitoring through site audit (annually for contractors and every 3 years for PHOs), client surveys and clinic efficiency assessment. The providers were surveyed for their family planning training needs annually. The results of this survey help to guide the FPP in selecting the training topics.

IV.C. Child Health

Title V provides \$248,200.00 for Child Health. Budget cuts to Title V over the past few years have decreased funding by about \$82,000. The program is staffed by the Maternal and Child Health Section Manager, the Child Health Program Manager, and the Maternal and Child Health Educator.

Child Health is primarily an infrastructure building program serving all children from birth through age 12, with a focus on children from birth through eight. The Program seeks to educate parents, providers, stakeholders, and early childhood champions regarding issues relevant to the National and State Performance Measures, specifically immunizations, oral health, health insurance, home visiting, children witnessing violence, and motor vehicles crashes and safety. One significant conduit of education is the Early Childhood Action Network (ECAN). Through the work of the ECAN Steering Committee, listserv, and website (www.earlychildhoodnm.com) information is disseminated statewide. Often, once the information has been spread, the constituency will pick up the impetus and work through legislative channels to educate, inform, and make positive changes for the health and well-being of the children of New Mexico.

Direct Health Care Services

Through subcontracts, the Child Health Program provides direct services for Home Visiting programs with two small populations: Las Cruces, Parents as Teachers; and Santa Fe, First Born ®. Volunteer home visiting provides services designed to improve results across one or more of the following domains: maternal and child health, early physical, cognitive, and emotional development, and family safety and stability, including family violence prevention. Additionally, several drugs and medical supplies for children are provided for the Public Health Offices. Beginning with FY11, the contract for Las Cruces home visiting was eliminated. Approximately 2,050 children benefit from Child Health direct services.

Enabling Services

As a form of outreach, the Child Health Program promotes National Children's Mental Health Awareness Day through a viral campaign and web site information. A book about feelings is being developed to be given to Pre-Kindergarten children and their families for the 2010 awareness day. Also, distribution of the Developmental Screening Record Booklet has reached approximately 10,000 families of young children. This booklet was created by a developmental-behavioral pediatrician to provide families of newborns and children through age five a guide to follow and talk about their child's development with his or her provider. The booklets are distributed through home visitors, public health offices, WIC offices, certified nurse midwives and licensed midwives, and community-based organizations. Parents Reaching Out (PRO) provided translations services. Other distribution items are From DAY ONE a Baby Knows and DAY TWO A Toddler's World & You. These booklets were developed in 1997 and continue to be a well-received outreach tool for use by home visitors, doctor's offices, and hospitals.

The Child Health Program also provides health education through several different venues. An annual Family Leadership (FLAN) Conference has been educating families in New Mexico for six years. The conference promotes the voices of families in order to influence the policies and the programs that affect them. FLAN builds on each family's strengths and knowledge and celebrates diversity. FLAN works for positive, family-friendly changes to systems that eliminate stereotyping and builds relationships to create positive outcomes for families, children, and communities. Training has been offered to home visitors and Head Start and Pre-K teachers in the use of the Ages & Stages Questionnaire (ASQ) and the ASQ: SE developmental screening tools. Funded through Project LAUNCH, the Maternal Child Health (MCH) Health Educator completed training in December 2009 and is now certified as a Child Care Health Consultant (CCHC) Trainer. As the CCHC Coordinator, she will train others in New Mexico to become Child Care Health Consultants. She will work with collaborating councils to determine the best groups for CCHC training and then adapt the training for the communities they serve. A team of state agency and private partners who can work together to build a strong Child Care Health Consultant system for New Mexico will be established in the next few years.

Population-Based Services

The child health program coordinates the distribution of the Developmental Screening Record booklets as previously mentioned in the Enabling Services Section.

The Child Health program collaborates with community organizations promoting responsible fatherhood. One organization, REEL Fathers 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. Project LAUNCH state staff has participated in collaboration efforts sponsored by REEL Fathers to bring to New Mexico the White House Office of Faith-based and Neighborhood Partnerships' Forums on Responsible Fatherhood. This link will enhance parent involvement.

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 New Mexico audience. Copies of the DVD were given to all state legislators during the 2010 Children’s Cabinet Days at the New Mexico Roundhouse in January. The DVD emphasizes the importance of investing in early childhood development to positively affect the health and wellbeing of children. It has proven to be a beneficial tool to link actions for early childhood initiatives in New Mexico.

Infrastructure-Building Services

The New Mexico Early Childhood Comprehensive Systems (ECCS) grant has been instrumental in the establishment of a new level of collaborative infrastructure to address improving outcomes for children. The ECCS grant supported the establishment of the Early Childhood Action Network (ECAN). ECAN is a large network of early childhood champions throughout the state. Partners are anyone interested in the early childhood population, either from a health, early learning, family support, early intervention perspective or those who have made early childhood a policy or programmatic priority. Partners are kept informed about early childhood related issues and topics of interest in New Mexico. ECAN has, over the past five years, developed a fine reputation throughout the state for its work in and promotion of early child issues. The ECAN name is recognized and respected. People request to be a part of the Early Childhood Action Network. Additionally, the NM Children's Cabinet, established in statute, advances cross-agency systems alignment. In 2004 a representative group of early childhood stakeholders and multi-agency state personnel in New Mexico began working toward creating a comprehensive Early Childhood Strategic Plan. In the spring of 2009 the plan was presented to the New Mexico Cabinet Secretaries of the Departments of Health; Children, Youth and Families; Public Education; and Human Services for their consideration of endorsement. Broad in its vision and goals, the plan allows for each Department to select the goals that are appropriate for individual programs and create objectives and strategies to carry out the goal, remain consistent with the plan, and ultimately reach an integrated vision for Health, Development, Early Learning, Investment, Public Engagement, Family Friendly Communities and Services, and Family Engagement for New Mexico’s children.

The Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) initiative is also focused on systems alignment and infrastructure building. An environmental scan which mapped out systems and programs that serve children in New Mexico from birth through eight years of age, and their families was produced as a part of the project’s first year. The scan included a financial map of funding streams that support programs to address the physical, emotional, social, and behavioral health of children. It assessed publicly funded family support and parent education programs; current social marketing and media programs whose target audiences are families and young children, birth to age eight, funded by various state agencies; public programs and funds dedicated to professional development of early childhood providers in all state agencies; and family friendly practices implemented by large and small businesses in New Mexico.

Within the Family Health Bureau, work and funding are easily blended among Title V/MCH programs, including ECCS and Project LAUNCH. Additional blended work occurs with WIC, Family Planning, Families FIRST, and Children's Medical Services as we all strive to cooperate and coordinate our work to improve the health and wellness of children and families in New Mexico.

The New Mexico Children's Cabinet Children's Report Card and Budget Report are annual reports that give evidence to the state of health and well-being of children and the strategic investment on their behalf in New Mexico. Featured in this document are the most recently available data and information tracking critical indicators within the five goal areas of the New Mexico Children's Cabinet: healthy, educated, safe, supported, and involved.

All public libraries in New Mexico have been contacted regarding programs to promote community-based strategies to engage primary caregivers, including fathers, in the early learning targeted activities and develop public health messages to promote parent involvement in effective early learning practices. In an effort to understand what kinds of community initiatives promote family reading to young children, it was learned that many public libraries in New Mexico have special programs that do this work. The state library provided a list of all libraries including a children's program contact. The list included 93 community and tribal libraries, and 3 military libraries. An email survey was sent to discover if the libraries had programs that encouraged families to read to young children age birth-five years. Those who responded in the positive provided a brief description and any data they may have kept. The email survey was done in August 2009 with telephone follow up to non-responders in December 2009.

Beginning with the 2009-2010 school year, the Department of Health began collecting BMI (Body Mass Index) levels for kindergarten and third grade students in 50 elementary schools in New Mexico. Students are not identified in this population-based BMI monitoring system.

The Department of Health provided schools with standardized equipment and trained school nurses how to collect height and weight data. The Department will analyze the data using the Centers for Disease Control and Prevention's BMI percentile analysis tool. The Department will provide each school with their BMI profile and will also conduct a statewide and regional BMI analysis by grade, sex and race ethnicity. The Department plans to survey 50 new schools each year.

The elementary-school age BMI system is one component of the State's efforts to reduce obesity rates. The Department of Health collaborates with state and local agencies and community partners across New Mexico to help communities develop policies and programs that support families in developing healthy eating and physical activity habits. The Department's program, Healthy Kids New Mexico, creates healthy environments and policies to empower children, families and communities to make healthy food choices and increase physical activity. The Department established the program with state and local partners in Las Cruces and has expanded to Chaves County and tribal communities.

This fall, Healthy Kids New Mexico will begin a campaign to encourage elementary school-age children to limit how many sugar-sweetened beverages they drink. The Department will also begin a pilot program to help elementary schools assess their environments, develop plans to promote healthy eating and physical activity and connect schools with other local partners that can assist them.

The Child Health Program's infrastructure building activities reach all children from birth to 12, or approximately 350,000 children.

IV.C.1. Childhood Injury Prevention Program

The Childhood Injury Prevention Program consists of one paid staff member, several volunteers, New Mexico SAFE KIDS Coalition and SAFE KIDS network of 12 coalitions and chapters, and the Consumer Product Safety Commission representation for the state. The paid staff member coordinates all media press releases, published articles, social marketing, program design, development, management, administration, fundraising, curriculum development and training

There are approximately 75 volunteers in 12 communities in SAFE KIDS coalitions and chapters providing social marketing, including distribution of literature and advertising, education and events for child car seat inspections, distributions, and installations, helmet distributions, fittings and related bicycle safety instruction, and home safety information

The program provides social marketing, education and events for child car seat inspections, distributions, and installations, helmet distributions, fittings and related bicycle safety instruction, home safety information, curriculum, and consulting and development of legislation and supporting data.

The Childhood Injury Prevention Program serves approximately 230,000 children ages 0-14 that represent the lower 50% of income level statewide. Numbers served by pyramid level are as follows:

- Direct services – approximately 25,000 children ages 0-14
- Population-Based Services – approximately 50,000 children ages 0-14
- Enabling Services – approximately 100,000 children ages 0-14
- Infrastructure building – approximately 100,000 children ages 0-14

Approximately 100,000 children ages 0-14 do not receive direct service who would benefit significantly from having access to a free car seat, a free bicycle helmet, and home safety inspection/counseling services. The Healthy Home Initiative endorsed by the Obama administration recently stated that 67% of all homes have a major health hazard, which has significant implications for the health and safety hazards present in low income housing particularly.

CIPP is currently collaborating with Head Start, Early Head Start, Families First, the

Home Visitors programs, and Regional Early Child Care Educational Conferences for home daycare providers to offer presentations and workshops to teachers, health educators, and parents regarding safety protocols specific to infants and toddlers, ages 0-3, and to small children, ages 3-5. Due to the limitations of program funding, CIPP has greatly increased its commitment to trainings for these organizations during the past year, averaging about one presentation or workshop every other week of the year.

The program needs more funding for social marketing, safety equipment, training and certification, as well as to advertise and produce safety events. The many dedicated volunteers in virtually every community are willing to manage events, including the installation of free car seats and the fitting of bicycle helmets, as well as to provide education.

CIPP capacity has decreased significantly during the past five years because of budget reductions at the federal, state, county and city levels. However, during the same time period the number of designated trauma center in New Mexico has increased from 4 to 8, and there are 3 more pending applications. Fortunately, in order to be certified as a trauma center, it is mandatory that a hospital also have an injury prevention program. 6 of the 8 hospitals with current certification have chosen to endorse and support a local SAFE KIDS chapter or coalition as their injury prevention program. Also, Kiwanis clubs throughout New Mexico have prioritized traumatic brain injury prevention during the past year, and as a result many of them have been willing to purchase helmets for free distribution during bicycle safety training “rodeos”, which they also have provided funding for. Kiwanis clubs have also been receptive to providing free car seats for car seat clinics for the same reason; preventing traumatic brain injury.

The total statewide budget for the Childhood Injury Prevention Program operates is \$89,000 per year, funded by the Title V MCH Block Grant, the state general fund, NM Trauma Authority grants, and charitable contributions. In order to meet the needs of all children, the program would need to increase it’s budget to about \$400.00 per year, or about \$2 per low income child.

IV.D. Adolescent Health

The Office of School and Adolescent Health (OSAH) focuses on school-aged populations, with limited emphasis on youth ages 18-24 via higher education supported programming.

OSAH is staffed by a financial specialist funded through Title V, and 18 field staff, 10 of whom are regional public health staff working directly with school health and behavioral health personnel. This staff includes a Director, School Health Officer, Behavioral Health Program Manager, School Based Health Center Clinical Operations Manager, Youth Suicide Prevention Coordinator, Adolescent Health Coordinator, Business Operations Manager, and School Health Consultant. All but two staff member salaries are paid through general funds. The Adolescent Health Coordinator position is supported with Title V funding.

The Adolescent Health Coordinator provides technical assistance on various adolescent health and positive youth development approaches, implements the NM Adolescent Health Strategic Plan which focuses on 7 capacity areas, promotes awareness and implementation of positive youth development approaches, and monitors OSAH Adolescent Health contracts.

OSAH coordinates the statewide school-based health center program (80 SBHCs), the public school nursing (support for over 500 nurses statewide), school behavior health development, youth suicide prevention and crisis response development, positive youth development and peer-to-peer program implementation.

Direct services

In FY 2010, 20,152 school-aged youth visited the SBHC's a total of 60,817 times. NM SBHCs are a unique health care model that includes comprehensive physical, behavioral and preventive health services provided to children and adolescents in their schools. The critical health care services are provided to students regardless of their ability to pay. Of the 60,817 visits, 9,442 were for reproductive health services, and 18,637 were for behavioral health services. Approximately 46,500 students have access to a SBHC.

Youth Suicide Prevention – OSAH's Behavioral Health Team, consisting of a program manager, youth suicide prevention coordinator and regional school mental health advocates facilitate crisis response in communities following the suicide of a student. Funding is also provided for the NM Suicide Crisis Line Network – consisting of three providers who provide 24/7 toll free coverage. The crisis lines are also members of the National Suicide Prevention Talk Line and respond to crisis calls statewide. FY '10 the Crisis Network responded to 22,223 calls.

Positive Youth Development – General funds from the youth suicide prevention budget are used to support peer-to-peer programming in 10 schools. FY '10 a total of 200 students received training as "Natural Helpers" – a curriculum that teaches young people to understand the warning signs of suicide, along with skills in referral to an adult. These youth also facilitated community and campus awareness events.

Natural Helpers and Native HOPE (Helping Our People Endure) are both school-based peer support program based on a simple premise: Within every school, an informal "helping network" already exists. Youth with problems naturally seek out other youth — and also adults--whom they trust. The main difference between these two programs is that Native HOPE incorporates Native American culture and traditions. OSAH also promotes other positive youth development forums such as OYE (Organizing Youth Engagement), Indigenous Soccer Cup, Youth Advisory Councils, Rez Hope, and the Annual Head to Toe Conference Positive Youth Development Track. (approximately 600-700 youth are impacted) Program and other youth forum goals include:

- increase youth leadership and engagement

- prevent problems of adolescence such as suicide/depression, youth violence and teen pregnancy/STDs.
- intervene effectively with troubled friends
- choose positive ways of taking care of themselves., and:
- contribute to improving their school and community

Population-Based Services:

DOH Funded SBHCs are required to conduct screening and assessment of youth seeking services. A Student Health Questionnaire is administered by the 3rd visit – the tool screens for a variety of health and behavioral health risks, including sexual activity, safety, nutrition/physical activity, depression/suicide risk, substance abuse and family/peer relationships. Some SBHCs also provide oral health screening and referral.

Enabling Services

SBHCs conduct PE/MOSAA determination for Medicaid, referral to community based programs, care coordination and case management.

Infrastructure building

Youth Suicide Prevention – funding is currently available to support awareness and gatekeeper training. OSAH’s Youth Suicide Prevention Coordinator provides workshops, presentations and also coordinates training for communities interested in learning about the warning signs of suicide, steps necessary to response to a crisis. OSAH has also conducted statewide planning with agencies and organizations to facilitate a multi-systemic coordinated programming and crisis response.

Positive Youth Development – MCH block grant funds are currently being used to support the implementation of the Statewide Adolescent Health Strategic Plan. Activities include convening of state agencies and youth-led organizations to coordinate activities, evaluate progress and provide guidance to promote adolescent health. Core partners include civic engagement and youth leadership development organizations and agencies.

There are currently not enough SBHCs, and the program is not able to reach a number of middle and high schools. Also, the program is not able to reach the schools that serve Native American youth.

Lack of funding is the primary reason for the program’s not being able to reach all youth in New Mexico. The program would benefit from more FTEs, and from an increase in funds to ensure that all NM schools have a SBHC. SBHCs are recognized as an important point of access and NM is currently partnering with Colorado in a demonstration project funded through CMS to demonstrate the quality of care and how to link SBHCs to the “medical home approach.” Grant and funding opportunities are often topic specific and communities don’t have the autonomy to decide how funds are utilized. Some school boards create barriers. There are not enough staff to provide much-needed

educational outreach to school communities regarding adolescent sexuality and other behavioral health topics, and youth rights and responsibilities. There are also cultural and geographic barriers.

Overall the Office of School and Adolescent Health capacity has remained steady. The School-Based Health Center Program is the primary recipient of funding and most of OSAH's attention is focused on increasing productivity and quality of services received through SBHCs.

Funding for youth suicide prevention and adolescent health continues to decline. Title V MCH Block grant funding has declined steadily over the last several years and is becoming more difficult to fund youth engagement and youth-led projects. Best and promising practice points in this direction, but funding for these types of activities is limited. Additional funding would support school and community projects that focus on youth-led programs such as Natural Helpers, TOPS and Native HOPE. There is greater awareness of Positive Youth Development approach principles more people want practical steps on how to implement and incorporate them within their work and daily lives. However, resources continue to decline and it is not possible to provide this at this time.

IV.E. Children's Medical Services (CMS)

The state office staff consists of the Title V Statewide CYSHCN Program Manager, the 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 and a Family Infant Toddler Coordinator who assists the Title V program to link with the statewide early intervention program, a clinic coordinator, financial specialist, office administrator, a health educator and clerical staff. The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, program managers and key state office staff. The management team meets monthly to review policy issues related to the implementation of the CMS programs.

Dr. Janis Gonzales was hired in 2008 as the CMS Medical Director and has been selected as the AAP EHDI Chapter Champion. The CMS State Office is down four crucial positions of fifteen total assigned to State Office. Vacant are: the Title V CYSHCN Director, the Health Educator in charge of NMMIP/Youth Transition, the Business Operations Specialist/Clinic Coordinator, and the Family Infant Toddler Program Coordinator. The 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. The program has recently hired the CMS Financial Manager.

CMS provides care coordination for Children and Youth with Special Health Care Needs, (CYSHCN), multidisciplinary pediatric outreach clinics, Newborn genetic and hearing screening and follow-up, payment for medical care for uninsured CYSHCN. CMS serves children and youth age birth to 21 that meet medical and financial guidelines (200% FPL). Financial guidelines are required only when CMS is a payor. The program also

serves adults with cystic fibrosis, and all babies born in New Mexico through newborn screening.

The NMDOH has made significant progress during the past five years both in coalition building and developing institutional support as well as in meeting the five State asthma program goals outlined in 2006: Conducting asthma surveillance; Increasing asthma education of health care professionals; Educating patients, families, schools, and communities about asthma; Improving access to and delivery of asthma care; and Mobilizing to reduce environmental exposure to asthma triggers. A series of strategies with measurable indicators are described for each goal in the state asthma plan. A 10% reduction in asthma youth hospitalization rates within 5 years was established as one of the ERD's health outcome goals. This whole process has been an important example of data to action.

Direct Health Care Services

CMS serves 5,500 clients through direct health care services. CMS has 73 staff in 29 field offices throughout the state along with 11 state office staff for a total of 84 staff currently. 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 putting in place 700 provider agreements which will require annual renewal, all while the Business Operations Specialist and the CMS Financial Manager Positions are vacant. The request to hire has been approved to fill four Social Worker positions and 1 Social Worker Supervisor position – these hires are in process. Unfortunately, the gain of the five field social worker positions is lost with the Public Health Division's decision to not replace five additional positions becoming vacant this coming year.

CMS coordinates 130 multidisciplinary specialty clinics statewide which include cleft palate, pulmonary, neurology, nephrology, metabolic, endocrine, and genetics. These clinics are in partnership with UNM and Presbyterian Health Services and other community partners. The CMS CYSHCN social workers provide care coordination as part of this system of care. For many families this is the only opportunity they have to see a pediatric specialist as this service is not readily available in the rural and frontier communities in the State.

Enabling Services

CMS social workers develop transition plans with youth beginning at age 14 to facilitate the transition into adult medicine, vocational rehabilitation, post high school education or based on the youth's interest and needs. The work around transition is not as active as

the program had hoped due to budget and staffing issues and the need to cover vacant caseloads. The enabling services reach approximately 1000 children.

Population Based Services

The Newborn Genetic Screening program screens for 28 conditions. The program works with the 34 birthing facilities & midwives to improve collection of newborn screens and minimize the collection of unsatisfactory specimens. Short-term and long-term follow-up for newborns that screen positive for a metabolic or genetic condition is provided by the CMS nurse consultant, CMS social workers and pediatric specialists from Oregon State Public Health Lab and from the University of New Mexico. Public education is also part of this effort and includes information on Newborn screening through brochures in English and Spanish, training provided to medical staff and families.

The Newborn Hearing Screening program restructured its short term follow-up program two years ago by hiring a coordinator and centralizing procedures. The goal was to improve follow-up for infants that did not pass their newborn hearing screen by reducing time between first contact and discharge from hospitals. The CMS social workers continued to provide long term care coordination for children diagnosed with a hearing loss, linkage to medical home and family support services. The program received supplemental funding from HRSA in 2009 that is being used to contract with Education of Parents of Indian Children with Special Needs (EPICS) to improve outreach and education to Native American families who have children that are deaf or hard of hearing.

The Newborn Hearing Screening Coordinator meets regularly with the New Mexico School for the Deaf to address lack of access to pediatric audiology services. The supplemental funding that was received from HRSA is also being used to provide technical training to audiologists on diagnostic procedures utilizing video conferencing and in addition a hands on practical experience at the annual meeting for audiologists in the State in the of Fall 2010. These programs serve approximately 30,000 children per year, which is the total live birth population.

Infrastructure-Building Services

The estimated population of children and youth with special health care needs for New Mexico is 59,000, or 12% of the population ages 0-17. CMS infrastructure likely reaches most of these children. SSI beneficiaries are offered care coordination services by the CMS CYSHCN program. Medicaid Salud! coverage in New Mexico is comprehensive; CMS assists families when their monthly income exceeds SSA limits (but still falls within CMS financial eligibility guidelines). CMS Social Workers also assist SSI recipients turning 18 to apply for benefits as adults. At one time CMS continually received a monthly list from New Mexico's Disability Determination Services program (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. For those denied benefits, information about Parents Reaching Out, a

Statewide Parent-to-Parent Organization would be provided. During FY 03, a change in the local Social Security Office computer system disabled capacity to generate an SSI denial list. Due to HIPAA constraints, Social Security is unable to provide the reports in this same manner at this time. Social Security is still working to remedy this problem.

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 served on the LEND Advisory Committee. 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.

The CMS Medical Director is a member of the AAP and is the EHDI Chapter Champion for the AAP. The Interim CMS Program Manager is a board member for two parent organizations; the Family to Family Health Information Center and Hands and Voices.

Children's Medical Services (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. 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. CMS assesses insurance options for clients. Social workers assure that Children and Youth with Special Health Care Needs (CYSHCN) do not temporarily lose Medicaid benefits due to Deficit Reduction Act (DRA) requirements for proving citizenship. Some children have been losing their Medicaid benefit because of the new requirement to verify citizenship. The CMS Family Infant Toddler (FIT) program now requires mandatory screening for insurance on all clients enrolled in the program. Additional FIT providers have been trained in PE/MOSAA.

The CMS-FIT staff works closely with Children Youth and Families (CYFD) to implement the requirements of the federal Child Abuse Prevention and Treatment Act (CAPTA) legislation where children birth to three years of age with a substantiated case of abuse and neglect must be referred to early intervention. Children's Medical Services participates in the New Mexico Interagency Coordinating Council (ICC) interagency group including the Division of Vocational Rehab (DVR), Medicaid, and Medicaid MCO/Salud! Programs, CMS, UNM Continuum of Care, the LEND Program, UNM Family and Community Partnerships Division of Center for Developmental Disabilities, Parents Reaching Out, EPICS, and Family Voices. The CMS Title V CYSHCN statewide program manager was appointed by the Governor to the Interagency Coordinating

Council (ICC). This is the advisory body to the FIT program. The Council is made up of representatives from Medicaid, CYFD, Public Education Department, the Public Insurance Commission, the NM Medical Society, the University of New Mexico, local early intervention providers, and families. With the retirement of the Title V CYSHCN Director, this position on the ICC will be filled by Dr. Janis Gonzales, the CMS Medical Director.

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 perinatologists 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.

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.

Unmet Need

CMS estimates that approximately 10% of CYSHCN benefit directly from its programs. There are multiple reasons why CMS is not able to serve more of the CYSHCN population including: recruitment and retention of licensed social workers, the state hiring freeze which has not included an exemption to hire for CMS social workers, lack of funding for more outreach clinics, and limited numbers of pediatric specialists.

Children with high needs are served by other programs within the State such as the medically fragile waiver and developmental disability waiver.

The CMS program budget is \$11 million in Title V and state general funds. To adequately serve 100% of the target population, the program would need to increase its budget five fold.

IV.E.1. Assessment of Data Needs and Capacity for CYSHCN

CMS has had chronic difficulty obtaining accurate data, resulting in decreased capacity for program evaluation and assessment. As part of our needs assessment, CMS decided to do a comprehensive analysis of our data needs and current capacity.

A data needs assessment of Children's Medical Services (CMS) was conducted in 2008 which would identify what data were being collected, what questions CMS had, and to propose methods to meet any gaps in the data's ability to answer these questions. CMS administers several programs which gather medical, demographic and financial data. This study had two main data gathering phases. The first examined the data capacity and the second examined data needs, and the structure of this report reflects this.

The first section, comprising three interrelated parts, describes the current data collection and the datasets which CMS maintains. It starts with a description of the various programs CMS runs and the data each collect. This information is then arranged in a chart to compare the different datasets' strengths and weaknesses. The first section concludes with a series of data flow charts detailing in graphic form how the datasets are put together. These three parts are complementary, and all three are necessary for full picture of the CMS data capacity.

The second section describes the data needs for the various CMS programs and the populations that they serve. Following each description is a logic model which condenses the data needs into one page and recommends various inputs and activities to meet the needs. Rather than collecting all the logic models together at the end of the section, it made more sense to intersperse them with the narratives so the reader need not flip back and forth between different parts of the report.

During the capacity assessment phase a number of datasets were identified and characterized. The different datasets are maintained by the various CMS programs for different uses. This is reflected in their relative strengths and weaknesses, which will be described. The datasets are used mainly for program purposes such as follow up or population level surveillance, although in at least one case a dataset also was analyzed and an article published. As a result, many of the datasets have good quality data on how to locate the individuals, and in some cases what services that client has received and when. However, demographic data are less reliable. While a few data linkages exist, most of the CMS datasets are currently maintained separately from each other. The introduction of a new data system, Challenger Soft, will link some of the CMS datasets and programs together.

Some of the programs in CMS have very specific reporting requirements and their data needs revolve around developing a better ability to meet these. Other programs and projects are able to meet their reporting requirements and have data needs pertaining to improving their program or expanding to include harder to reach populations. The need for a better picture of the geographic locations and distribution of the population served

came up for multiple programs. Another aspect which arose as a gap during the data needs assessment was data on Youth with Special Healthcare Needs (YSHCN) in transition to adulthood. While there is tracking being done to make sure these youth have appropriate health care coverage, specific data on how these youth and their families are actually faring are not available.

In order to meet its data needs, CMS would benefit from several inputs. CMS and the Maternal and Child Health Epidemiology program (MCH Epi) are both within the Family Health Bureau and are located in the same building, so they collaborate closely. Recently CMS has begun collaborating with the Environmental Public Health group; continuing to strengthen this relationship would increase the ability of CMS to treat and ultimately prevent certain illnesses among the children and youth populations in the State of New Mexico. In addition CMS would benefit from someone on staff with the expertise and dedicated time to analyze the vast amount of financial information. A clear need exists for someone to analyze the data generated by CMS programs, particularly the newborn screening programs, and to develop database linkages where appropriate. Software inputs and liaisons with programs outside the Department of Health will also help CMS use its data more effectively.

Children's Medical Services (CMS) collects data for a variety of programs. Most datasets have basic demographic information on the individual such as name, date of birth, and address. Some are linked to other datasets, which can provide information such as mother's name, date of birth and education. The datasets are used for quality assurance, providing services such as early intervention (secondary prevention) and also surveillance with a goal of primary prevention. Consequently, some of the datasets contain very reliable data on how to find a small number of individuals. Others provide very accurate counts of specific diagnoses but the ability to locate the individuals is of unknown reliability. Overall the data CMS maintains are good for conducting follow up. However, several of the datasets are accessible by only a single individual or are maintained only on paper. CMS has been working to implement a new data collection system called Challenger Soft. This software will maintain individual client records, initially for the newborn hearing and genetic screening along with birth defects but with plans to incorporate more datasets in the next couple years.

The following descriptions of each dataset include information about who collects and inputs the data, what is gathered and how it is used, and the approximate number of client records in each dataset.

INPHORM

The Integrated Network for Public Health Official Records Management (INPHORM) is a database which contains records for approximately 4,000 clients. This dataset is electronic and the information is mostly entered by the social workers in the field. There are linkages to the Public Health Division's (PHD) INPHORM system, but most other groups have moved over to the Billing Electronic Health Record (BEHR). Both INPHORM and BEHR are linked to Medicaid and private insurance so that these can be

billed. BEHR is a true health maintenance record while INPHORM is a database, however BEHR does not meet the case management needs which CMS has. There is a major issue with INPHORM in that clients become hidden from view within the database. Each client must be renewed annually, and if the renewal date is missed the system hides the client. There is no way to locate these people until they try to access services and are denied. Since the system hides clients from view, this causes population and diagnosis counts to be low.

INPHORM collects demographic information on all of the clients including their diagnoses. These are usually listed by ICD-9 code, but on occasion the client's diagnosis is listed using an old CMS code. The two coding systems are mixed in together and there is no key provided. This causes issues when trying to locate everyone with a certain condition in order to schedule a specialist clinic since a search using ICD-9 codes will not uncover people listed under the CMS code for the same diagnosis. Another issue with the client demographics has to do with the Race & Ethnicity characteristic. The system automatically classifies 'White Hispanic' as 'Anglo', so a lot of people end up listed as 'Other' to avoid this problem. Therefore, the Race & Ethnicity section has a very large number of 'Others' making any stratification by the Race & Ethnicity characteristic of questionable reliability.

The INPHORM system has several auto-generated report options. For example, one option is to list by social worker all clients with a certain diagnosis by ICD-9 code. However, since the results must be adjusted before they are meaningful (for example, clients listed by CMS internal diagnosis codes added back in), the output of these reports is not very helpful and the feature is not used very frequently. Alternatively, more detailed requests for data can be made to the DOH IT helpdesk. These results are returned in an Excel spreadsheet. This is helpful as the data can be more easily cleaned and manipulated.

Since there are issues with duplicate records and multiple visits for a single client, the file must first be cleaned before it can be used to answer whatever question is being asked. In addition, since clients whose renewal dates are missed are hidden, case counts are not considered reliable. The DOH IT helpdesk used to fill data requests in less than a week, but recently the person at DOH IT who handled these requests resigned and no one else has figured out how to fill the requests yet. INPHORM is being phased out by the Department of Health, so CMS will soon be looking to replace this system.

Flu Vaccination

A subset of the INPHORM clients is in the Flu Vaccination dataset. This dataset is an Excel sheet of approximately 1,300 clients for whom it is very important that they receive the flu shot. Data is collected through an extensive back and forth over email between the central coordinator and the social workers in the field, but only the coordinator actually enters the data into the Excel spreadsheet. Every diagnosis in this Excel file is by ICD-9 code, avoiding the confusion of combining ICD-9 codes with CMS internal codes. In addition, the language spoken at home is listed and it is noted whether or not

the phone number on file actually works. If the phone is not working then the mailing address is used to contact the family at the beginning of the flu season and then again for follow up.

In the past this data has been analyzed by a Maternal and Child Health epidemiologist stratifying by age, region of the state, potential language barriers and certain health conditions. An article was published in *New Mexico Epidemiology* showing that children with Spanish speaking parents, rather than being at increased risk of not being vaccinated, were actually more likely to receive the flu shot. In addition, children with asthma were more likely to receive the flu shot. It will be interesting to note what affect the new national recommendation to vaccinate all children over 6 months has on the vaccination rate for this upcoming flu season.

NMMIP

Children and youth with high cost diagnoses are enrolled in the New Mexico Medical Insurance Pool (NMMIP). People are eligible either because they have been denied coverage by another insurer or because they have been diagnosed with certain conditions. Data is collected to confirm eligibility, including on income to qualify for the reduced premium. All the paperwork and faxes around enrollment in the program are stored in a locked filing cabinet. An Excel file tracks the 163 currently enrolled clients through age 21. When they turn 20 an age-out warning comes up in the spreadsheet. These clients are then made aware of the Low Income Premium Program which CMS will temporarily pay for if there is a clear commitment on the client's part to take over the premiums. This data file also tracks how many stay with the Low Income Premium Program and over 80% do take over and continue to make the payments.

FIT KIDS

CMS is a contracted provider to the New Mexico Family Infant Toddler program (FIT). The CMS FIT program coordinates services for between 150 and 200 kids from birth to age 3 (at which point they transfer into Part B which will follow them through school until age 21). The data is collected in the FIT KIDS (Key Information Data System) and analysis is done by FIT (which is under a different DOH division). Clients can be referred to the CMS FIT program by any of the newborn screening programs discussed below, or by their primary care provider or an Early Intervention (EI) program. To qualify, these babies must have either a diagnosed developmental delay, an established condition, or be at risk for a developmental delay. The specific qualification is noted in the demographics section. CMS can act as either the care coordinator or just provide social work for a client whose care is coordinated by an EI provider.

When CMS FIT provides care coordination then they are the only ones allowed to enter demographics into FIT KIDS. The demographics include home address, language spoken at home and family size. There is also room to list up to three ICD-9 diagnoses. The system also tracks important dates for service coordination such as the referral date, when the Individual Family Service Plan (IFSP) was in place, and when services actually

began. This data is all entered by social workers or clerks in the field from the paper charts. In these cases the EI provider can only enter number of service hours provided. When CMS FIT is only providing social work for a client whose care is coordinated by an EI provider, then that provider is the only one who can enter demographics and CMS FIT just adds hours of service provided.

The system is linked to Medicaid and private insurance so that they can be billed. However, whether the claim is actually paid by the insurance it is not linked back automatically. Instead, Medicaid sends a .pdf report which must be entered in by hand. The data system has a query builder to make data requests, but this feature is not used since the auto-generated reports meet all the needs of CMS. Data is used for quality assurance, such as compliance with 30 and 45 day timelines. There is also a chart audit form used to collect information on how social workers are functioning. This is used for quality assurance and training purposes. All the audits are in paper form in a binder on a shelf.

NBGS

The Newborn Genetic Screening (NBGS) collects data on almost every birth in the State of New Mexico. If a screen comes back positive the Oregon State Public Health Lab calls the CMS public health nurses to alert them of the result and to confirm the name and phone number of the baby's Primary Care Provider (PCP). The demographic information for the baby and the mother (which is self-reported) then also becomes available to CMS from the Oregon lab. The lab faxes a copy of the demographic information from the blood spot kit along with the lab results and copies of correspondence with the PCP. This information is available much sooner after the birth than any data from Vital Records is, since some of the metabolic diagnoses are life threatening. If the phone number and street address on the form are not accurate the public health nurses will turn to other sources to find the baby, such as WIC or Omnicaid (which processes medical insurance claims for CMS) and as a last resort the local police.

As genetic disorder cases are confirmed they are entered into the national newborn screening database. Only one person has permission (i.e. a password) to enter data for New Mexico. In addition, a dataset is maintained for internal use which gathers more information than the national database collects. Both collect baby's name and date of birth, mother's name and date of birth, time from birth to referral to a physician and time until treatment begins. The internal data also tracks false positives, the date the physician was contacted, the date the UNM metabolic team was contacted, when a referral was made to either UNM metabolic or CMS, and when the case was entered into the national database. This is all kept in an annual Excel sheet. There is a separate Excel sheet specifically for hemoglobin traits such as sickle cell. This is used to track six different traits in the State of New Mexico. It is maintained separately since the national database only gathers total incidence and does not break it down by specific type. Within this dataset CMS also tracks date of referral to the sickle cell council and the city where the affected person lives. The hemoglobin dataset was developed in response to interest expressed by the legislature and researchers in sickle cell traits among Hispanic

populations.

Quality assurance for the short term aspect is done using monthly data reports from the Oregon lab. These reports, one for each birthing facility and one for the state as a whole, show how many specimens arrive at the lab within 5 days of birth. CMS can also make requests of the lab, for example birth defects by age group of mothers or geographic location. Long term follow up data is collected at the regional health office level, but this data is not currently being gathered centrally. A form has been developed which will be used by Challenger Soft so that information such as last medical visit and development or school evaluations can be entered by the social worker into a central database.

NBHS

The data for the Newborn Hearing Screening program (NBHS) is currently in two or three different places. In the past, within six weeks of a birth Vital Records would send over a birth file which would indicate the results of the screening: either a pass or a referral for follow up testing. This would also have full demographic information on the baby and the mother. However, due to issues surrounding the Vital Records system upgrade, no data has come over to the NBHS program since July of 2007.¹ This data has been analyzed in past years by an MCH epidemiologist for quality assurance. The report produced broke down births by hospitals so that screening rates and pass rates could be calculated and local issues such as malfunctioning equipment can be identified and resolved. Since the screening rate uses total reported births as a denominator, Vital Records data is required to generate the report. Consequently, this report has not been run since July of 2007.

Fortunately data is also reported from hospitals directly to the NBHS program; when a referral is made a form is faxed over within a week. This form indicates whether the baby failed the screen, was transferred or discharged without being screened, or has a risk factor for hearing loss. These babies are then followed until either they pass the screen or they are diagnosed with a hearing loss and entered into Early Intervention (EI) services. While the communication between state headquarters and the social workers in the field involves faxing the form back and forth, all the information is entered into a Stata file at the state office. The demographics include the baby's name and date of birth, the mother's name, street address, and phone number. In addition, there is a field for mailing address if different from street address. No other CMS dataset contains a separate field for mailing address. The form also collects risk factors for hearing loss such as cytomegalovirus infection.

In the future, the NBHS program will be within the Challenger Soft system. This is currently nearing the end of development. The birthing facilities and the audiologists

¹This year Vital Records shifted from an old DOS based system to a web based system. They then also implemented the new (2003) birth certificate. While data is flowing into Vital Records, they are having issues pulling data out for dissemination to programs such as NBHS. *Update:* Vital Records has begun sending data over to CMS and MCH Epi programs again as a flat file, which is parsed and disseminated internally by an MCH epidemiologist.

making diagnoses may also be able to report directly into the data system instead of faxing the form if the program is able to develop and extend web based access to the dataset to these professionals.

Birth Defects

The Public Health Division is currently tracking the 12 birth defects which are reportable conditions in the State of New Mexico. A Stata file for birth defects in New Mexico going back to 1995 is stored in an un-networked computer in the office of the Public Health Division's medical director. Data is gathered on hospital discharges which are received quarterly in the form of ICD-9 diagnosis codes and procedure codes. Hospitals deposit this information into a secure .ftp site where it can be retrieved by the medical director. It is believed that coverage is pretty complete since these birth defects almost always result in hospital visits. However, birth defects on children who are residents but born outside of the state and who may receive services outside of the state may be missed.

In addition, some reports are sent in by specialists who are likely to see infants and young children with certain birth defects. These reports are received on an irregular basis, usually when prompted by a phone call. Birth files through 2006 and death files through 2003 have been linked into the Stata file. The main purpose of this dataset is surveillance, with a goal of primary prevention. Early intervention, a secondary prevention activity, is shifted to FIT. The data are analyzed by the medical director and also by someone from the Environmental Public Health Tracking group. They examine geographic distribution of birth defects in relation to known genetic risks and suspected environmental pollutants. They are not yet able to make birth defects a priority for either of them. The dataset is also used to identify children with specific birth defects, and to provide a list to the FIT program within CMS for follow up. For these children, a letter is also sent to their provider informing the provider that their patient may be eligible for FIT and/or CMS services.

Conclusion

Screening and surveillance data must be gathered for a specific use. Most of the data collected by CMS on Children and Youth with Special Health Care Needs (CYSHCN) is used to find the child and provide early intervention services. For this reason many of the datasets collect thorough demographic data and are able to locate the child. The National Survey of CYSHCN provides another source of data which is valuable to CMS. The most recent survey, conducted by telephone in 2005-2006 and publicly available at <http://cshcndata.org/Content/Default.aspx>, provides data which CMS uses to fulfill certain national reporting requirements.

The CMS datasets are weaker in other areas, for example not all of them have many characteristics about the mother and none measure paternal involvement. The birth defects dataset is intended for surveillance and primary prevention of future birth defects. Therefore it is stronger in terms of general demographics such as race & ethnicity and

geographic location. This data is not used for active case management so information such as whether the phone number works is not relevant, nor are data on referral to follow up and enrollment into services collected.

While many of the datasets described above are in electronic form and accessible to multiple people, some of them are not. The CMS FIT chart audit results and the information such as family income collected while enrolling clients in NMMIP are maintained in paper form. This means that if someone sought to link these datasets with other data it would not be possible without first converting them to electronic form. How likely such a desire is in the future is beyond the scope of this report to determine. More importantly, they represent a single point of failure. If the person who maintains the file is unavailable, it will be difficult to use the information. While the rest of the datasets are maintained electronically in one form or another, they are not linked together. Therefore, the programs cannot easily communicate and benefit from each other's strengths. Challenger Soft, as it has been developed to date, will meet this concern for only some of the datasets. As it stands right now Challenger Soft is only working on the program side and issues on the financial side are not yet being addressed. Due to staffing shortages, analysis capacity, both in CMS and in MCH Epi, is lacking.

V. Selection of State Priority Needs

Participants in the five regional meetings identified the following 25 priorities in their communities:

- Access to Services and Health Insurance for the MCH Population
- Asthma
- Breastfeeding
- Child Abuse
- Child and Youth Obesity
- Child/Youth Unintentional Injury
- Cohesion and Reimbursement of Special Needs Services
- Diabetes
- Harm Reduction from Drug Abuse
- Hunger and Food Insecurity
- Immunizations
- Infant Mental Health
- Infant Mortality and Morbidity
- Intimate Partner Violence
- Male Involvement in Family Planning and Fatherhood
- Maternal Depression
- Oral Health
- Positive Youth Development
- Preconception and Prenatal Care
- Rural Access to Services and Providers
- Teen Pregnancy and STDs

- Transition to Adulthood for Children with Special Health Care Needs
- Youth Alcohol and Substance Abuse
- Youth Mental Health
- Youth Violence

V.A. Methods for Selecting the Priorities:

These priorities were identified through a series of regional meetings in each of New Mexico's five regions. The meetings were attended by partners, stakeholders, DOH employees and the general public. Meeting participants, along with DOH managers and staff weighted the priorities according to the following criteria:

Problem has serious health consequences
A large number of individuals are affected by the problem
Disproportionate effects among subgroups of the population
Problem results in significant economic/social cost
Problem is cross-cutting to multiple issues/ life span effect
Potential for problem to be prevented or mitigated.

A score of "1" indicated a higher severity and "5" indicated lower severity. The exception was the last item where "1" indicated that it was highly preventable, and "5" that no resources existed to address it. (See appendix 11 for a complete description of the weighting criteria.)

Once the 25 priorities were identified, the FHB worked with IT to create the online survey. The ranks were tallied, the weights were applied, and the Needs Assessment team developed the following priorities based on these results, and based on the understanding of which priorities were within the scope of the FHB versus those that are key areas of focus for other programs. Many of the priorities identified below encompass more than one of the priorities that ranked highly in the survey. This was particularly true of those relating to maternal care and adolescent behavioral health. A table comparing the 2005 and 2010 priorities is in appendix 12.

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

- Increase accessibility to care for pregnant women and mothers that provides care before, during and after pregnancy
- Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence.
- Increase awareness and availability of family planning and STD prevention options.
- Promote awareness of childhood injury risks and provide injury prevention strategies to families and caregivers of children.
- Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options.

- Increase the proportion of mothers that exclusively breastfeed their infants at six months of age.
- Decrease disparities in maternal and infant mortality and morbidity.
- Promote healthy lifestyle options to decrease obesity and overweight among children and youth.
- Maintain specialty outreach clinics for children and youth with special health care needs.
- 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

Although working with clients and families around transition remains an important part of the care coordination provided by CMS social workers, due to critical staffing shortages and increased caseloads it was felt that CMS needed to re-prioritize and focus on improving the care coordination infrastructure in general for all CYSHCN. In addition, we have prioritized the coordination and staffing of the multidisciplinary pediatric specialty outreach clinics, despite the increased work load carried by the social workers, as we feel these clinics provide a vital network and infrastructure of specialty care to CYSHCN that would otherwise be inaccessible to many families in rural parts of the state.

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.

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. Performance measures that did not meet this criteria were:

SPM 01: pertaining to counties and tribal entities implementing positive youth development strategies. The State does not have the capacity to measure this.

SPM 04: pertaining to children witnessing violence. The team determined that this issue is more appropriately housed with the Children, Youth and Families Division.

SPM 05: pertaining to the healthy birth "index." It is currently not possible, within the capacity of Title V programs, to make significant improvements in all of the six criteria.

SPM 08: pertaining to syphilis screening for new mothers. The needs assessment team determined that other issues are more urgent.

State Performance Measures that were retained were:

- Increase the percent of mothers receiving support services through community home visiting/support programs
- Reduce unintended pregnancy in New Mexico to less than 30% of live births.
- Reduce the proportion of women who report being physically abused by their husband or partner during pregnancy

New state performance measures are:

- Decrease the percent of women with a live birth who had no health care coverage for prenatal care
- Decrease the percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted
- Increase the percent of children under age 12 who are appropriately secured while in a motor vehicle
- Decrease the percent of middle school students that report using alcohol within the past 30 days.
- 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 affect and monitor them are:

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

VI. Outcome Measures - Federal and State

VI.A. Maternal Health

Department of Health FY 11 Performance measures for the Family Health Bureau, Maternal Health Programs include: Decreasing the percent of very low birth weight live births, Increasing the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, Increasing the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester, and increasing the percent of women receiving pre-conceptual, prenatal and postpartum services.

Each of these measures is addressed through existing partnerships with doctors, midwives, institutions and entities in the community that contract with Maternal Health to provide direct services to women of childbearing age. The University of New Mexico, Presbyterian Health Services and a myriad of private practices contract with the Maternal Health Program to provide unlimited access to qualified clients. The High Risk Prenatal Care Fund pays for services through a network of providers within the state. This safety net covers high risk, medically indigent women who would otherwise have no access to care.

The outcomes of these programs are measured in clients served and indicators affected. The number of births the women with low or no prenatal care decreased from 10.8 in 2005 to 8.9 in 2007. The number of low birth weight infants increased from 8.5 in 2005 to 8.9 in 2007 however the percentage of these infants born in facilities for high-risk deliveries increased from 78 to 83 percent in the same time frame. Significant gains in

all outcomes measures are still to be made and efforts to implement effective changes continue.

VI.B. Child Health

MCH Child Health Program does not provide direct services but seeks to educate parents, providers, stakeholders, and early childhood champions regarding issues relevant to the National and State Performance Measures, specifically immunizations, oral health, health insurance, home visiting, children witnessing violence, and motor vehicles crashes and safety. One significant conduit of education is the Early Childhood Action Network (ECAN). Through the work of the ECAN Steering Committee, listserv, and website (www.earlychildhoodnm.com) information is disseminated statewide. Often, once the information has been spread, the constituency will pick up the impetus and work through legislative channels to educate, inform, and make positive changes for the health and well-being of the children of New Mexico.

Families FIRST

Families FIRST (FF) is a case management program of the New Mexico Department of Health, Public Health Division and it is funded by Medicaid to provide perinatal case management to Medicaid eligible pregnant women and children 0-3 years old. The purpose of perinatal case management services is to provide a voluntary home visit to eligible clients, to establish a medical home, and to assist clients in gaining access to needed medical, social and educational services that are necessary to foster positive pregnancy outcomes and promote healthy infants and children in New Mexico. The FF program, with most of our statewide sites being located in the Public Health Offices, assists clients in the application process for Medicaid eligibility as early in a woman's pregnancy as possible. This helps facilitate early access to prenatal care, and early education about pregnancy. Clients are informed of and referred to community support services. All clients are assessed for domestic and sexual violence, received family planning education, are taught the importance of car seat use, and are given educational material about child safety.

For the first time this year the FF program was able to secure funding from the state's Human Services Department to increase the number of pregnant and post partum women screened for signs of possible perinatal mood disorders, and have them referred for evaluation and possible treatment. The plan in the coming years is to continue to secure additional funding to continue this effort. A perinatal mood disorder is highly treatable and has a greater success when identified and treated early in its course.

VI.C. Children and Youth with Special Health Care Needs

The priority setting process has become especially critical in recent years as the state funding for the CYSHCN program has greatly decreased and we have had to decide what to fund and how to allocate our limited financial resources. In addition, the hiring freeze that has been in effect for the past two years has severely limited the program's capacity to hire and several positions have been eliminated from the program. The program has

had to make difficult decisions about how best to use the staff's time and energy. Travel has been extremely restricted and training of staff has become lower in priority as social workers are stretched to maintain services to clients while carrying high caseloads.

Linkages Between Assessment, Capacity and Priorities

CMS begins with assessment of the needs of CYSHCN in the state, looking at the data that is available. Then we assess the capacity to meet the need and determine what the priorities of the program will be, based on funding sources and provider limitations.

An example of this is with the Asthma Summits described above. From the information obtained at the Summits it was clear that asthma rates in New Mexico are higher than the national average, especially in the Southeast corner of the state (and possibly the Northwest although this data is limited due to difficulty with obtaining data from Indian Health Services.)

After obtaining this information the CMS Management team made the decision to allocate funding to increase the number of asthma outreach clinics that would take place around the state. When we met with pulmonologists from UNM, however, it became clear that there was a limit to the number of clinics that the providers could participate in due to their other commitments and the loss of several sub-specialty providers. The CMS program began contracting with Presbyterian Health Services in 2008 and was able to add 10 additional asthma clinics by utilizing the services of the Presbyterian Pediatric Pulmonologist. We are now struggling to maintain the current number of clinics due to cuts to the contract and care and support budgets.

The Newborn Hearing Screening program was concerned that the lost to follow-up rate for infants who did not pass their hospital screen was exceeding the national standards. The current system was developed to encourage community based care whereby the CMS social workers would follow-up with families from the local hospitals. After several years the program realized that this system was not effective. The CMS social worker caseloads were high and priority was given to children with already established special health care needs. With additional funding from the CDC the program reevaluated the current system and decided to restructure follow-up. The process was centralized and a follow-up Coordinator was hired. This reorganization has significantly reduced the time between discharge from the hospital and first contact with the Coordinator. The program also received feedback from the Newborn Hearing Screening advisory committee regarding gaps in coverage for pediatric audiology specifically diagnostic services. When supplemental funding was available from MCHB this need was prioritized based on years of feedback from providers and community partners. Several initiatives are now underway: diagnostic equipment was purchased for a practice in the Southeast; hands on training on diagnostic procedures for audiologists; a telehealth project in Gallup NM.

Strengths and Weaknesses of the Process

The National Survey of Children with Special Health Care Needs, feedback from the numerous advisory boards and community partners assist the CMS program identifying priorities. Limitations occur around implementation based on fiscal constraints with the State budget especially the past few years. The statewide hiring freeze has resulted in a 30% vacancy rate for CMS. The remaining staff have struggled to cover caseloads and meet the core needs of CYSHCN.

VII. Needs Assessment Summary

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:

The program capacity in New Mexico has suffered from budget cuts resulting in the November, 2008 hiring freeze and subsequent staffing shortages. Children's Medical Services has been particularly hard-hit; nurses and clerks are exempted from the hiring freeze, but social workers are not. Social workers are traveling long distances to cover vacancies, as entire counties would otherwise lack CYSHCN care coordination services.

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. The dearth of pediatric subspecialists and pediatric dentists in most NM counties makes access to needed care especially difficult for CYSHCN.

Program and system capacity have increased in many areas. Obesity surveillance, legislation toward injury prevention and domestic violence reporting, and 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 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. The Newborn Genetic Screening program has responded to the legislative request to add conditions to the newborn screening panel, and is investigating the feasibility of participating in pilot studies of new screening techniques for lysosomal storage disorders.

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.

Glossary of Acronyms and Abbreviations

A	AAP	American Academy of Pediatrics
	ASQ	Ages & Stages Questionnaire
B	BBER	Bureau of Business and Research, University of New Mexico
	BEHR	Billing Electronic Health Record
	BRFSS	Behavioral Risk Factor Surveillance System
C	CAPTA	Child Abuse Prevention and Treatment Act
	CASSP	Child and Adolescent Services System Program
	CCHC	Child Care Health Consultant
	CDC	Centers for Disease Control and Prevention
	CMS	Children's Medical Services
	CYFD	Children, Youth, and Families Department
	CYSHCN	Children and youth with special health care needs
D	D/HH	Deaf/Hard of Hearing
	DDS	Disability Determination Services program
	DHHS	U.S. Department of Health and Human Services
	DOH	Department of Health
	DRA	Deficit Reduction Act
	DSI	Developmental Screening Initiative
	DVR	Division of Vocational Rehab
E	ECAN	Early Childhood Action Network
	ECCS	Early Childhood Comprehensive Systems
	ECP	Emergency Contraception Pill
	EHDI	Early Hearing Detections and Intervention
	EI	Early Intervention
	EPICS	Educating Parents of Indian Children with Special needs
	EPSDT	Early Periodic Screening Diagnostics and Treatment
	ER	Emergency Room
	ERD	Epidemiology and Response Division
F	FF	Families FIRST
	FHB	Family Health Bureau
	FIT	Family Infant Toddler
	FIT KIDS	Key Information Data System
	FLAN	Family Leadership Action Network
	FPL	Federal Poverty Level
	FPP	Family Planning Program
H	HIDD	Hospital In-patient Discharge Data
	HIPAA	Health Insurance Portability and Accountability Act
	HPC	Health Policy Commission

New Mexico Title V Maternal and Child Health Block Grant 2010 Needs Assessment

	HPSA	Health Professional Shortage Area
	HRF	High Risk Prenatal Care Fund
	HRSA	Health Resources and Services Administration
	HV	Home Visiting
I	IAA	Inter-Agency Agreement
	ICC	Interagency Coordinating Council
	IDEA	Individuals with Disabilities Act
	INPHORM	The Integrated Network for Public Health Official Records Management
	ISD	Income Support Division
	ITSD	Information Technology and Services Division
L	LAUNCH	Linking Actions for Unmet Needs in Children's Health
M	LBW	Low Birth Weight
	MANA	Midwives Alliance of North America
	MCH	Maternal and Child Health
	MCH Epi	Maternal and Child Health Epidemiology
	MCHB	Maternal and Child Health Bureau
	MCO	Managed Care Organization
	MFM	Maternal-Fetal Medicine
	MOSSA	Medicaid On Site Application Assistance
	MSD	Medical Services Division
	MVC	Motor Vehicle Collision
N	NBGS	Newborn Genetic Screening
	NBH	Newborn Hearing
	NBHS	Newborn Hearing Screening program
	NHANES	National Health and Nutrition Examination Surveys
	NM BFTF	New Mexico Breastfeeding Task Force
	NM HSD	New Mexico Human Services Department Medical Assistance Division
	MAD	
	NMAC	New Mexico Asthma Coalition
	NMACNM	the New Mexico chapter of the American College of Nurse Midwives
	NMDOH	New Mexico Department of Health
	NMMA	the New Mexico Midwives Association
	NMMIP	New Mexico Medical Insurance Pool
	NMSA	New Mexico Statutes Annotated
	NMSD	New Mexico School for the Deaf
	NMSKC	New Mexico SAFE KIDS Coalition
	NMTPC	New Mexico Teen Pregnancy Coalition
	NMVRHS	New Mexico's Bureau of Vital Records and Health Statistics
	NSCSHCN	National Survey of Children with Special Health Care Needs
O	OB GYN	Obstetrician/Gynecologist
	OIP	Office of Injury Prevention
	OSPHL	Oregon State Public Health Lab
P	PALS	Physician Access Line for Service

New Mexico Title V Maternal and Child Health Block Grant 2010 Needs Assessment

	PCP	Primary Care Provider
	PED	Public Education Department
	PHD	Public Health Division
	PHOs	Public Health Offices
	PRAMS	New Mexico Pregnancy Risk Assessment Monitoring System
	PRO	Parents Reaching Out
R	RPHCA	Rural Primary Health Care Act
S	S.M.A.R.T	Specific, Measureable, Attainable, Realistic and Timely
	SAMHSA	Substance Abuse and Mental Health Services Administration
	SCHIP	State's Child Health Insurance Program
	S-CHIP	State Children's Health Insurance Program
	SIDS	Sudden Infant Syndrome
	SNAP	The Supplemental Nutrition Assistance Program
	SSDI	State Systems Development Initiative
	STD	Sexually Transmitted Diseases
T	TANF	Temporary Assistance for Needy Families
	Taos	
	M.E.N	Taos Men Engaged in Nonviolence
	TOP	Teen Outreach Program
U	UNM	University of New Mexico
	UNM	University of New Mexico's Bureau of Business and Economic
	BBER	Research
	UNM	University of New Mexico Extension of Community
	ECHO	Healthcare Outcomes
	UNM	University of New Mexico Interdisciplinary Leadership
	LEND	Training Program
W	WIC	Women, Infant, Children
	WISQARS	Web-based Injury Statistics Query and Reporting System
Y	YRBS	Youth Risk Behavior Survey
	YRRS	Youth Risk and Resiliency Survey
	YSHCN	Youth with Special Healthcare Needs

- ¹ HRSA <http://mchb.hrsa.gov/programs/blockgrant/overview.htm>
- ² <http://weather.nmsu.edu/News/climate-in-NM.htm>
- ³ University of New Mexico Bureau of Business and Economic Research <http://bber.unm.edu/>
- ⁴ NSCH <http://www.nschdata.org/Content/Default.aspx>
- ⁵ Kaiser State Health Facts <http://www.statehealthfacts.org/>
- ⁶ New Mexico Public Education Department <http://www.ped.state.nm.us/>
- ⁷ University of New Mexico Bureau of Business and Economic Research <http://bber.unm.edu/>
- ⁸ New Mexico Voices for Children <http://www.nmvoices.org/familybudgetcalculator.htm>
- ⁹ Department of Workforce Solutions <http://www.dws.state.nm.us/LMI/dws-surr.html>
- ¹⁰ US Census <http://quickfacts.census.gov/qfd/index.html>
- ¹¹ University of New Mexico Bureau of Business and Economic Research <http://bber.unm.edu/>
- ¹² HRSA <http://hpsafind.hrsa.gov/>
- ¹³ Kaiser State Health Facts <http://www.statehealthfacts.org/>
- ¹⁴ Annie E. Casey Kids Count Data Center <http://datacenter.kidscount.org/>
- ¹⁵ <http://www.womenscommission.state.nm.us/Publications/FY%2008%20Annual%20Report.pdf>
- ¹⁶ http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ¹⁷ http://www.nmvoices.org/attachments/nmhc_databook_09.pdf
- ¹⁸ <http://nmchildrenscabinet.com/2009Report.pdf>
- ¹⁹ <http://nmhealth.org/ERD/HealthData/yrrs.shtml>
- ²⁰ <http://nmhealth.org/pdf/NMDOHfy10StrategicPlan.pdf>
- ²¹ NMVRHS http://www.vitalrecordsnm.org/documents/2007_AR_Volume1MLok_111209awgraphs.pdf
- ²² NMVRHS http://www.vitalrecordsnm.org/documents/2007_AR_Volume1MLok_111209awgraphs.pdf
- ²³ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ²⁴ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ²⁵ NMVRHS http://www.vitalrecordsnm.org/documents/2007_AR_Volume1MLok_111209awgraphs.pdf
- ²⁶ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ²⁷ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ²⁸ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ²⁹ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ³⁰ NM BRFS, 2006 data. Data provided by the NM Diabetes Prevention and Control Program.
- ³¹ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ³² NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ³³ NMVRHS http://www.vitalrecordsnm.org/documents/2007_AR_Volume1MLok_111209awgraphs.pdf
- ³⁴ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ³⁵ CDC National Immunization Survey <http://www.cdc.gov/nis/>
- ³⁶ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ³⁷ NM PRAMS http://www.health.state.nm.us/phd/prams/DOH%20PRAMS%20Report_WEB.pdf
- ³⁸ Kaiser State Health Facts <http://www.statehealthfacts.org/>
- ³⁹ Annie E. Casey Kids Count Data Center <http://datacenter.kidscount.org/>
- ⁴⁰ Kaiser State Health Facts <http://www.statehealthfacts.org/>
- ⁴¹ Annie E. Casey Kids Count Data Center <http://datacenter.kidscount.org/>
- ⁴² NM Office of Injury Prevention
- ⁴³ CDC NHANES <http://www.cdc.gov/nchs/nhanes.htm>
- ⁴⁴ NM WIC program
- ⁴⁵ NM YRRS <http://nmhealth.org/ERD/HealthData/yrrs.shtml>
- ⁴⁶ NM YRRS <http://nmhealth.org/ERD/HealthData/yrrs.shtml>
- ⁴⁷ NM YRRS <http://nmhealth.org/ERD/HealthData/yrrs.shtml>
- ⁴⁸ NM YRRS <http://nmhealth.org/ERD/HealthData/yrrs.shtml>
- ⁴⁹ NM Office of Oral Health
- ⁵⁰ NM YRRS <http://nmhealth.org/ERD/HealthData/yrrs.shtml>

Appendix 1 -- Regional Needs Assessment Meeting Participants

Last	First	Position
Region I Needs Assessment Meeting Participants (7/28/09)		
Murison	Lynn	DOH
Ruple	Dottie	DOH
Thomas	Wilann	San Juan Safe Communities Initiative
Miller	Anne H.	San Juan Regional Medical Center
Valencia	Pete	congressman Ben R. Lujan
Scherver	Barbara	PMS/Farmington Community Health Center
Mrzlak	Rebecca	San Juan Regional Medical Center
Groblebe	Michele	DOH
flores	Yolanda	DOH
Orrantia	Norma	DOH WIC
Zuhrt-Brew	Anne H.	Optum Health
Crossley	Becky	DOH
Trujillo	Alice	San Juan County College
Walker	Barbara	central consolidated
Region II Needs Assessment Meeting Participants (7/31/09)		
Asher	Susan	Social Worker
Sandoval	Barbara	Social Worker
Cruz	Yolanda	Health Council
Belanger	Theresa	Medical Social Worker
Kirby	Carole	Nurse Epidemiologist
Biles	Mary Helen	Care Coordinator
Fisher	Valerie	Family Planning
Herrera	Craig	CMS Social Worker
Schalch	Kim	CMS/FIT
Granito-Tibbets	Michaela	CMS/FIT
Abeyta	Diana	CHI DOH Region 2
Garcia	Lisa	MCH Council Coordinator
Krassner	Madelyn	CMS Region 2 Program Manager
Brown	Laura	Physician
Matthews	Elizabeth	FHB Medical Director
Merrill	Susan	CMS
Moore	Roberta	Maternal Health Program Manager
Martinez	Emelda	Chief, FHB
Battiston	Laura	WIC supervisor
Cordova	Jessica	Health Education Manager
Straus	Kim	Brindle Foundation
Chacon	Susan	CMS
Panagakos	Marcia	Social Worker Christus St. Vincent
Berliner	Elena	Health Promotion Specialist
Daniel	Kate	Region II Epidemiologist
Henderson	Valery	LN IBCLC Region II
Region III Needs Assessment Meeting Participants (11/03/08)		

Schesser	Carol	UNMH Maternity & Family Planning
Montoya	Jerry	DOH/PHD
Elliot	Robyn	NM DOH
Magnusson	Mary	NM DOH
Mason	Leigh	Bernalillo Co. Community Health Council
Syed	Rubina	DOH/OSAH
Mason	Janet	NM DOH-PH NEHO OSAH
Farmer	Jim	NMDOH/PHD/OSAH
Williams	Alicia	Reg 1,3/ CMS
Medina-Lucero	Tessa	NMDOH OSAH
Baca	Judy	Reg 3 Health Promotion
Birkhauser	Debbie	NM Alliance for school based health care
Bader	Donna	APS Nursing Services
Tafoya	Jessica	NMTPC
Valencia	Robert	NM Young Fathers Project
Meyer	Mary	WIC Sandoval Health Commons
Kistin	Naomi	WIC Sandoval Health Commons
Fishburn	Peter	NMDOH/PHD
Region IV Needs Assessment Meeting Participants (11/17/08)		
Lara	Shanna	WIC
Blatnik	Margie	WIC
Garcia	Marty	WIC
Collins	Patty	Lea County Health Council
Lara	Jeff	Health Promotion
Doyle	Lila	reach 2000/MCH program
Morrow	Julie	NM DOH OPCHI
Bell	Andrea	Curry County Wellness Council
Burch	Erinn	Curry County Wellness and United Way
Marney	Terri	Curry County Wellness Council
Trujillo	Rebecca	NMDOH/OSAH
Ellington	Dyan	NMDOH/TUPAC
Orozco	Alissa	NNDOH/CMS
Wier	Teri	NMDOH/CMS
Sillivent	Lynn	NMDOH/CMS
Region V Needs Assessment Meeting Participants (8/28/09)		
Humes	Humes	MVPRC Executive Director
Henry	Laura	HHS Alliance Facilitator
Myers	John	DAC Alliance
Mares	Claudia	DAC-HHS youth initiative coordinator
Sanchez	Molly	LCDF Early Head Start Director
Garcia	Jonah	LCDF Healthy Start Program Director
Carver	Angelina	Mesilla Valley Healthcare FNP
Cline	Betty	SGHHFL Family Outreach
Carver	Keith	Bair Foundation Primary Care Parent

goodman	melanie	senator bingaman's office
jimenez	Lillian	MVPRC Coordinator
Flores	Janet	NMDOH Epidemiologist
Beers	Beth	SGHHFL Family Outreach project director

Appendix 2 – Invitations and Agenda for Regional Meetings

Please attend the Title V Maternal & Child Health Block Grant Comprehensive Needs Assessment Region I Meeting

Tuesday, July 28 2009
10:00am – 3:00pm

San Juan Community College Suns Room
4601 College Boulevard, Farmington, NM

The federal funding agency, the U.S. Department of Health and Human Services, Health Resources and Services Administration (DHHS/HRSA), requires that a statewide MCH/CYSCHN needs assessment be conducted every five years for two main purposes: 1) in order to receive federal funds, and 2) to help states make the most appropriate program and policy decisions that promote the health of women, children, adolescents, CYSHCN and their families.

The purpose of this meeting is to determine and rank the priority needs for Northwest area. These priorities will be added to those determined by the other four regions, and results will be included in the Needs Assessment for the 2010-2015 period. Both HRSA and the New Mexico Department of health will use these results to make funding and programming decisions that serve the Maternal and Child Health population.

Input from state government staff, stakeholders, and community partners is vital. Your input will enable us to conduct a needs assessment that is accurate and relevant to MCH public health programming in your region.

The last needs assessment was submitted to DHHS/HRSA in 2005. It is available at <http://www.health.state.nm.us/TitleV/> You are encouraged look at the 2005 Needs Assessment before the meeting.

Agenda

10:00-10:30	Greetings and Introductions
	Overview of the Title V Block Grant and Needs Assessment – Guidance, Indicators, and Measures
10:30-12:00	Q-Sort priorities
12:00-1:00	Lunch on your own
1:00-2:30	Complete Q-Sort and select priority areas
2:30-3:00	Wrap-up and next steps

**Please attend the Title V Maternal & Child Health Block Grant
Comprehensive Needs Assessment Region II Meeting**

**Santa Fe, Friday, July 31 2009
Rosemont Assisted Living Center
2961 Galisteo Rd. Santa Fe, NM 87505
10:00am – 3:00pm**

The federal funding agency, the U.S. Department of Health and Human Services, Health Resources and Services Administration (DHHS/HRSA), requires that a statewide MCH/CYSHCN needs assessment be conducted every five years for two main purposes: 1) in order to receive federal funds, and 2) to help states make the most appropriate program and policy decisions that promote the health of women, children, adolescents, CYSHCN and their families.

The purpose of this meeting is to determine and rank the priority needs for Region II. These priorities will be added to those determined by the other four regions, and results will be included in the Needs Assessment for the 2010-2015 period. Both HRSA and the New Mexico Department of health will use these results to make funding and programming decisions that serve the Maternal and Child Health population.

Input from state government staff, stakeholders, and community partners is vital. Your input will enable us to conduct a needs assessment that is accurate and relevant to MCH public health programming in your region.

The last needs assessment was submitted to DHHS/HRSA in 2005. It is available at <http://www.health.state.nm.us/TitleV/> You are encouraged look at the 2005 Needs Assessment before the meeting.

Agenda

10:00-10:30	Greetings and Introductions
	Overview of the Title V Block Grant and Needs Assessment – Guidance, Indicators, and Measures
10:30-12:00	Q-Sort priorities
12:00-1:00	Lunch - working lunch – either pack a lunch or bring cash for take out sandwich order
1:00-2:30	Complete Q-Sort and select priority areas
2:30-3:00	Wrap-up and next steps

**You are invited to the Title V Maternal & Child Health Block Grant
Comprehensive Needs Assessment Region III Meeting**

Albuquerque, November 3rd, 2008
United Way 2340 Alamo SE 2nd Floor Training Center
9:00am-4:15pm

The purpose of this meeting is to 1) determine the regional needs in 10 priority areas, and 2) to explore how the annual Title V multi-million dollar grant can best be used to serve New Mexico's MCH population.

Input from state government staff and community partners is vital. Your input will enable us to conduct a needs assessment that is accurate and relevant to MCH public health programming in your region.

The last needs assessment was submitted to DHHS/HRSA in 2005. It is available at <http://www.health.state.nm.us/TitleV/> You are encouraged look at the 2005 Needs Assessment before the meeting.

Agenda

- 9:00-10:30** **Greetings and Introductions**
Overview of the Title V Block Grant and Needs Assessment – Guidance, Indicators, and Measures
- 10:30-10:45** **Break (snacks provided)**

10:45-12:15 **Working Groups I**

Immigrants and MCH	Access to/use of health care; Insurance Coverage	Transition and CYSHCN	Preconception and Prenatal Issues	Positive Youth Development
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12:15-1:15 **Lunch**

1:15-2:45 **Working Groups II**

Obesity	Teen Births and Chlamydia	Violence	Male Involvement and Fatherhood	Unintentional Injury
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2:45-3:00 **Break (snacks provided)**

3:00-3:45 **Presentation of results from working groups**

3:45-4:15 **Wrap up and next steps**

**You are invited to the Title V Maternal & Child Health Block Grant
Comprehensive Needs Assessment Region IV Meeting**

Roswell, November 17th, 2008\
Region IV Administrative Office
#9 E. Challenger
9:00am-4:15pm

The purpose of this meeting is to 1) determine the regional needs in 10 priority areas, and 2) to explore how the annual Title V multi-million dollar grant can best be used to serve New Mexico's MCH population.

Input from state government staff and community partners is vital. Your input will enable us to conduct a needs assessment that is accurate and relevant to MCH public health programming in your region.

The last needs assessment was submitted to DHHS/HRSA in 2005. It is available at <http://www.health.state.nm.us/TitleV/> You are encouraged look at the 2005 Needs Assessment before the meeting.

Agenda

9:00-10:30 Greetings and Introductions
Overview of the Title V Block Grant and Needs Assessment –
Guidance, Indicators, and Measures

10:30-10:45 Break (snacks provided)

10:45-12:15 Working Groups I

Immigrants and MCH	Access to/use of health care; Insurance Coverage	Transition and CYSHCN	Preconception and Prenatal Issues	Positive Youth Development
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12:15-1:15 Lunch

1:15-2:45 Working Groups II

Obesity	Teen Births and Chlamydia	Violence	Male Involvement and Fatherhood	Unintentional Injury
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2:45-3:00 Break (snacks provided)

3:00-3:45 Presentation of results from working groups

3:45-4:15 Wrap up and next steps

**Please attend the Title V Maternal & Child Health Block Grant
Comprehensive Needs Assessment Region V Meeting**

Friday, August 28, 2009

**NM Farm and Ranch Heritage Museum, Organ View Room
4100 Dripping Springs Rd
Las Cruces, NM 88011**

10:00am – 3:30pm

The federal funding agency, the U.S. Department of Health and Human Services, Health Resources and Services Administration (DHHS/HRSA), requires that a statewide MCH/CYSCHN needs assessment be conducted every five years for two main purposes: 1) in order to receive federal funds, and 2) to help states make the most appropriate program and policy decisions that promote the health of women, children, adolescents, CYSCHN and their families.

The purpose of this meeting is to determine and rank the priority needs for Region II. These priorities will be added to those determined by the other four regions, and results will be included in the Needs Assessment for the 2010-2015 period. Both HRSA and the New Mexico Department of health will use these results to make funding and programming decisions that serve the Maternal and Child Health population.

Input from state government staff, stakeholders, and community partners is vital. Your input will enable us to conduct a needs assessment that is accurate and relevant to MCH public health programming in your region.

The last needs assessment was submitted to DHHS/HRSA in 2005. It is available at <http://www.health.state.nm.us/TitleV/> You are encouraged look at the 2005 Needs Assessment before the meeting.

Agenda

10:00-10:30	Greetings and Introductions
	Overview of the Title V Block Grant and Needs Assessment – Guidance, Indicators, and Measures
10:30-12:00	“Weighting” priorities
12:00-1:30	Lunch
1:30-3:00	Q-Sort priorities
3:00-3:30	Wrap-up and next steps

Instructions - Windows Internet Explorer provided by Department of Health
 http://www.nmhealth.org/itlev/survey/Instructions.html

This survey is anonymous. Participation in this survey is voluntary, and does not affect your eligibility for services or benefits from the State of New Mexico. The State of New Mexico is an Equal Opportunity Provider and Employer.

Home > Instructions

Home Instructions Priorities [Begin Survey Here](#)

Priorities

- [Access to Care](#)
- [Asthma](#)
- [Breast-feeding](#)
- [Child Abuse](#)
- [Child-Youth Injury](#)
- [Child-Youth Obesity](#)
- [Diabetes](#)
- [Harm Reduction](#)
- [Hunger](#)
- [Immunizations](#)
- [Infant Mental Health](#)
- [Infant Mortality & Morbidity](#)
- [Intimate Partner Violence](#)
- [Male Involvement](#)
- [Maternal Depression](#)
- [Oral Health](#)

Instructions

Demographics: Before taking our survey, please take the time to fill out this short demographics section. After you submit the information, you will be directed to the Priorities Pyramid. Please answer these questions FIRST.

Pyramid: The Pyramid is made up of 25 empty boxes, and on the left are 25 "Priorities". Please Click, Hold and Drag each "Priority" into an empty box in the pyramid according to how YOU think they should be ranked. Which issues are the most important or urgent in your community? There is no right or wrong order. We want YOUR opinion! The most important/urgent priority goes in box #1, the least important or urgent priority in box #25. Please do this after answering the Demographics questions.

Special Note: Towards the end of the survey, you may need to Click, Hold, SCROLL (using the mouse wheel) and Drag the priority to get to the bottom.

Priorities: When you select an issue, its full name and a brief definition will open in a new tab. If you wish to know more about an issue, click on the link in the balloon and it will take you to a detailed "issue brief."

[Watch a Video Demonstration](#)



The video demonstration shows a list of 25 health priorities on the left side of the screen. A pyramid structure is shown in the center, consisting of 25 empty boxes arranged in a pyramid shape (1 box at the top, 2 boxes in the second row, 3 in the third, 4 in the fourth, 5 in the fifth, 4 in the sixth, 3 in the seventh, 2 in the eighth, and 1 at the bottom). The video shows a user clicking on a priority from the list and dragging it into one of the boxes in the pyramid.

Start | OnlineQ - Microsoft Outlook | PW: Transmission of a H... | RE: note about pyramid... | C:\Documents and Settin... | APPX.01 Pyramid Left2Rt... | Document1 - Microsoft... | Document2 - Microsoft... | Instructions - Windo... | 11:03 AM

Demographics - Windows Internet Explorer provided by Department of Health
http://www.nmhealth.org/titlev/survey/Demographics.html

NEW MEXICO DEPARTMENT OF HEALTH Health Priorities Survey
This survey is anonymous. Participation in this survey is voluntary, and does not affect your eligibility for services or benefits from the State of New Mexico. The State of New Mexico is an Equal Opportunity Provider and Employer.

Home > Instructions > Demographics
Home Instructions Priorities → [Begin Survey Here](#) ←

Demographics: Please answer the personal description information below. You may skip any question, but please answer as many as you can to help us determine which issues are most important to which groups of New Mexicans.
If you are unable to complete this survey online and you would like to have your responses recorded, please call the Title V office at 505-476-8892. Your identity will be kept confidential and will not be recorded.

Sex: Male Female

Age: 18 or younger

What is your Race? (check all that apply)
Black or African-American
American Indian/Alaska Native
Asian or Pacific Islander
White

What is your Ethnicity? (check all that apply)
Hispanic or Latino
Non-Hispanic
Native American
Other/Unknown

Household Income Level: \$0-\$20,000 per year

How many people live in your household? 1

County of Residence: Bernalillo

Are you currently a parent or primary caregiver for a child or children? Yes No

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Pyramid Survey - Windows Internet Explorer provided by Department of Health

http://www.nhhealth.org/titlev/survey/pyramidsurvey.php

File Edit View Favorites Tools Help

Pyramid Survey

Special Notes: If you are unable to complete this survey online and you would like to have your responses recorded, please call the Title V office at 505-476-8892. Your identity will be kept confidential and will not be recorded.

[Read Detailed Instructions](#) or [Watch a Video Demonstration](#)

Child Abuse

Child-Youth Injury

Child-Youth Obesity

Diabetes

Harm Reduction

Hunger

Immunizations

Infant Mental Health

Infant Mortality & Morbidity

Intimate Partner Violence

Male Involvement

Maternal Depression

Oral Health

Positive Youth Development

Prenatal Care

Rural Access

Special Needs Services

Special Needs Transition

Teen Pregnancy & STDs

Priority 1

Priority 2

Priority 3

Priority 4

Priority 5

Priority 6

Priority 7

Priority 8

Priority 9

Priority 10

Priority 11

Priority 12

Priority 13

Priority 14

Priority 15

Priority 16

Priority 17

Priority 18

Priority 19

Priority 20

Priority 21

Priority 22

Priority 23

Priority 24

Priority 25

Done

Start OnlineQ - Microsoft Outlook FW: Transmission of a H... RE: note about pyramid ... C:\Documents and Settin... APPX 01 Pyramid Left2Rt... Pyramid Survey - Win... Internet 100% 10:59 AM

Results from the New Mexico Online Survey of Maternal and Child Health Priorities

April, 2010



Results from the New Mexico Online Survey of Maternal and Child Health Priorities

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Maternal and Child Health Priority Ranks by Administrative or Clinical Health Care Professional	41
Maternal and Child Health Priority Ranks by Government and Non-Government Employment	44
Maternal and Child Health Priority Ranks by Education	47

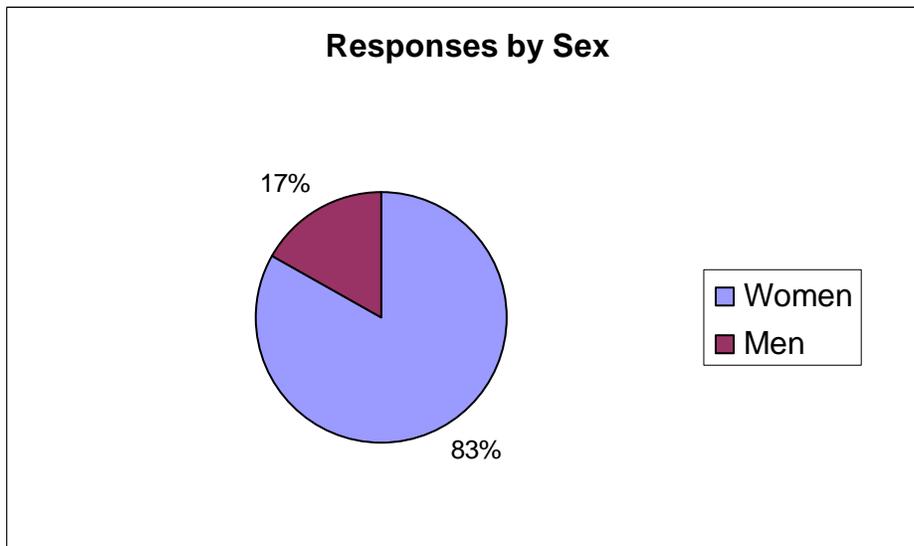
I. Characteristics of Respondents to the Online Maternal and Child Health Priorities Survey (Demographics)

There were 518 complete responses collected between March 9 and April 5, 2010.

Note: percentages do not always total to 100 because of rounding and unreported data. Demographic numbers do not always add up to the total number of responses because of missing data.

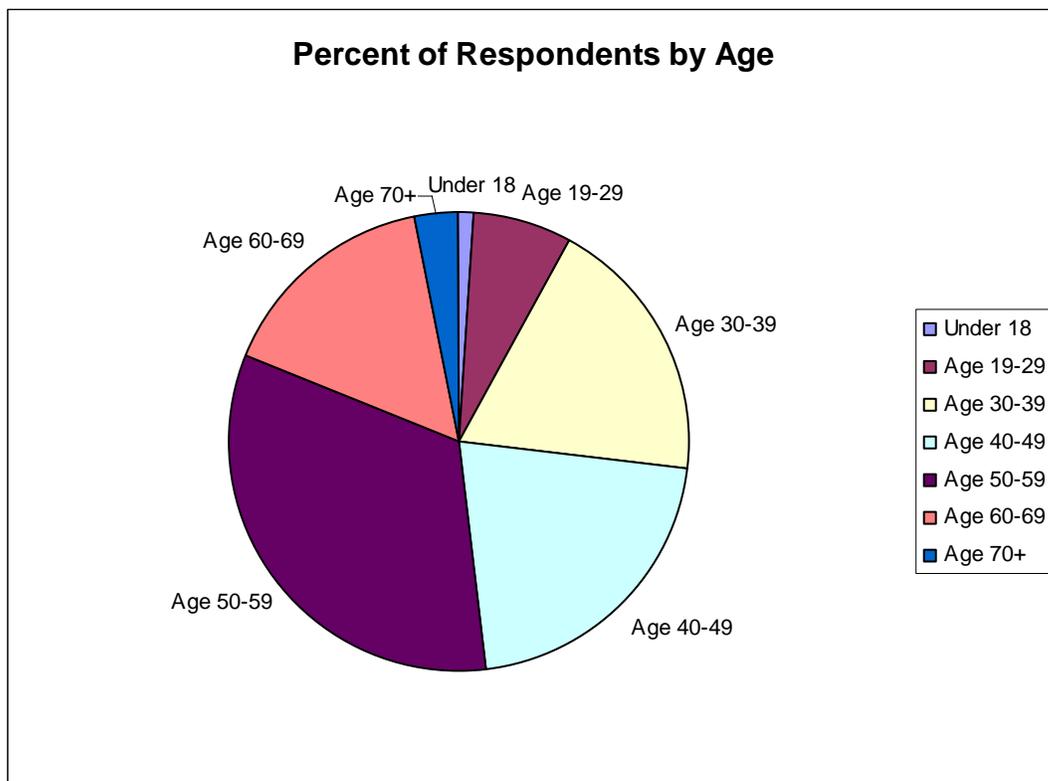
Responses by Sex:

425 women and 87 men responded.



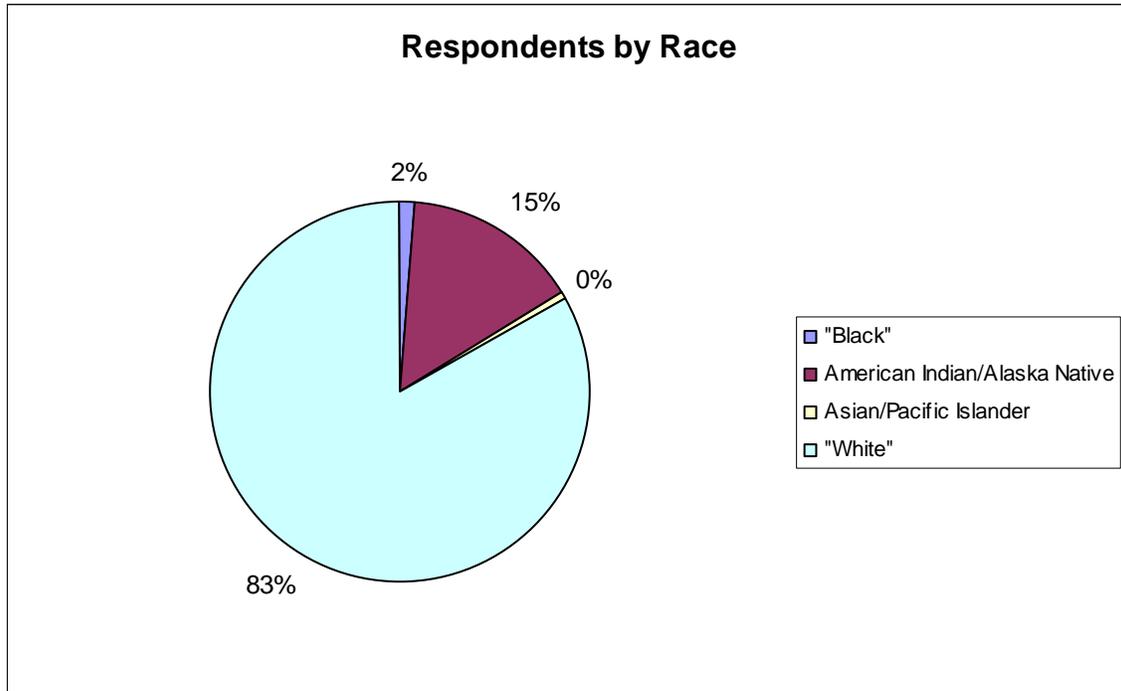
Responses by age-group:

- 1% of respondents were under age 18
- 7% were age 19-29
- 19% were age 30-39
- 21% were age 40-49
- 33% were age 50-59
- 16% were age 60-69
- 3% were age 70 and older



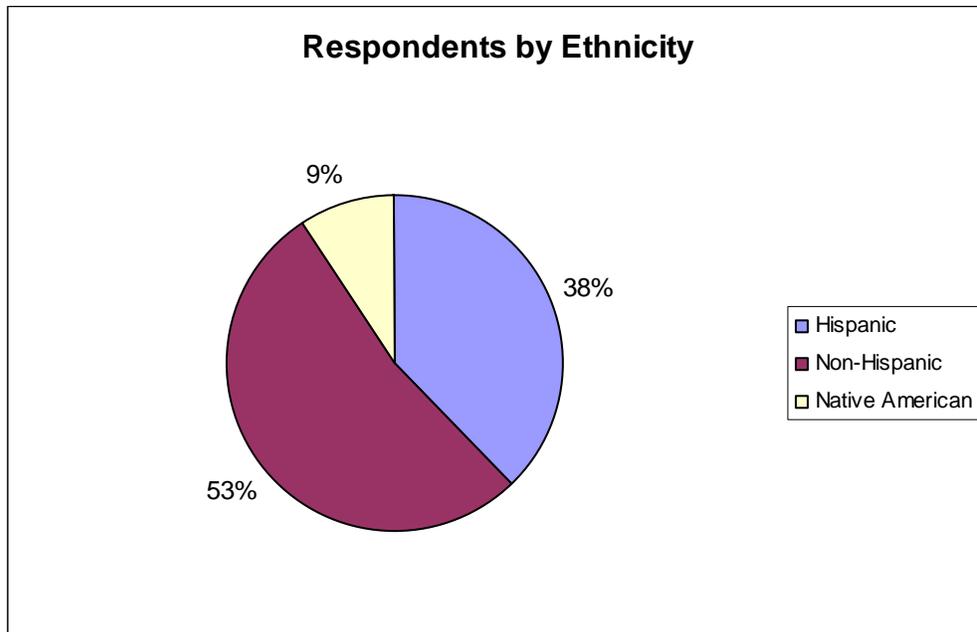
Responses by Race:

There were 7 “Black” respondents, 69 American Indian/Alaska Native respondents, 2 Asian/Pacific Islander respondents, and 384 were “White”.



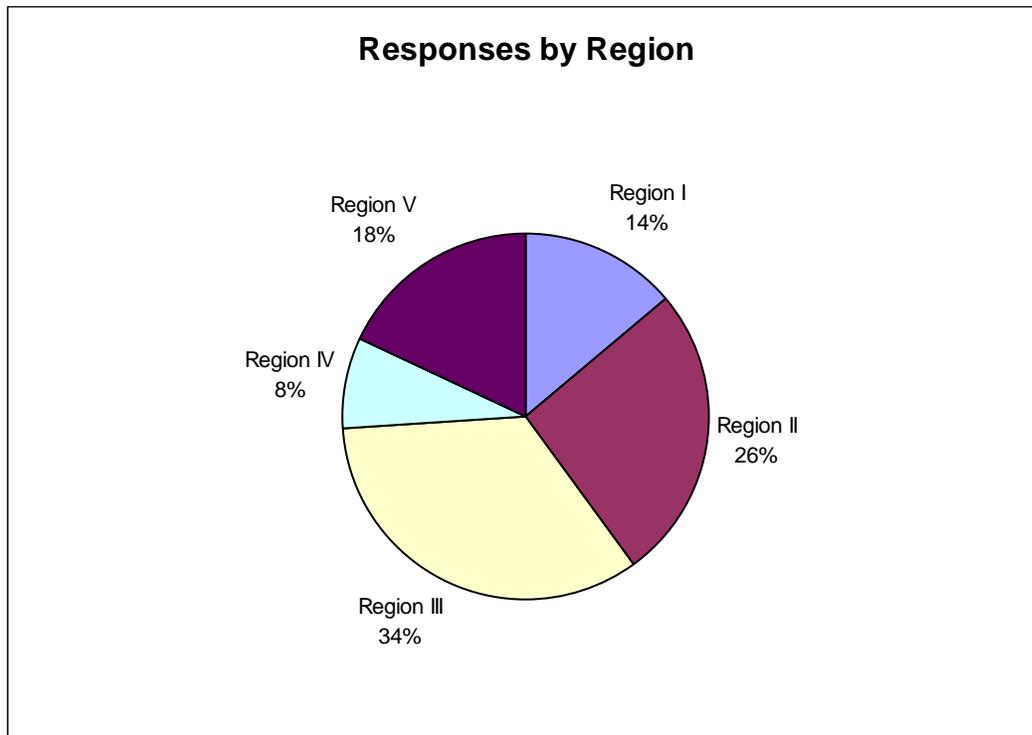
Responses by Ethnicity:

169 respondents were Hispanic, 236 were non-Hispanic, and 41 were Native American.

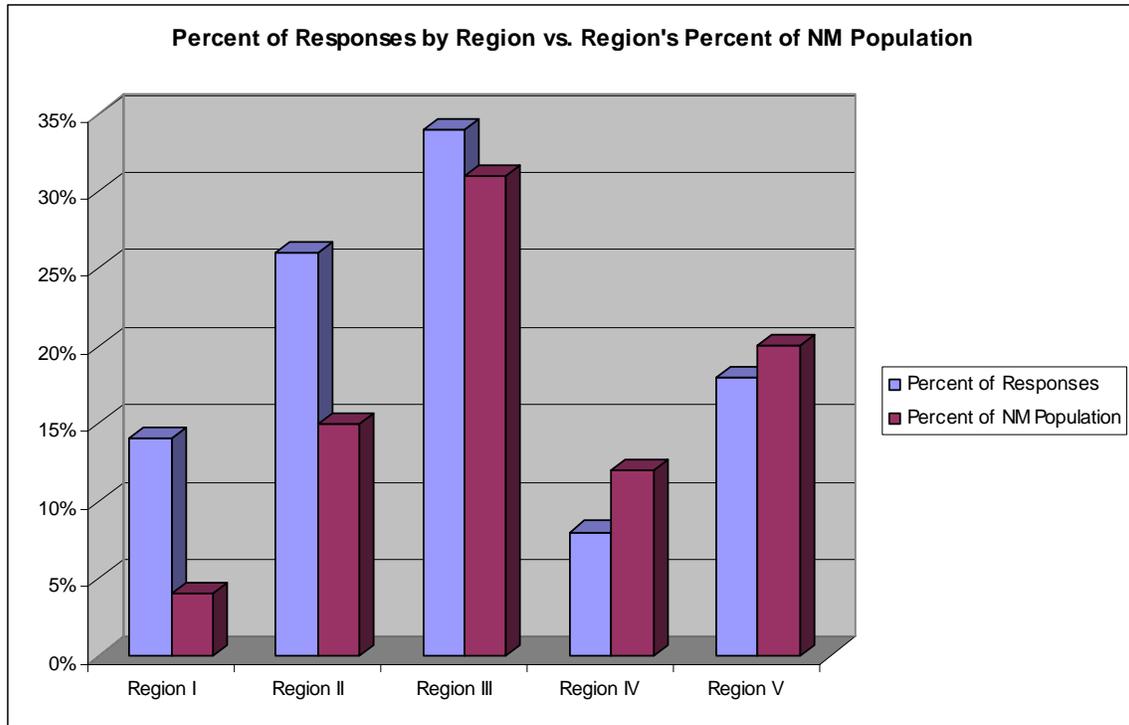


Responses by Region:

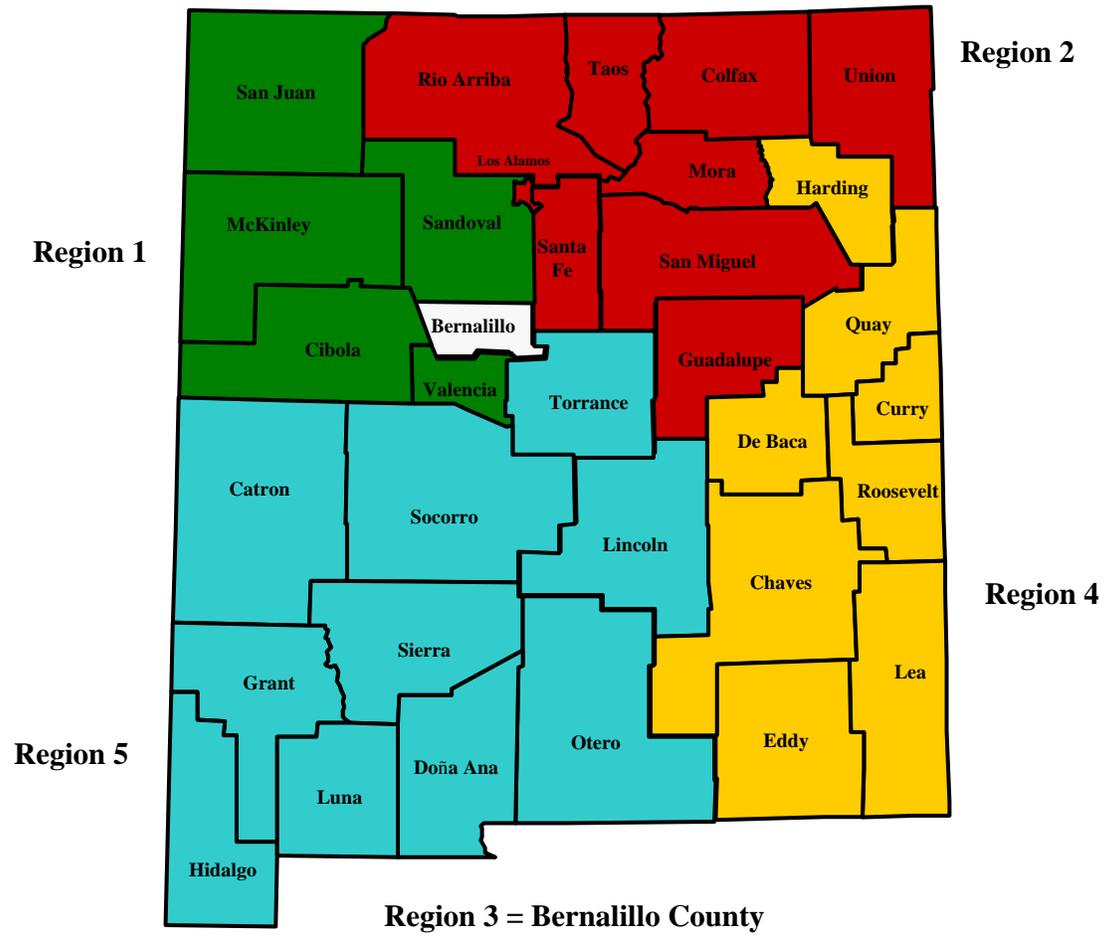
- 14% (75) of responses came from region one, which represents 4% of the NM population
- 26% (133) of responses came from region two, which represents 15% of the NM population
- 34% (174) of responses came from region three, which represents 31% of the NM population
- 8% (42) of responses came from region four, which represents 12% of the NM population
- 18% (94) of responses came from region five, which represents 20% of the NM population



Reponses by Region, continued.

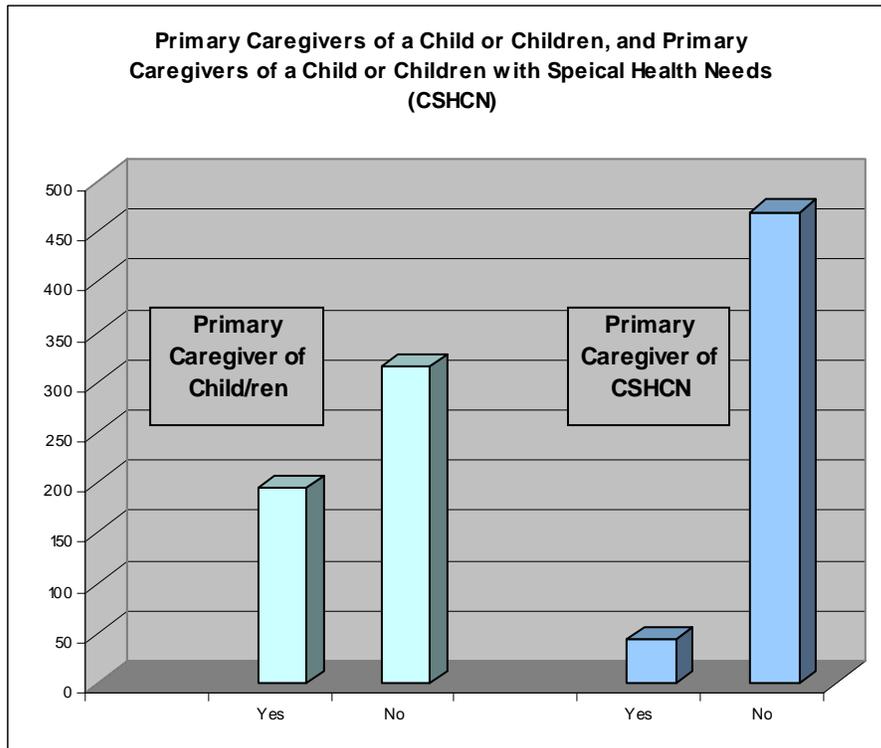


Map of Public Health Division Regions



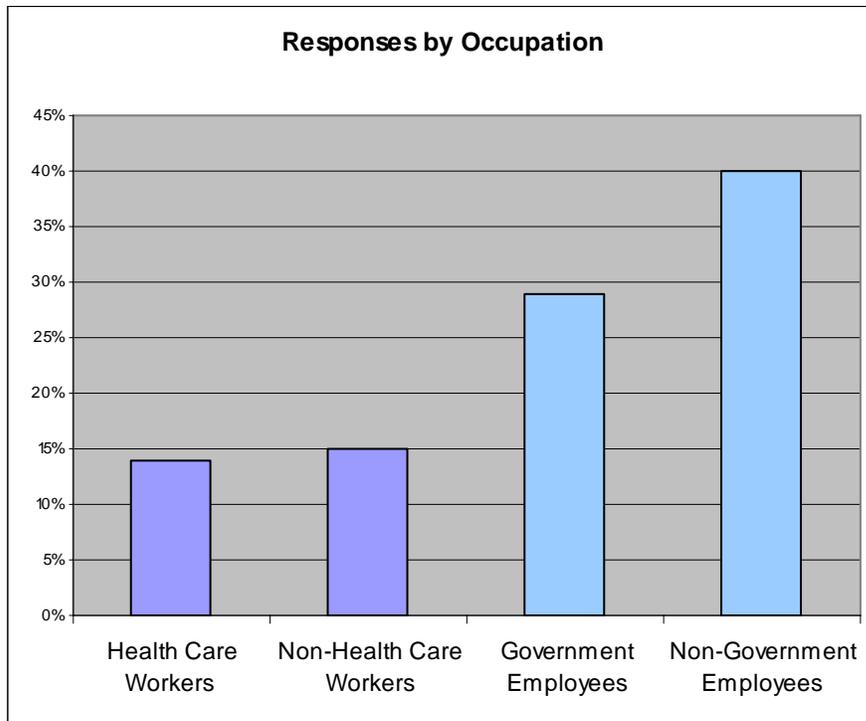
Responses by caregiver status:

- 195 respondents were the primary caregivers of a child or children, and 315 were not.
- 44 respondents were the primary caregivers of a child or children with special needs, and 469 were not.



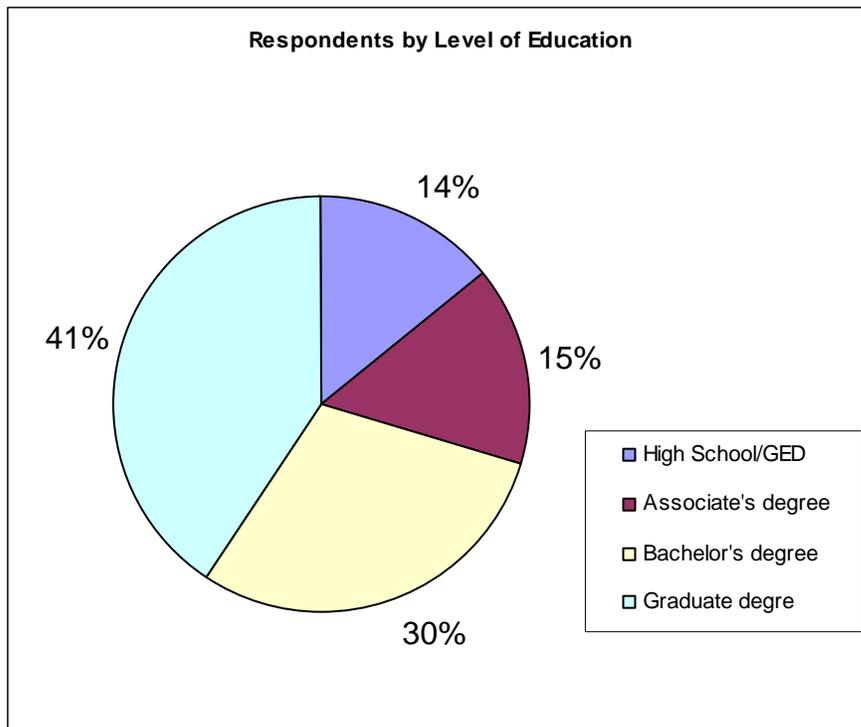
Responses by Occupation:

- 37% of respondents were health care workers and 63% were in other occupations.
- 44% were employed by the government, 56% were not.



Responses by level of education:

- 14% of respondents had graduated from high school or received a GED
- 15% had an associate's degree
- 29% had a bachelor's degree
- 40% of respondents had a graduate degree



Respondents' Ranks of Maternal and Child Health Priorities: Statewide and by Region

*All regions ranked Access to Services and Health Insurance for the MCH Population and Child Abuse as their top two priorities

Statewide: 518 Responses	Rank
Access to Services and Health Insurance for the MCH Population	1
Child Abuse	2
Teen Pregnancy and STDs	3
Youth Alcohol and Substance Abuse	4
Hunger and Food Insecurity	5
Preconception and Prenatal Care	6
Positive Youth Development	7
Youth Mental Health	8
Rural Access to Services and Providers	9
Child and Youth Obesity	10
Youth Violence	11
Intimate Partner Violence	12
Diabetes	13
Infant Mortality and Morbidity	14
Immunizations	15
Child/Youth Unintentional Injury	16
Cohesion and Reimbursement of Special Needs Services	17
Maternal Depression	18
Oral Health	19
Harm Reduction from Drug Abuse	20
Male Involvement in Family Planning and Fatherhood	21
Infant Mental Health	22
Asthma	23
Breastfeeding	24
Children with Special Health Care Needs Transition to Adulthood	25

Region 1 * 75 Responses	Rank
Access to Services and Health Insurance for the MCH Population	1
Child Abuse	2
Youth Alcohol and Substance Abuse	3
Teen Pregnancy and STDs	4
Youth Mental Health	5
Preconception and Prenatal Care	6
Youth Violence	7
Positive Youth Development	8
Hunger and Food Insecurity	9
Child and Youth Obesity	10
Rural Access to Services and Providers	11
Diabetes	12
Intimate Partner Violence	13
Child/Youth Unintentional Injury	14
Immunizations	15
Infant Mortality and Morbidity	16
Male Involvement in Family Planning and Fatherhood	17
Maternal Depression	18
Cohesion and Reimbursement of Special Needs Services	19
Infant Mental Health	20
Harm Reduction from Drug Abuse	21
Oral Health	22
Asthma	23
Children with Special Health Care Needs Transition to Adulthood	24
Breastfeeding	25
*Region 1, in the Northwest part of the state, includes the following counties: Cibola, McKinley, Sandoval, San Juan, Valencia.	

Region 2* 133 Responses	Rank
Access to Services and Health Insurance for the MCH Population	1
Child Abuse	2
Hunger and Food Insecurity	3
Positive Youth Development	4
Preconception and Prenatal Care	5
Youth Alcohol and Substance Abuse	6
Teen Pregnancy and STDs	7
Rural Access to Services and Providers	8
Youth Mental Health	9
Child and Youth Obesity	10
Youth Violence	11
Intimate Partner Violence	12
Diabetes	13
Cohesion and Reimbursement of Special Needs Services	14
Infant Mortality and Morbidity	15
Maternal Depression	16
Immunizations	17
Child/Youth Unintentional Injury	18
Oral Health	19
Male Involvement in Family Planning and Fatherhood	20
Infant Mental Health	21
Harm Reduction from Drug Abuse	22
Asthma	23
Breastfeeding	24
Children with Special Health Care Needs Transition to Adulthood	25
Region 2, in the Northeast part of the state, includes the following counties: Colfax, Guadalupe, Los Alamos, Mora, Rio Arriba, San Miguel, Santa Fe, Taos, Union.	

Region 3* 174 Responses	Rank
Access to Services and Health Insurance for the MCH Population	1
Child Abuse	2
Preconception and Prenatal Care	3
Hunger and Food Insecurity	4
Teen Pregnancy and STDs	5
Youth Mental Health	6
Positive Youth Development	7
Youth Alcohol and Substance Abuse	8
Child and Youth Obesity	9
Youth Violence	10
Rural Access to Services and Providers	11
Intimate Partner Violence	12
Infant Mortality and Morbidity	13
Diabetes	14
Child/Youth Unintentional Injury	15
Immunizations	16
Cohesion and Reimbursement of Special Needs Services	17
Maternal Depression	18
Oral Health	19
Harm Reduction from Drug Abuse	20
Infant Mental Health	21
Male Involvement in Family Planning and Fatherhood	22
Asthma	23
Breastfeeding	24
Children with Special Health Care Needs Transition to Adulthood	25
Region 3 is Bernalillo County.	

Region 4* 42 Responses	Rank
Child Abuse	1
Access to Services and Health Insurance for the MCH Population	2
Teen Pregnancy and STDs	3
Youth Alcohol and Substance Abuse	4
Preconception and Prenatal Care	5
Hunger and Food Insecurity	6
Positive Youth Development	7
Rural Access to Services and Providers	8
Child and Youth Obesity	9
Diabetes	10
Youth Mental Health	11
Youth Violence	12
Intimate Partner Violence	13
Child/Youth Unintentional Injury	14
Immunizations	15
Oral Health	16
Cohesion and Reimbursement of Special Needs Services	17
Male Involvement in Family Planning and Fatherhood	18
Infant Mortality and Morbidity	19
Asthma	20
Harm Reduction from Drug Abuse	21
Maternal Depression	22
Infant Mental Health	23
Children with Special Health Care Needs Transition to Adulthood	24
Breastfeeding	25
*Region 4, in the Southeast part of the state, includes the following counties: Chaves, Curry, De Baca, Eddy, Harding, Lea, Quay, Roosevelt.	

Region 5* 94 Responses	Rank
Access to Services and Health Insurance for the MCH Population	1
Child Abuse	2
Youth Alcohol and Substance Abuse	3
Teen Pregnancy and STDs	4
Rural Access to Services and Providers	5
Hunger and Food Insecurity	6
Preconception and Prenatal Care	7
Youth Mental Health	8
Positive Youth Development	9
Youth Violence	10
Child and Youth Obesity	11
Diabetes	12
Intimate Partner Violence	13
Immunizations	14
Infant Mortality and Morbidity	15
Maternal Depression	16
Harm Reduction from Drug Abuse	17
Cohesion and Reimbursement of Special Needs Services	18
Male Involvement in Family Planning and Fatherhood	19
Child/Youth Unintentional Injury	20
Oral Health	21
Asthma	22
Breastfeeding	23
Infant Mental Health	24
Children with Special Health Care Needs Transition to Adulthood	25
*Region 5, in the Southwest part of the state, includes the following counties: Catron, Doña Ana, Grant, Hidalgo, Lincoln, Luna, Otero, Sierra, Socorro, Torrance.	

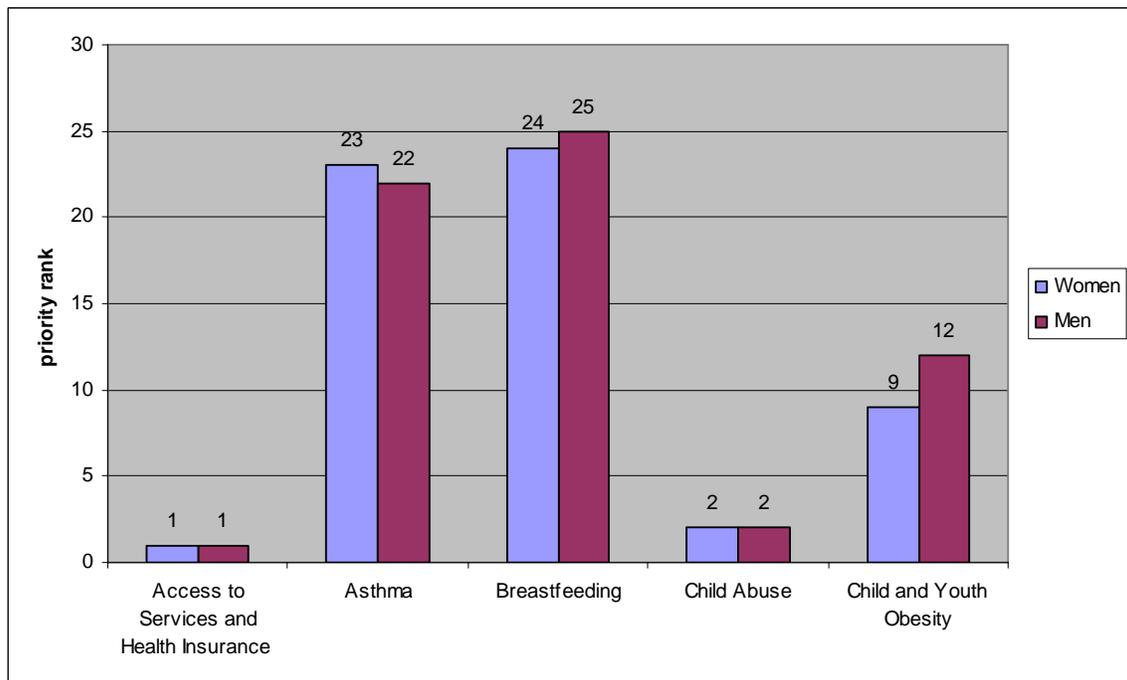
Maternal and Child Health Priorities Compared by Region	State	Region 1	Region 2	Region 3	Region 4	Region 5
Access to Services & Health Insurance for the MCH Population	1	1	1	1	2	1
Asthma	23	23	23	23	20	22
Breastfeeding	24	25	24	24	25	23
Child Abuse	2	2	2	2	1	2
Child and Youth Obesity	10	10	10	9	9	11
Child/Youth Unintentional Injury	16	14	18	15	14	20
Adulthood	25	24	25	25	24	25
Cohesion and Reimbursement of Special Needs Services	17	19	14	17	17	18
Diabetes	13	12	13	14	10	12
Harm Reduction from Drug Abuse	20	21	22	20	21	17
Hunger and Food Insecurity	5	9	3	4	6	6
Immunizations	15	15	17	16	15	14
Infant Mental Health	22	20	21	21	23	24
Infant Mortality and Morbidity	14	16	15	13	19	15
Intimate Partner Violence	12	13	12	12	13	13
Male Involvement in Family Planning and Fatherhood	21	17	20	22	18	19
Maternal Depression	18	18	16	18	22	16
Oral Health	19	22	19	19	16	21
Positive Youth Development	7	8	4	7	7	9
Preconception and Prenatal Care	6	6	5	3	5	7
Rural Access to Services and Providers	9	11	8	11	8	5
Teen Pregnancy and STDs	3	4	7	5	3	4
Youth Alcohol and Substance Abuse	4	3	6	8	4	3
Youth Mental Health	8	5	9	6	11	8
Youth Violence	11	7	11	10	12	10

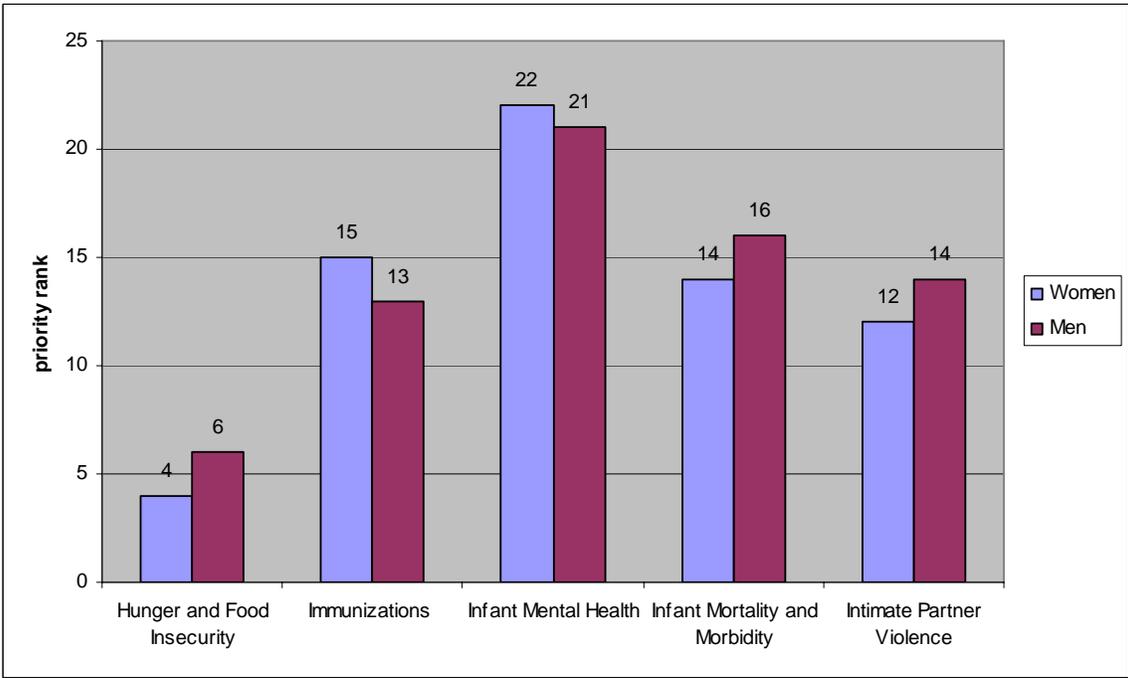
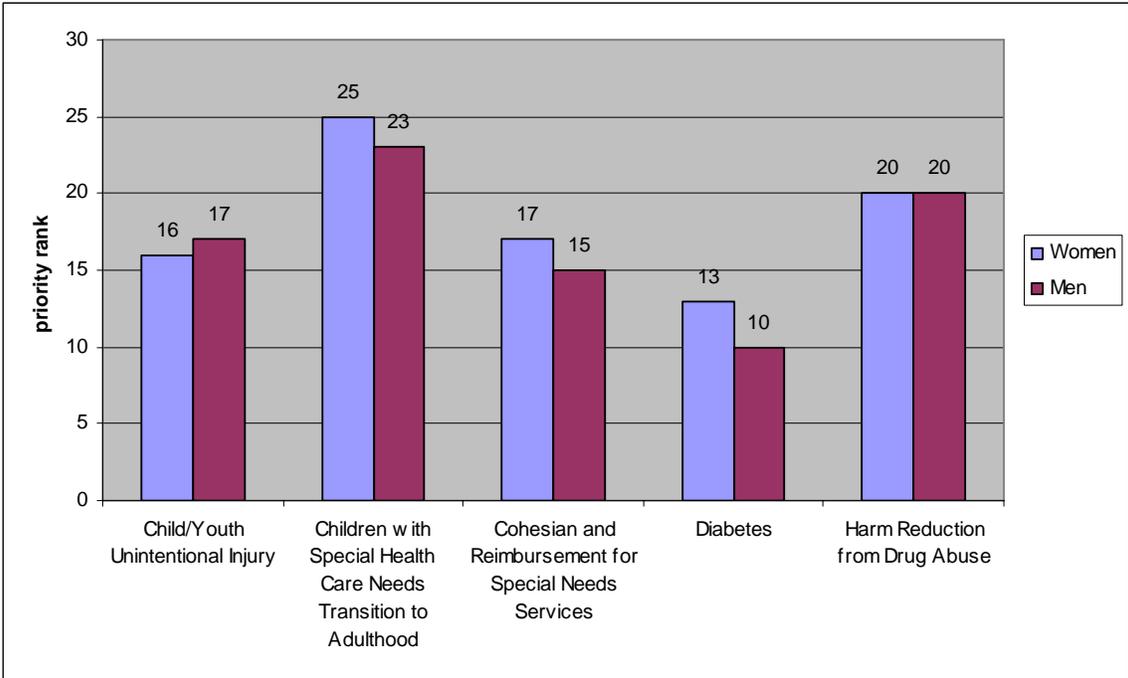
Maternal and Child Health Priority Ranks by Sex.

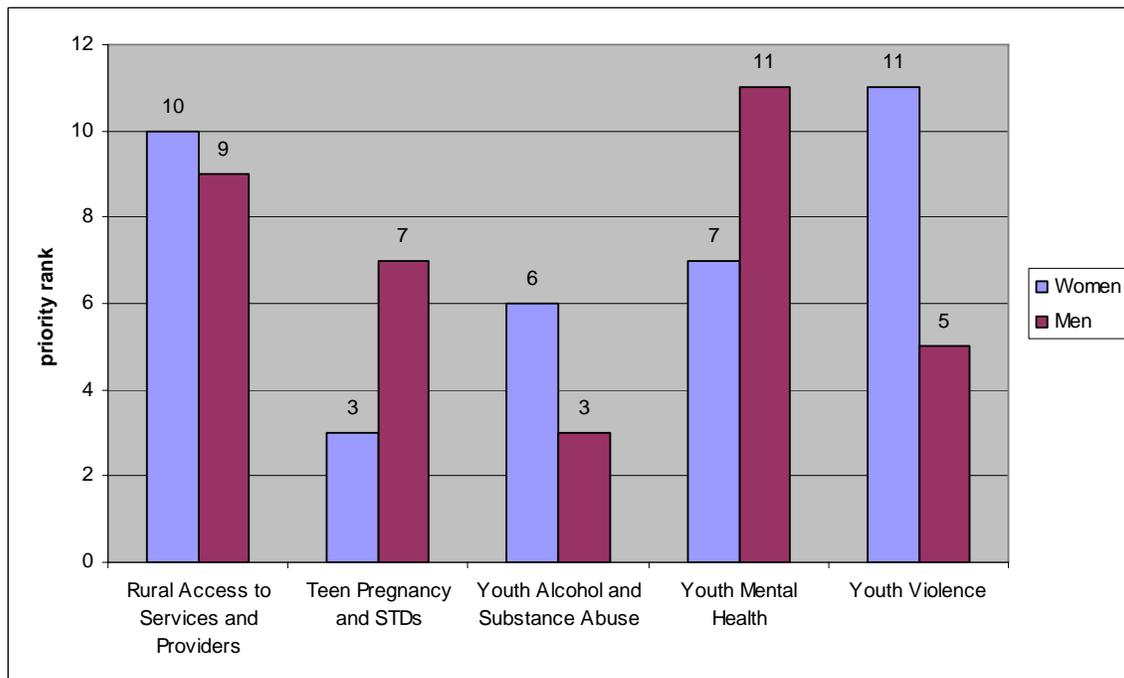
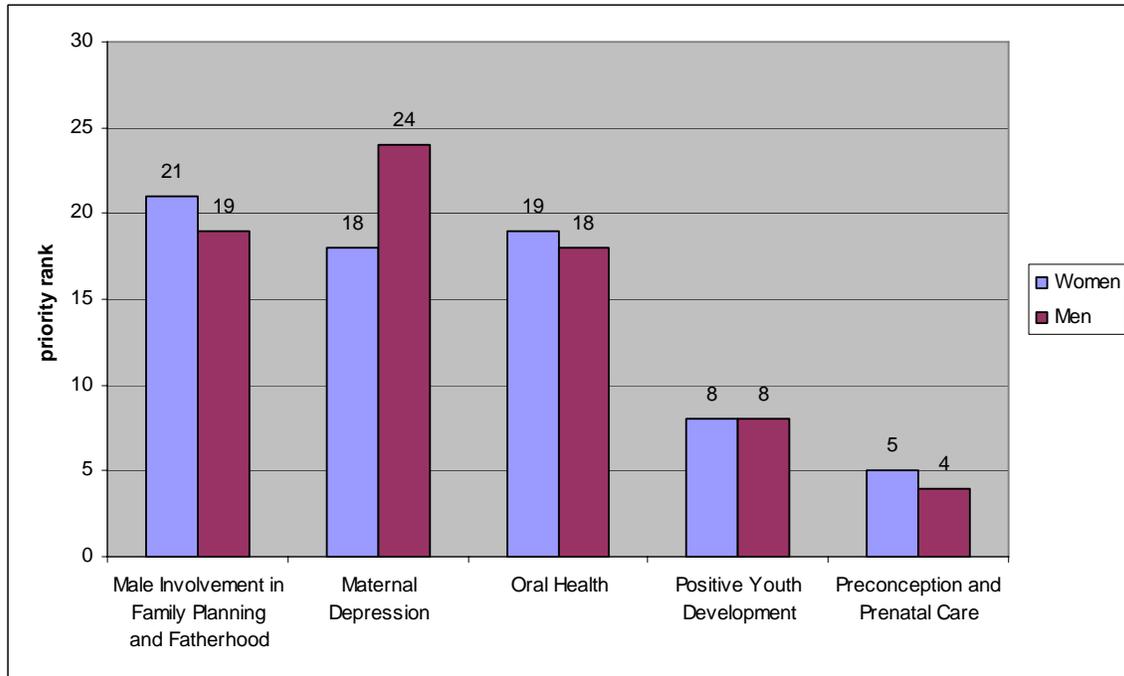
A lower rank number indicates that respondents felt the priority was more important, and a higher rank number indicates that respondents felt the priority was less important. For example, 1 = most important, 25 = least important.

Priorities are presented in alphabetical order.

425 women, and 87 men responded.







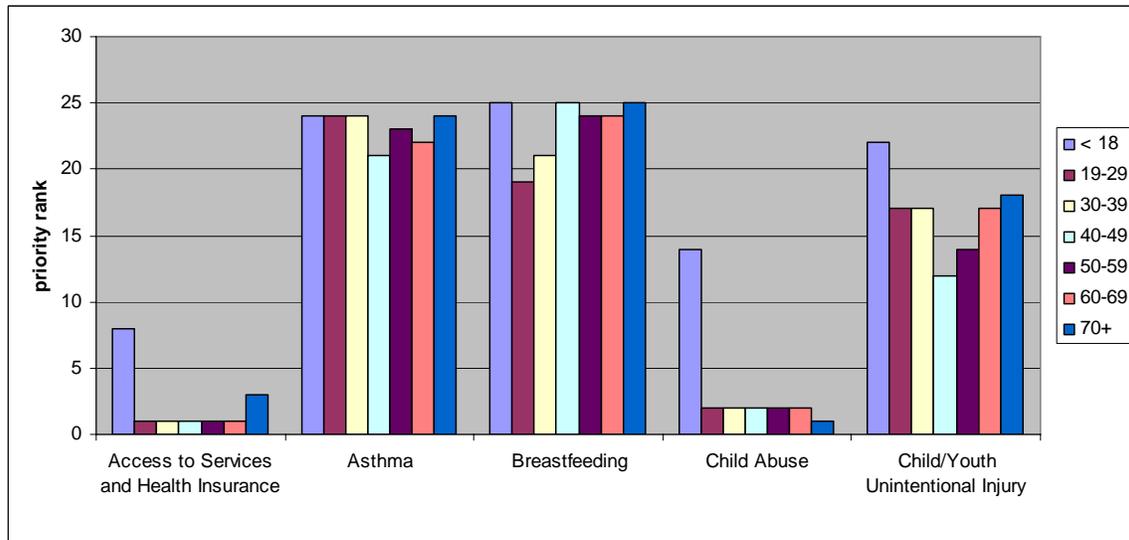
Maternal and Child Health Priority Ranks by Age.

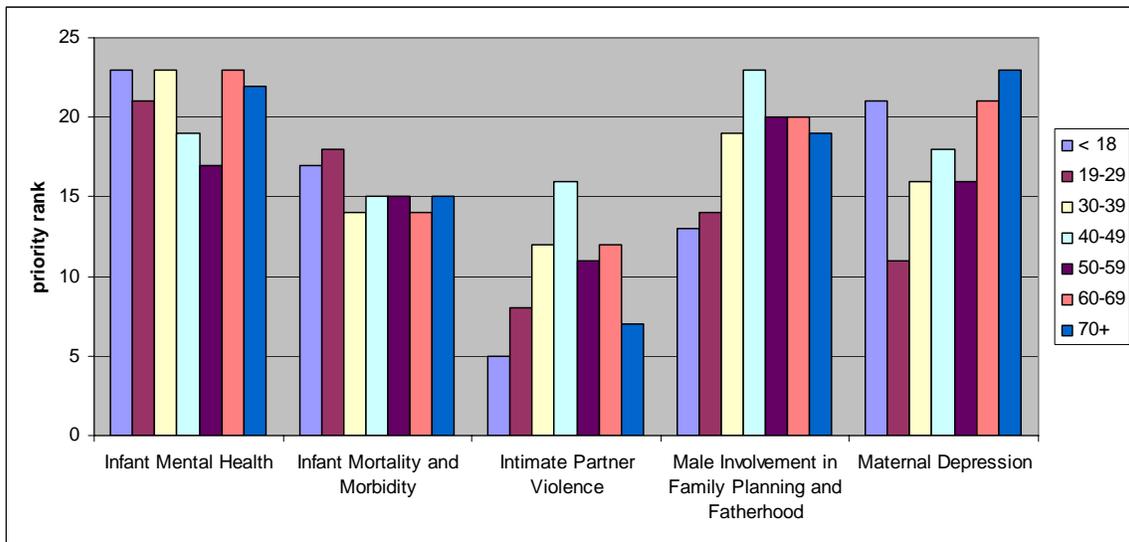
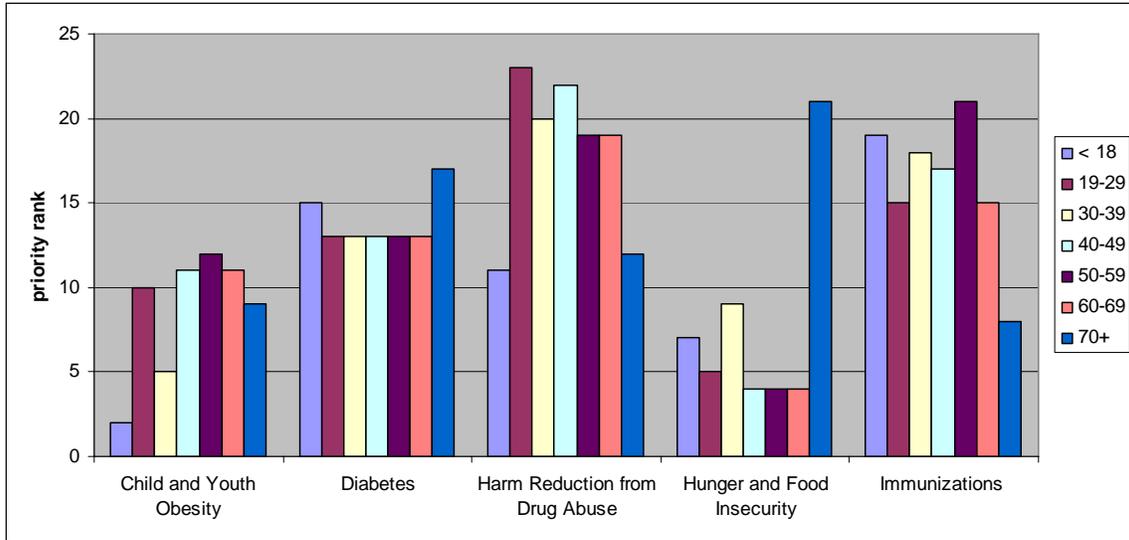
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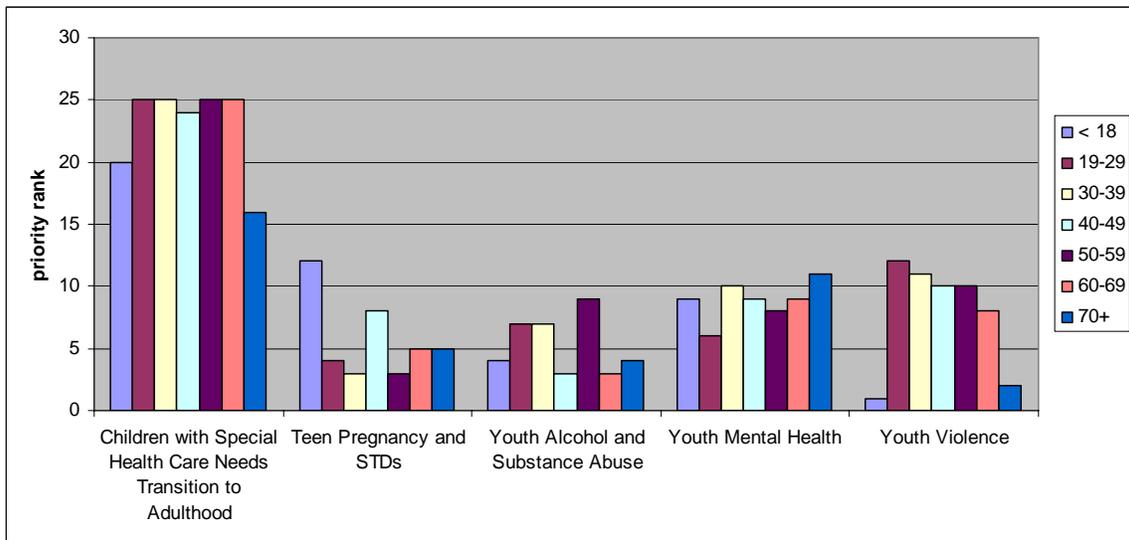
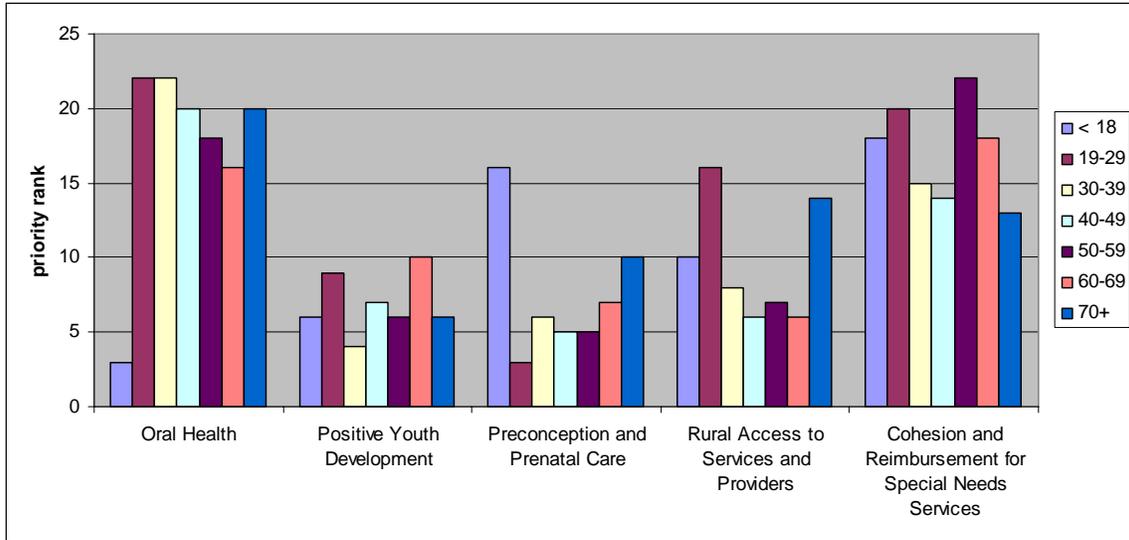
Priorities are presented in alphabetical order.

Please note that there were very few respondents under age 18, and few over age 70, therefore their results should be interpreted with caution.

- 5 respondents were under age 18
- 38 were age 19-29
- 98 were age 30-39
- 106 were age 40-49
- 172 were age 50-59
- 82 were age 60-69
- 14 were age 70 or older







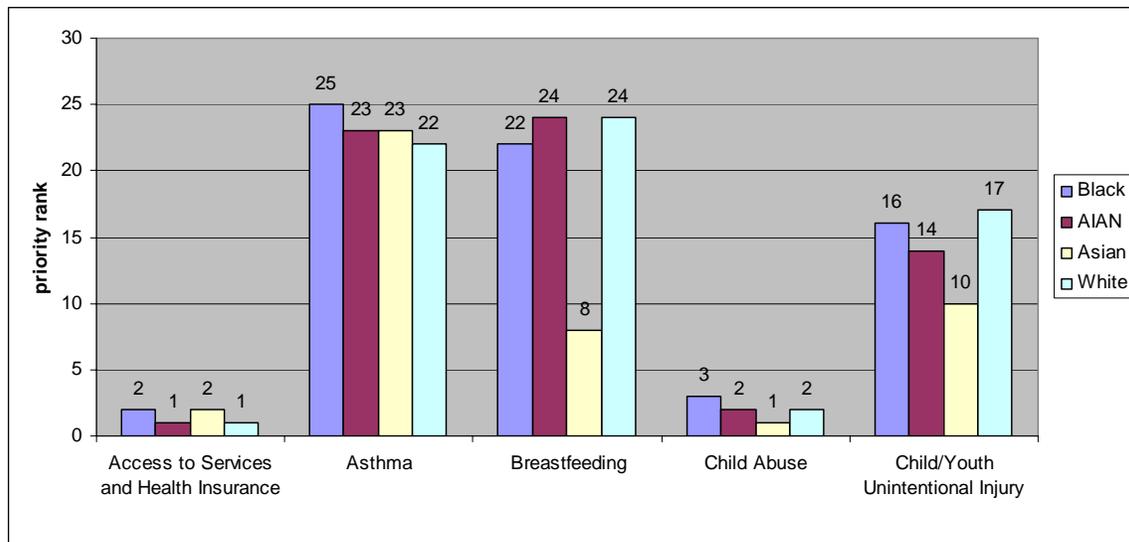
Maternal and Child Health Priority Ranks by Race.

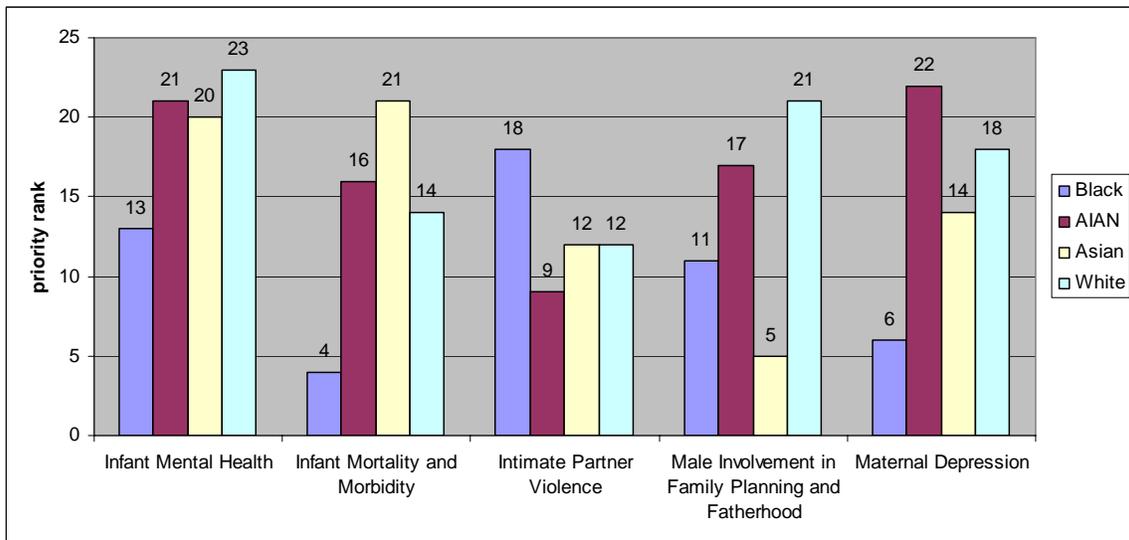
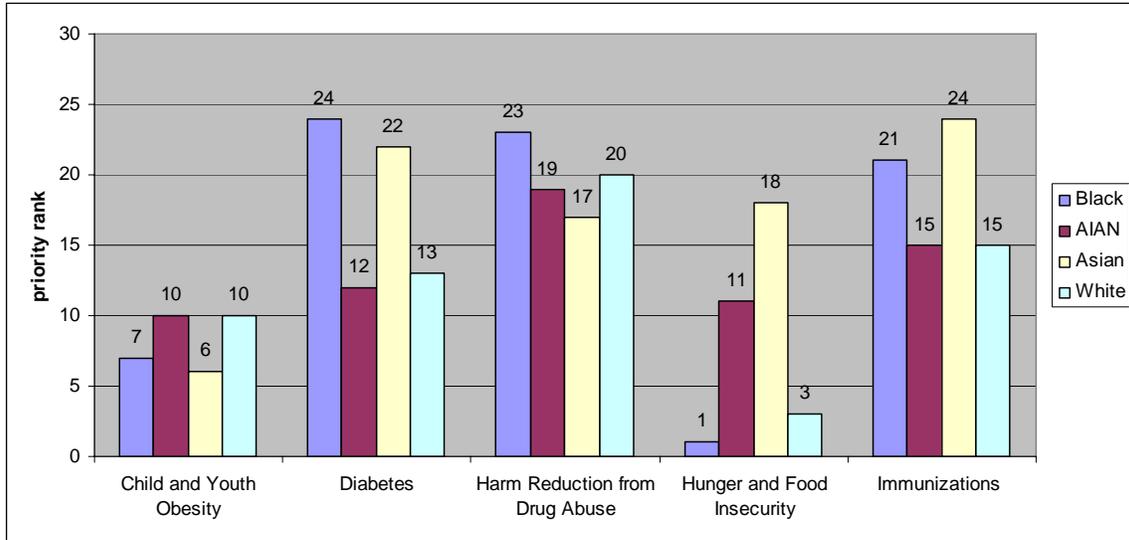
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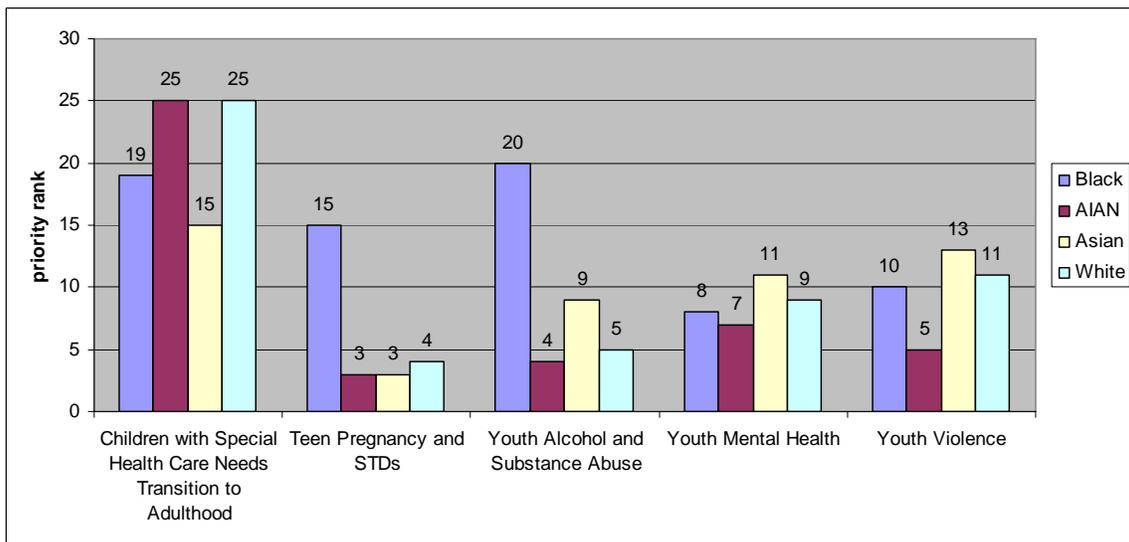
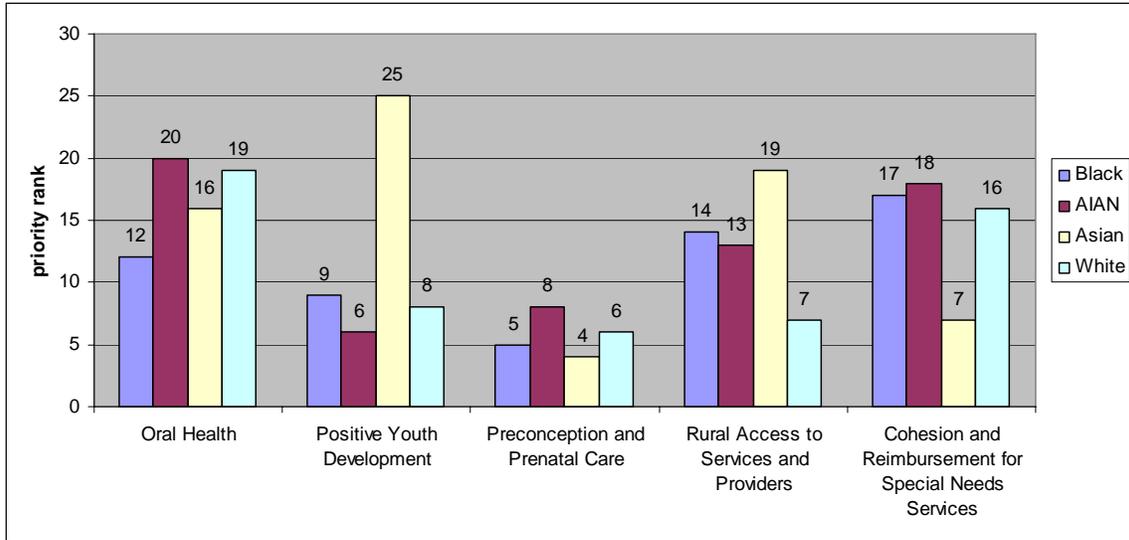
Priorities are presented in alphabetical order.

Please note that there were very few African-American and Asian/Pacific Islander respondents and therefore their results should be interpreted with caution.

There were 7 “Black” respondents, 69 American Indian/Alaska Native respondents, 2 Asian/Pacific Island respondents and 384 “White” respondents.





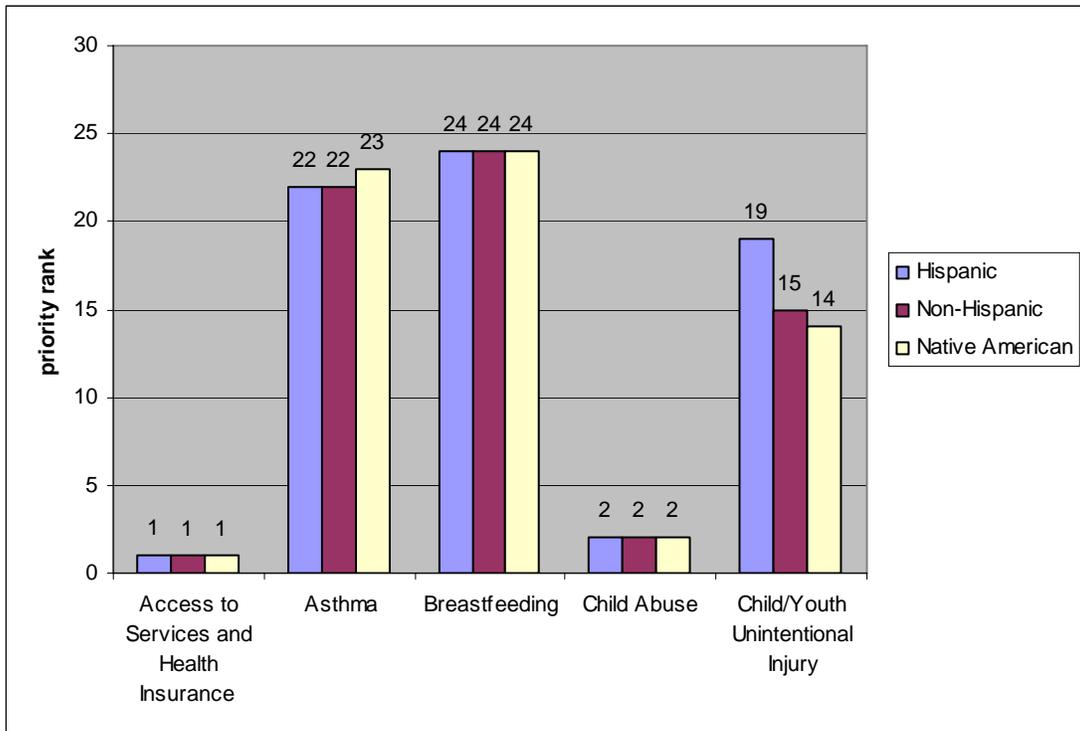


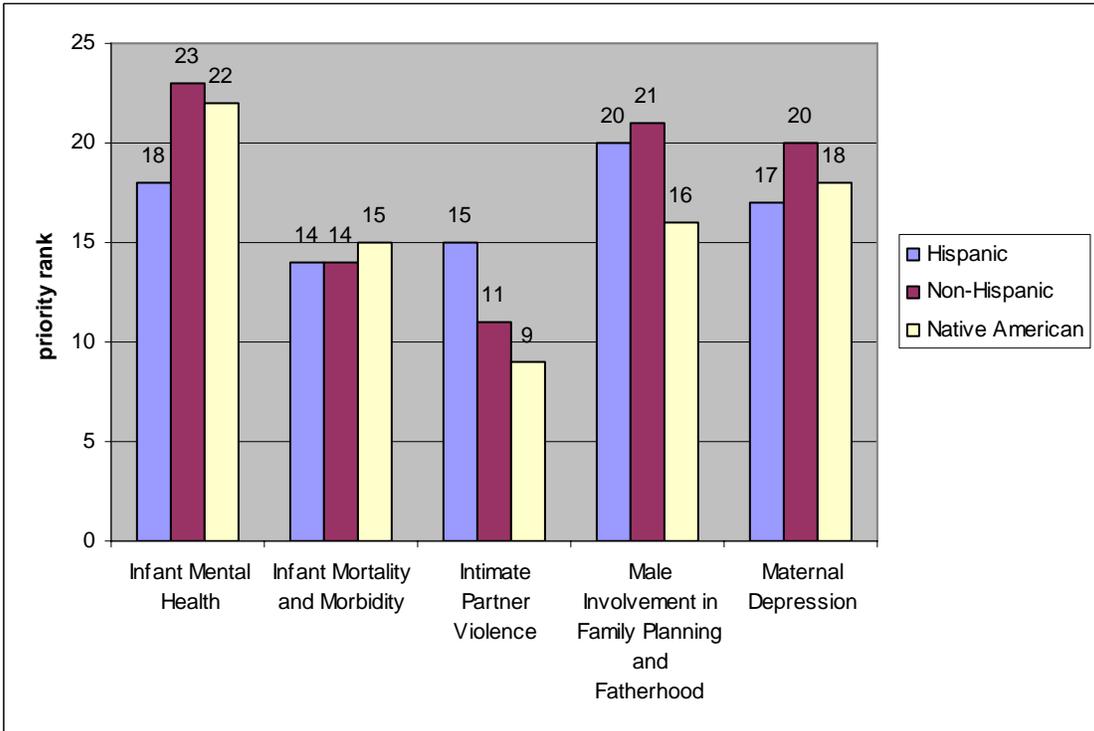
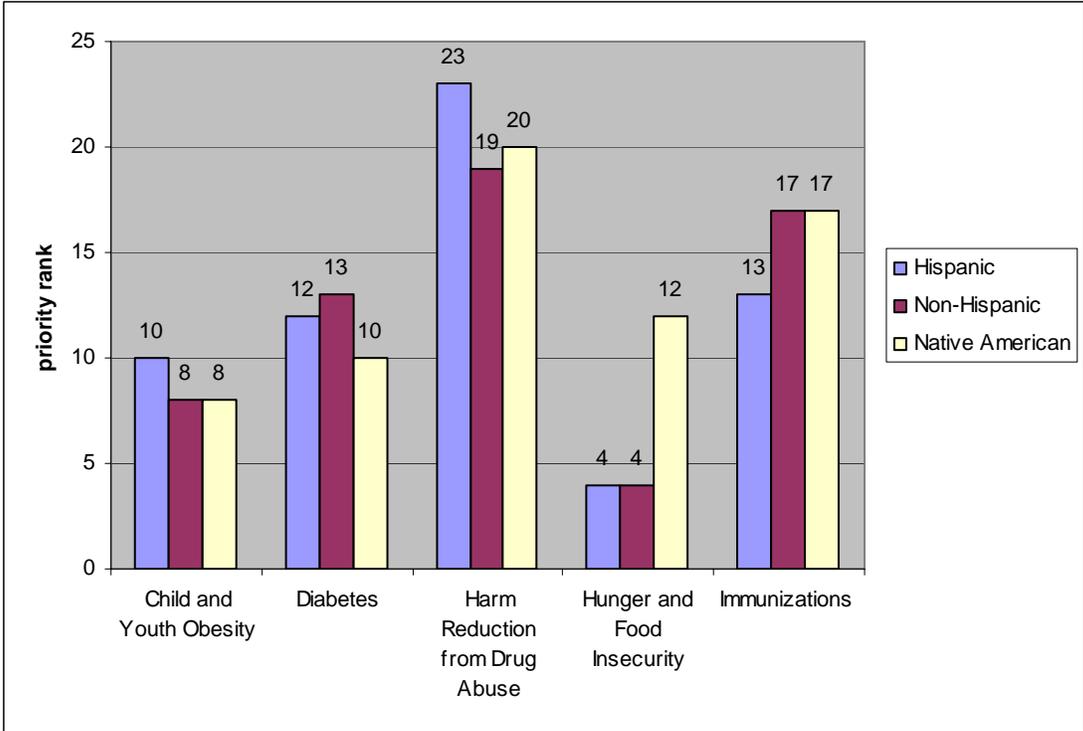
Maternal and Child Health Priority Ranks by Ethnicity.

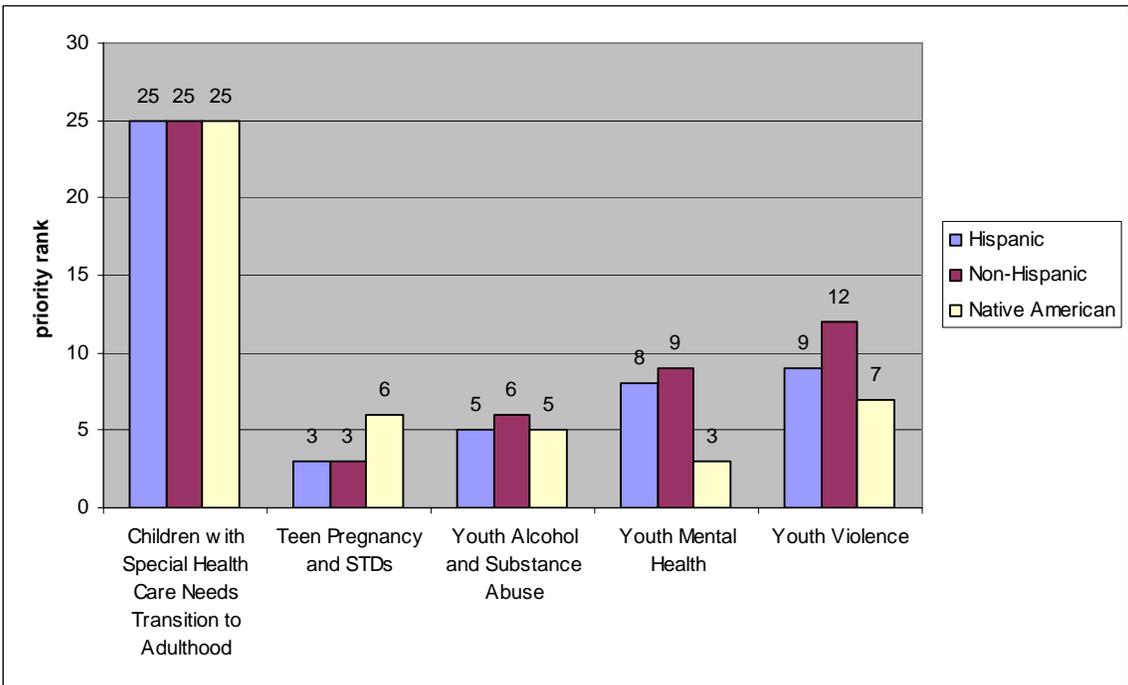
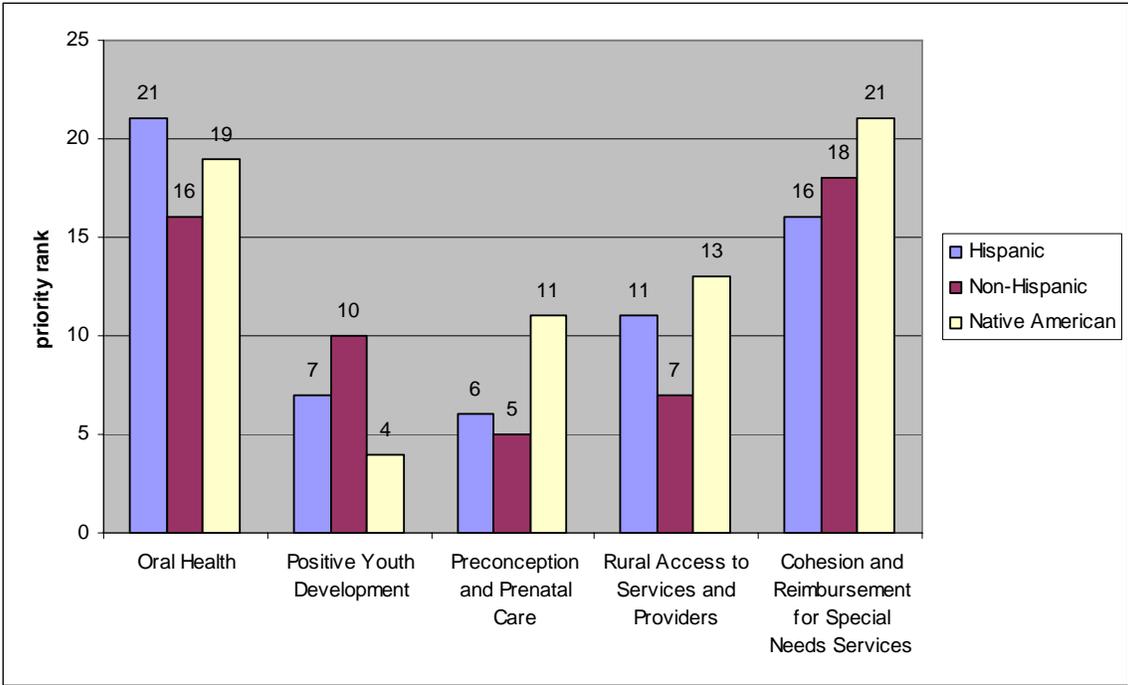
A lower rank number indicates that respondents felt the priority was more important, and a higher rank number indicates that respondents felt the priority was less important. For example, 1 = most important, 25 = least important.

Priorities are presented in alphabetical order.

- 169 respondents were Hispanic
- 236 were Non-Hispanic
- 41 were Native American





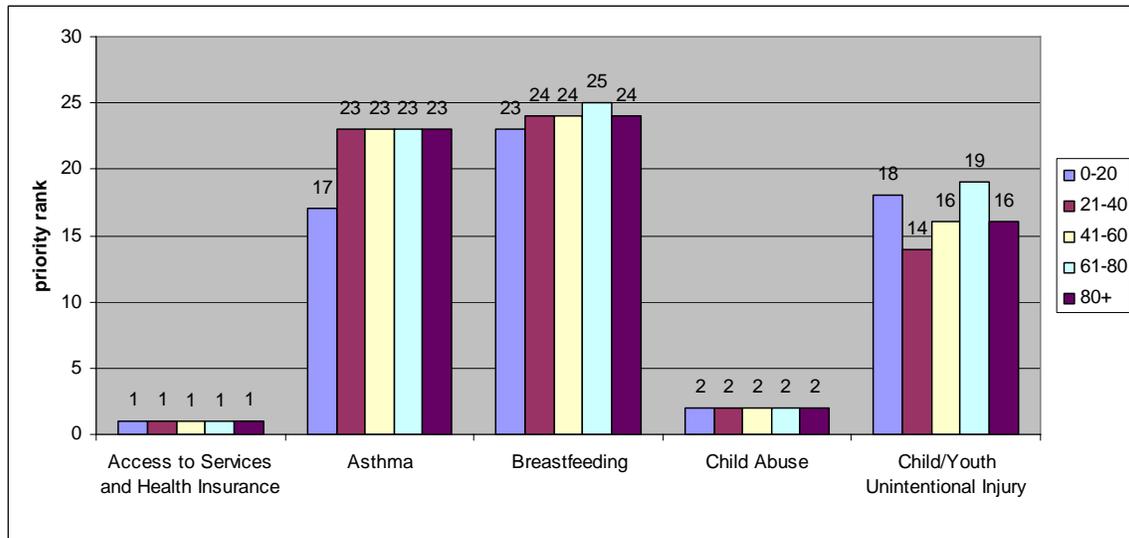


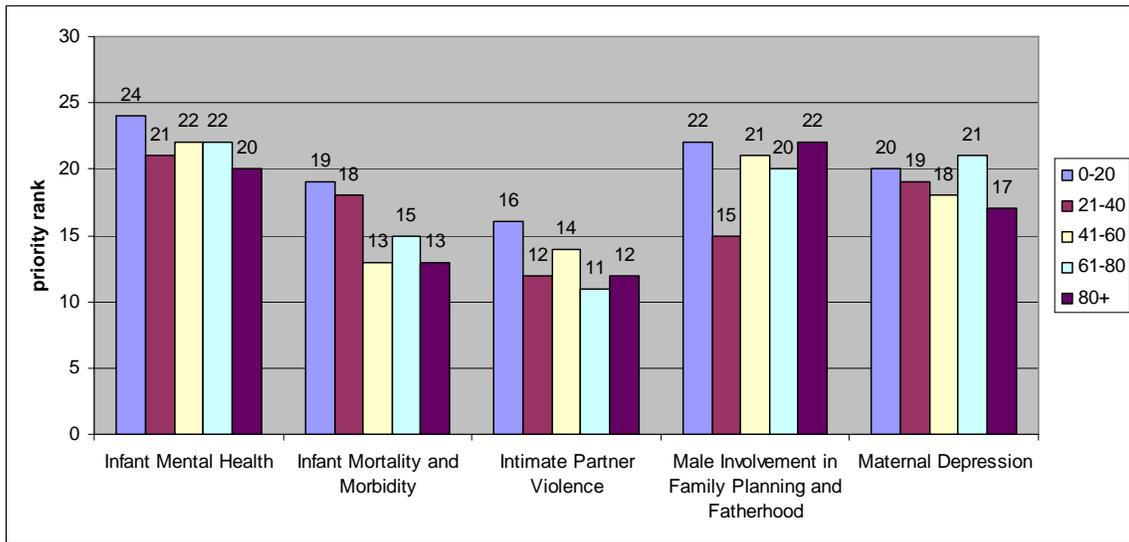
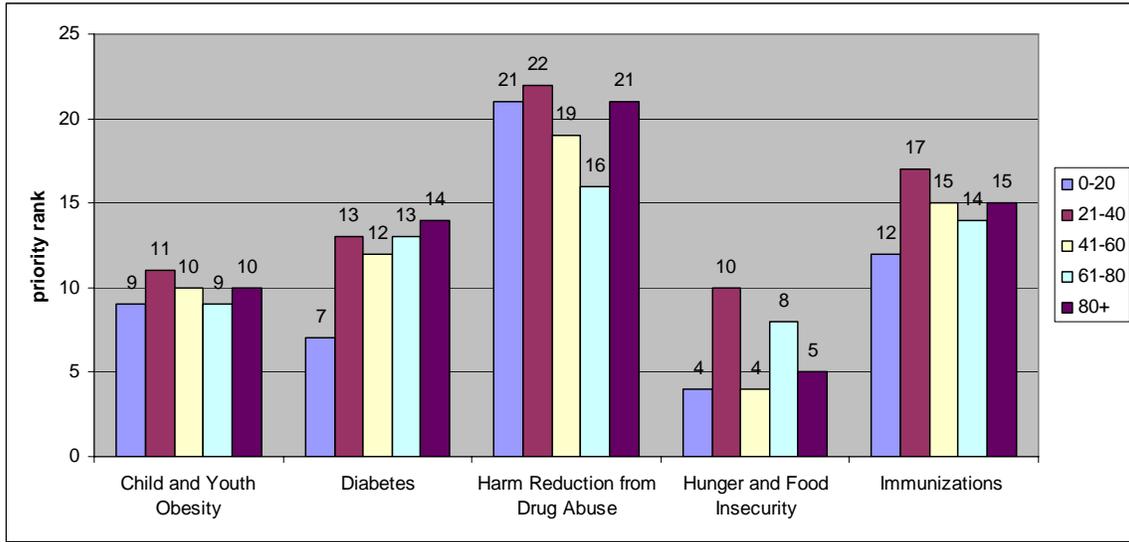
Maternal and Child Health Priority Ranks by Income.

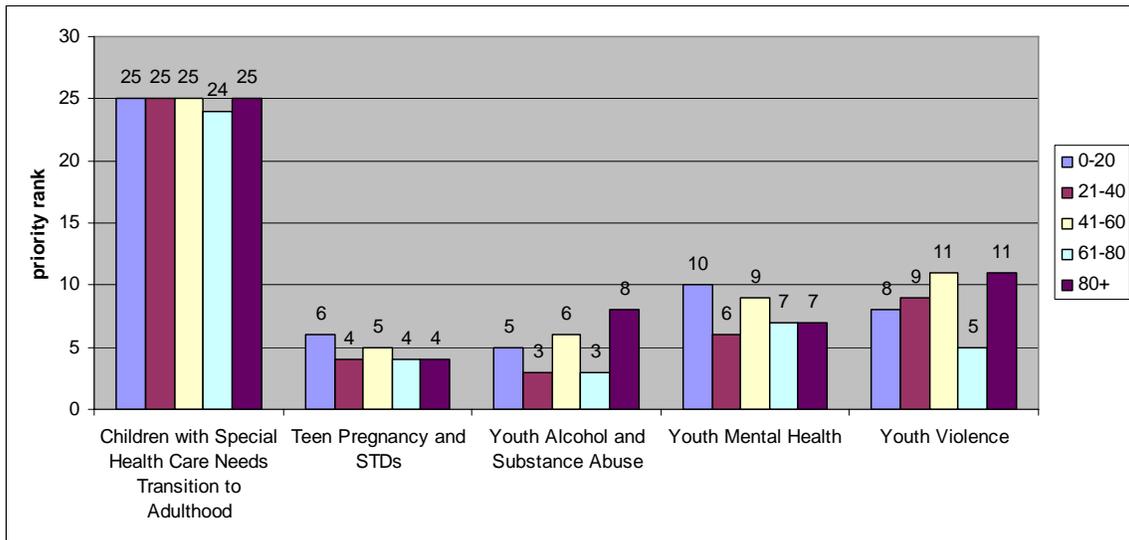
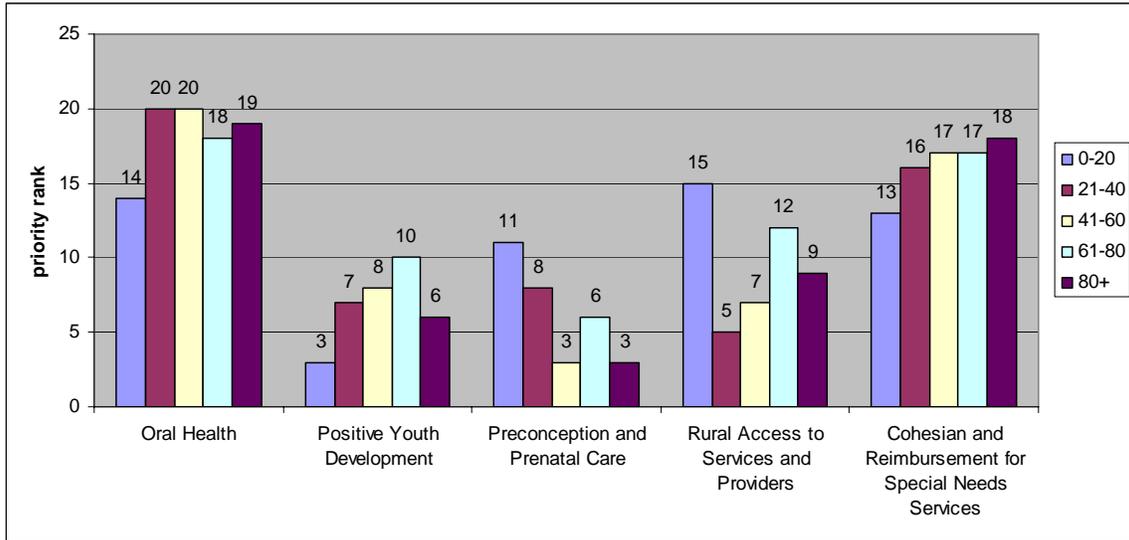
A lower rank number indicates that respondents felt the priority was more important, and a higher rank number indicates that respondents felt the priority was less important. For example, 1 = most important, 25 = least important.

Priorities are presented in alphabetical order.

- 39 respondents had a household income of \$0-20 thousand dollars per year
- 103 had a household income of \$21-40 thousand per year
- 140 had a household income of \$41-60 thousand per year
- 99 had a household income of \$61-80 thousand per year
- 131 had a household income of over \$80 thousand dollars per year





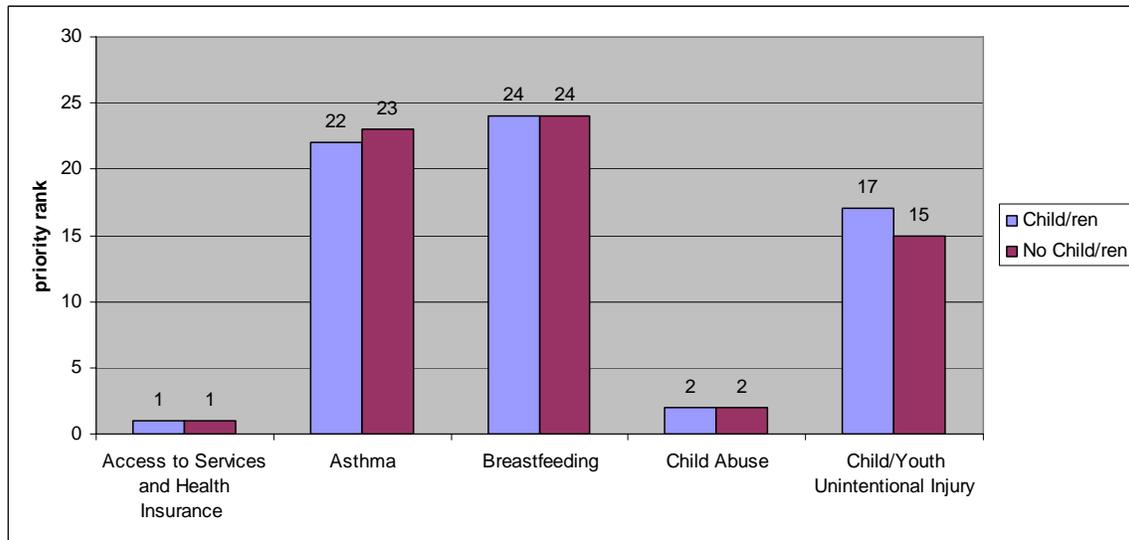


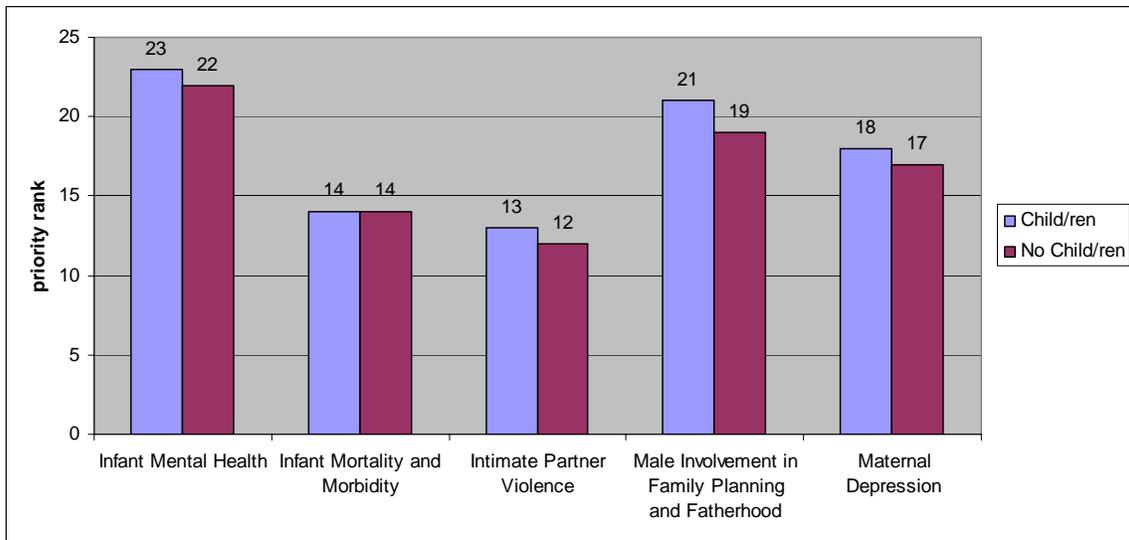
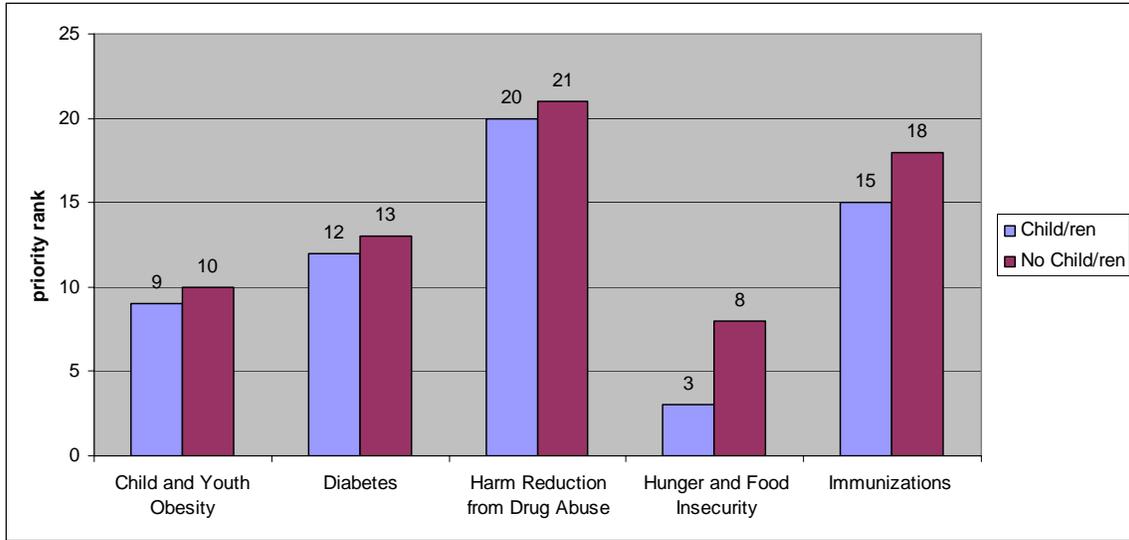
Maternal and Child Health Priority Ranks by Primary Caregiver of Children or Not.

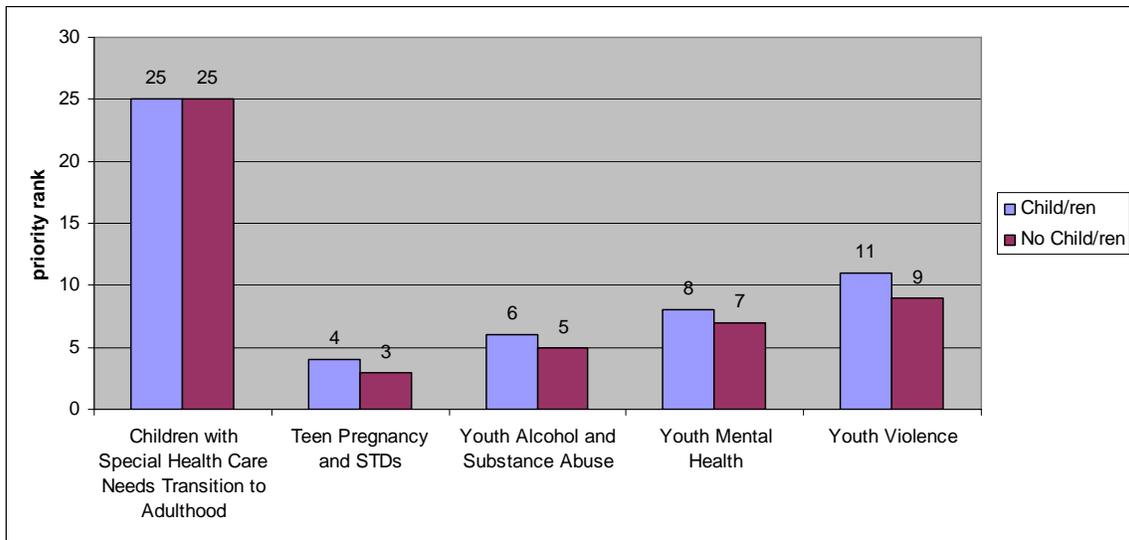
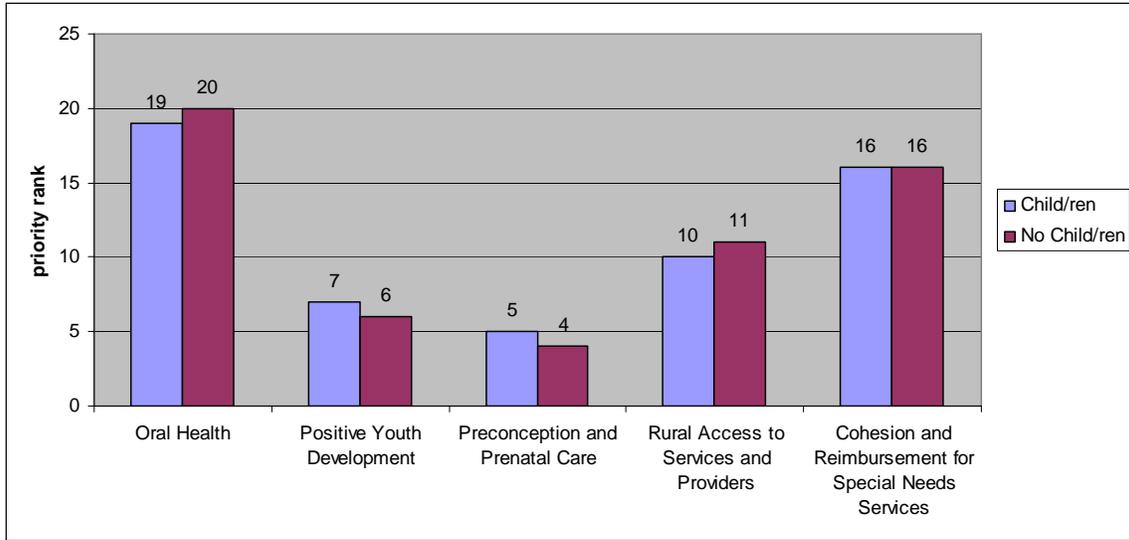
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Priorities are presented in alphabetical order.

195 respondents were the primary caregivers of a child or children, and 315 were not.





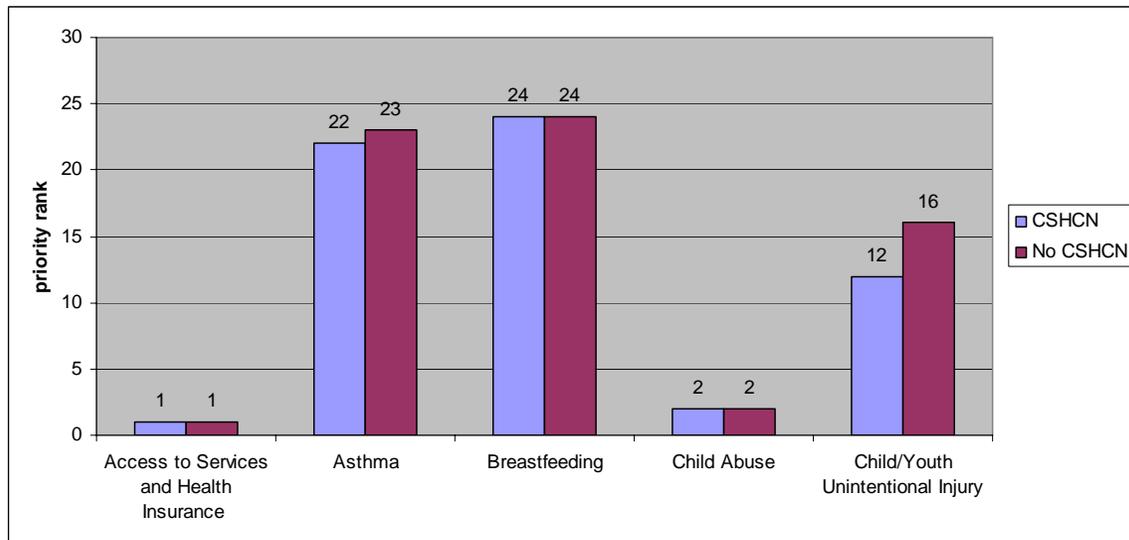


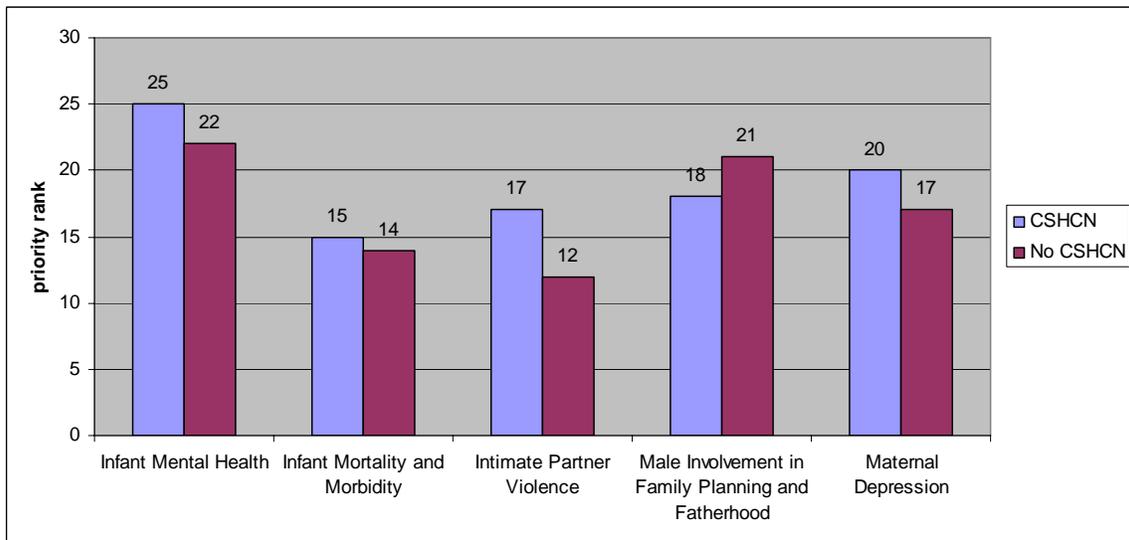
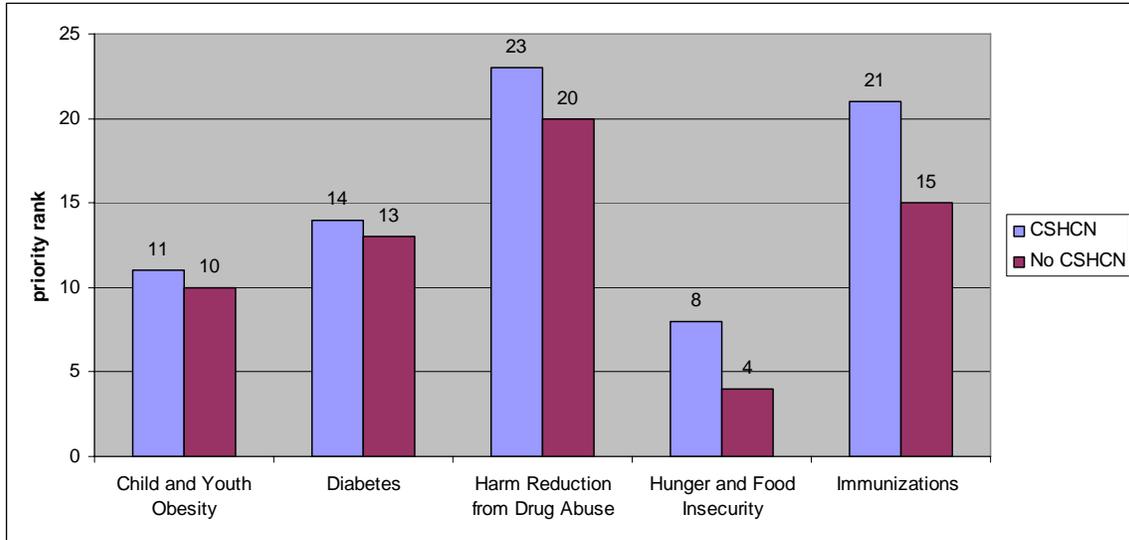
Maternal and Child Health Priority Ranks by Primary Caregiver of a Child or Children with Special Health Needs (CSHCN) or Not.

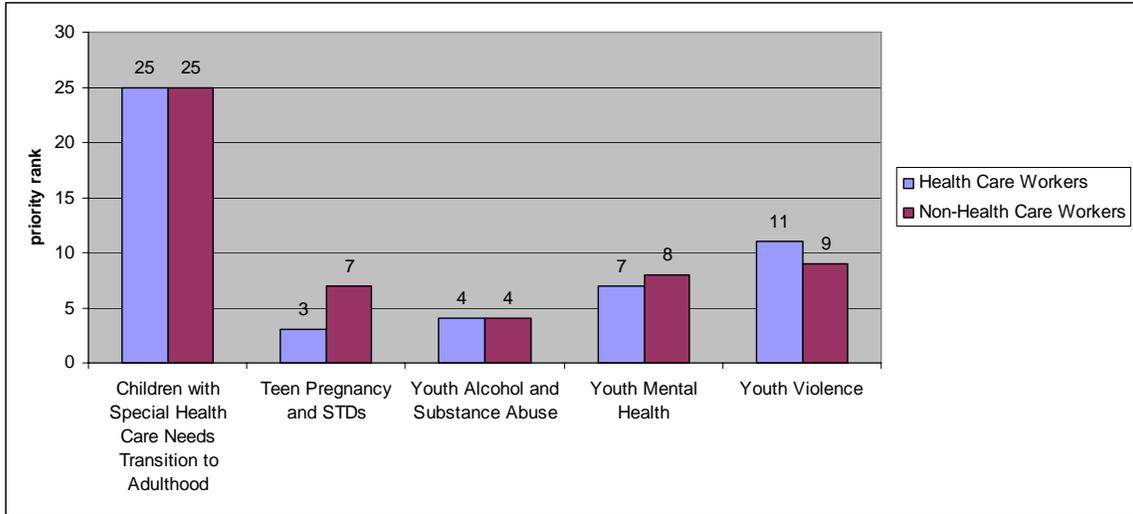
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Priorities are presented in alphabetical order.

44 respondents were the primary caregivers of a child or children, and 469 were not.





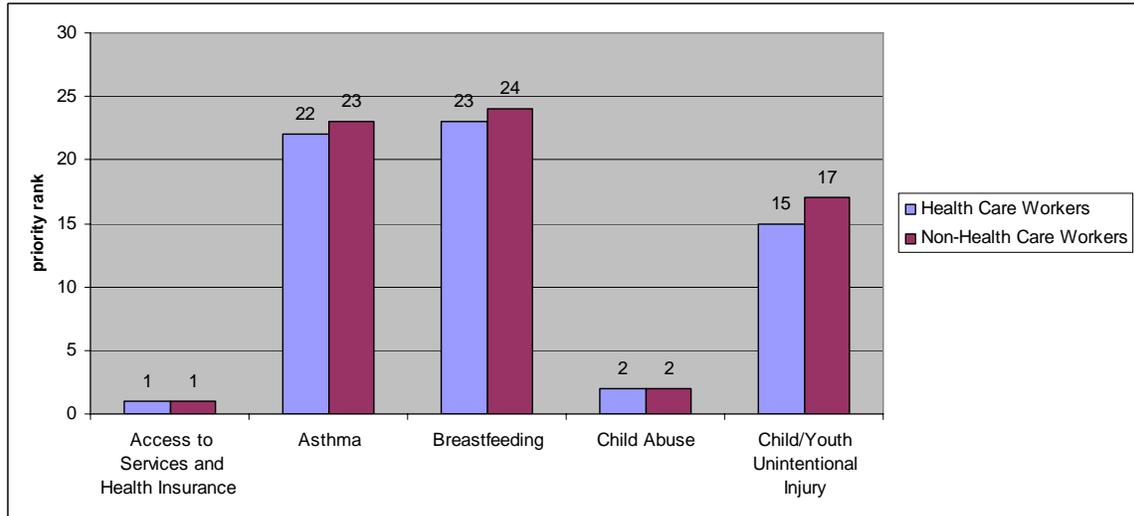


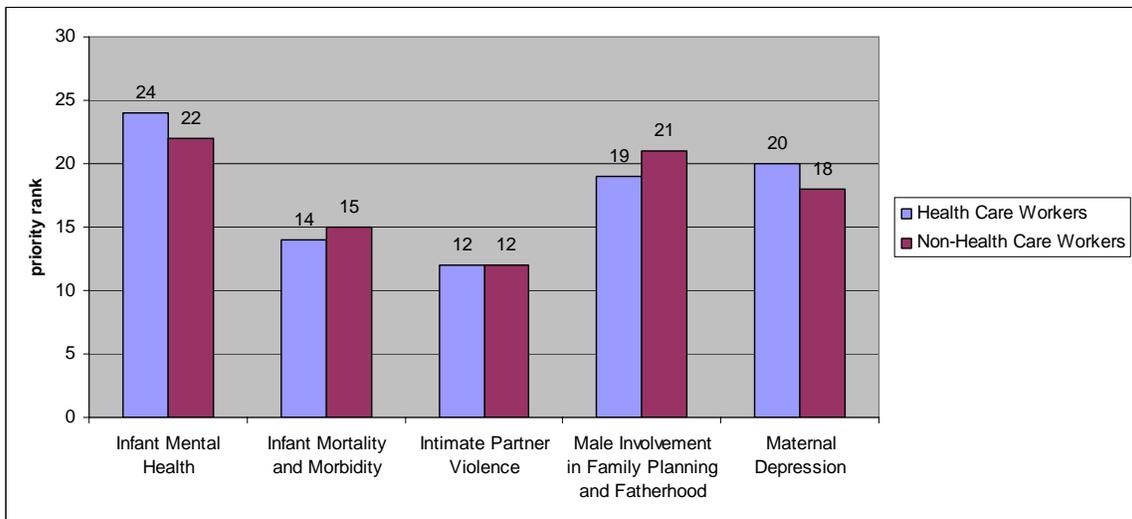
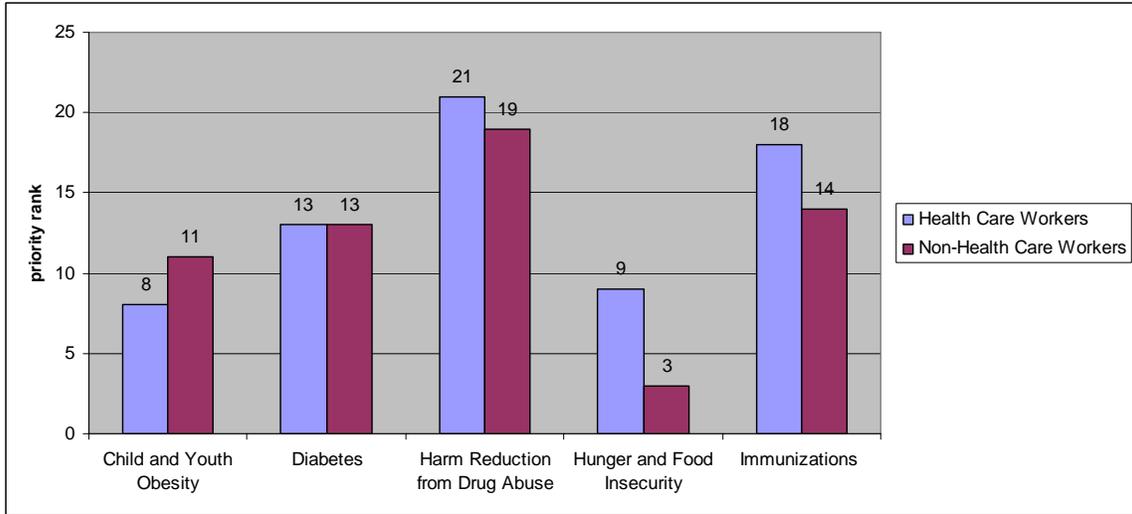
Maternal and Child Health Priority Ranks by Health Care and Non-Health Care Employment.

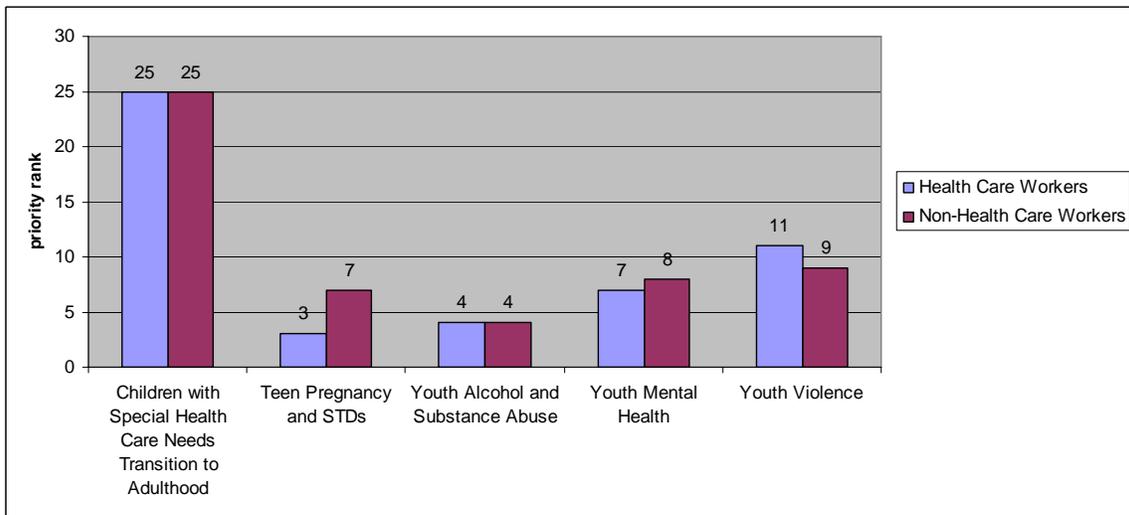
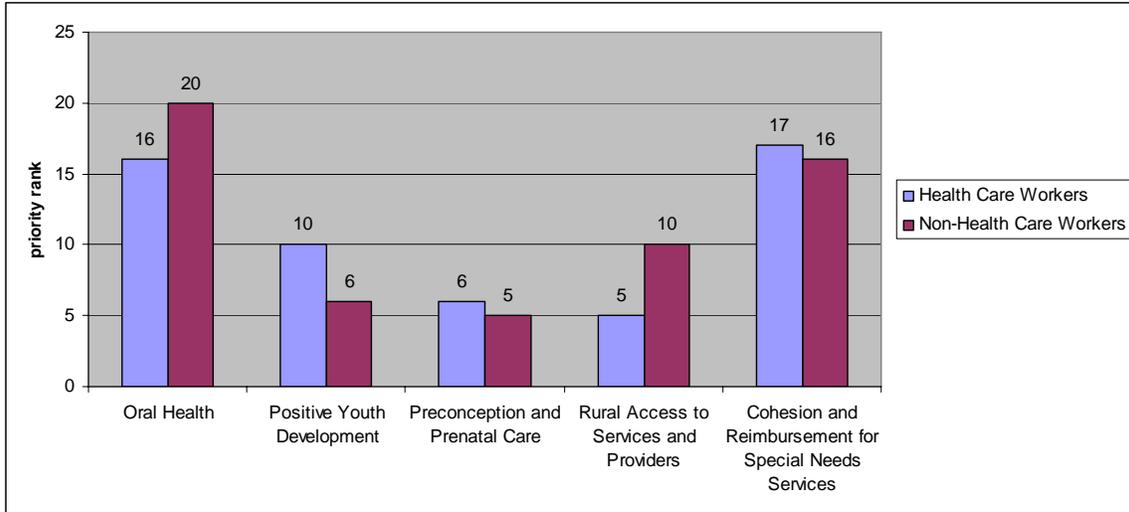
A lower rank number indicates that respondents felt the priority was more important, and a higher rank number indicates that respondents felt the priority was less important. For example, 1 = most important, 25 = least important.

Priorities are presented in alphabetical order.

182 respondents were administrative or clinical health care professionals,
309 were not.





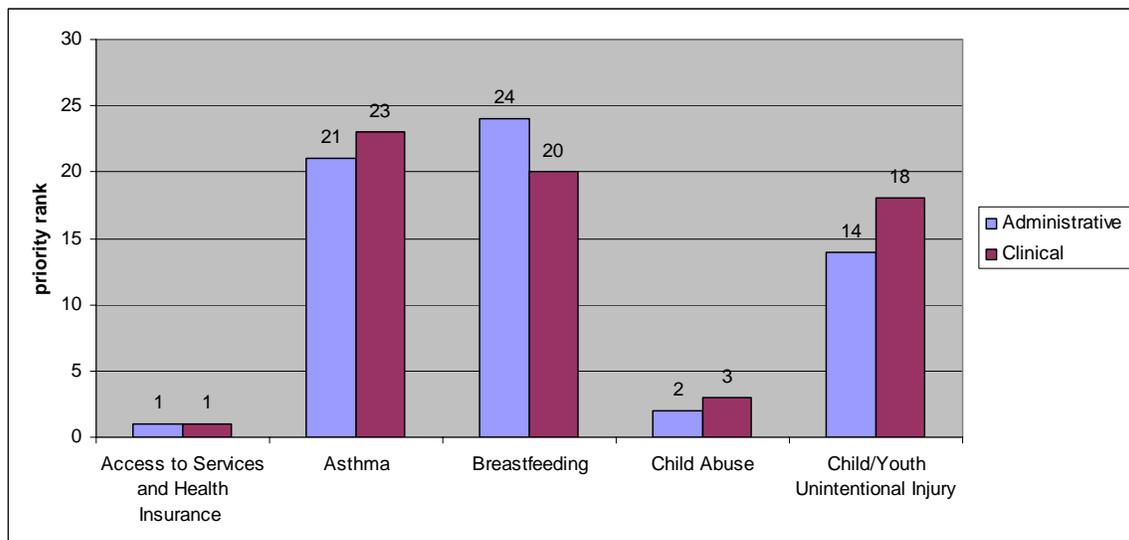


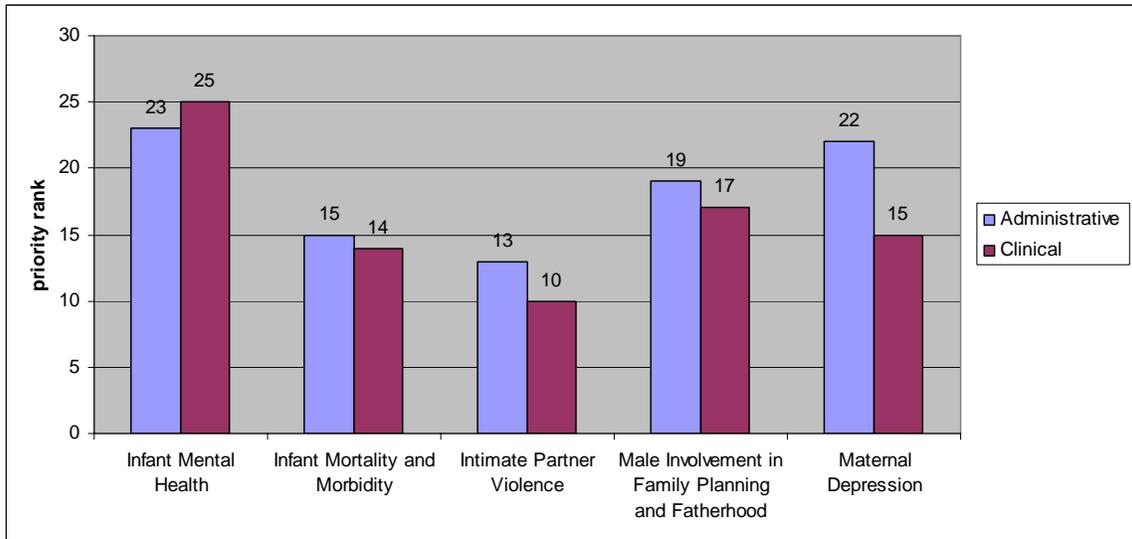
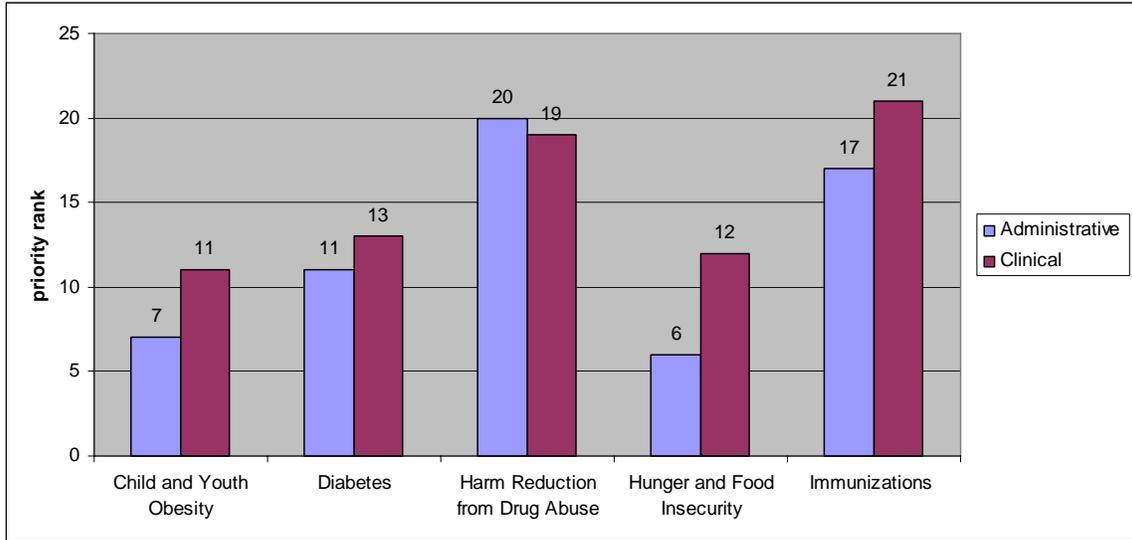
Maternal and Child Health Priority Ranks by Administrative or Clinical Health Care Professional

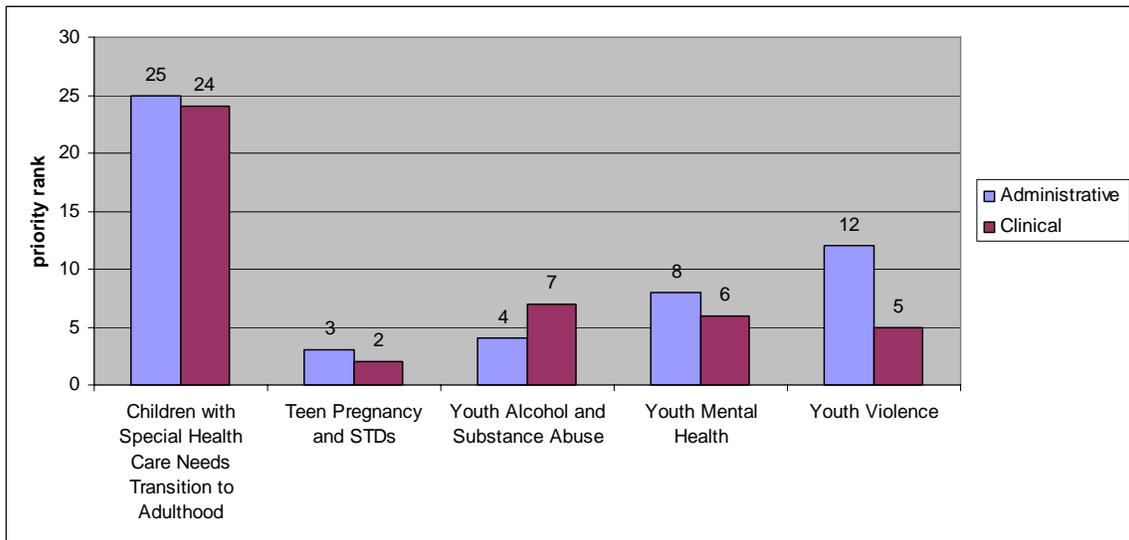
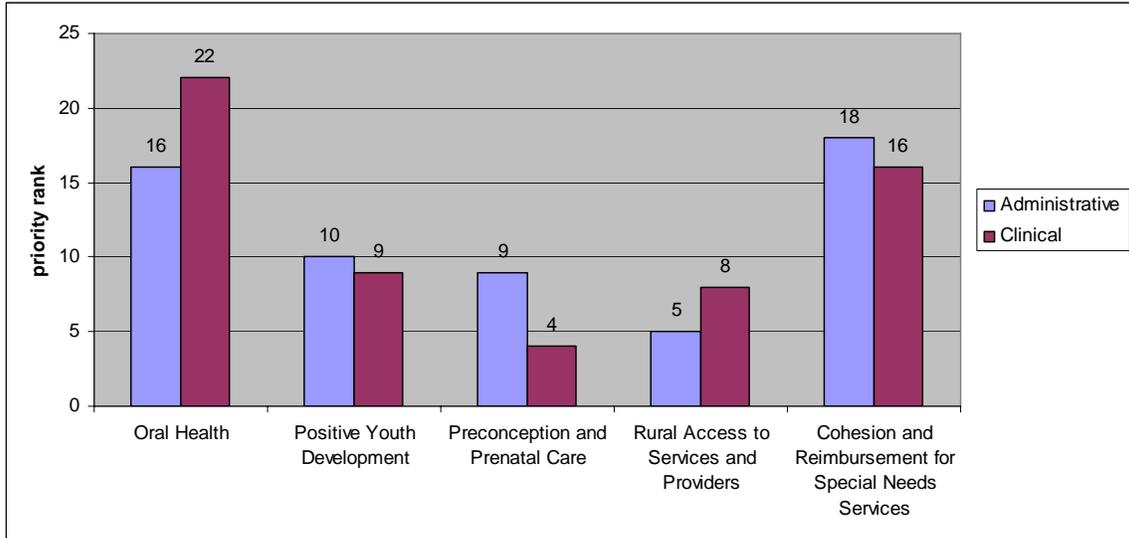
A lower rank number indicates that respondents felt the priority was more important, and a higher rank number indicates that respondents felt the priority was less important. For example, 1 = most important, 25 = least important.

Priorities are presented in alphabetical order.

109 respondents were administrative health care workers and 73 were clinical health care workers.





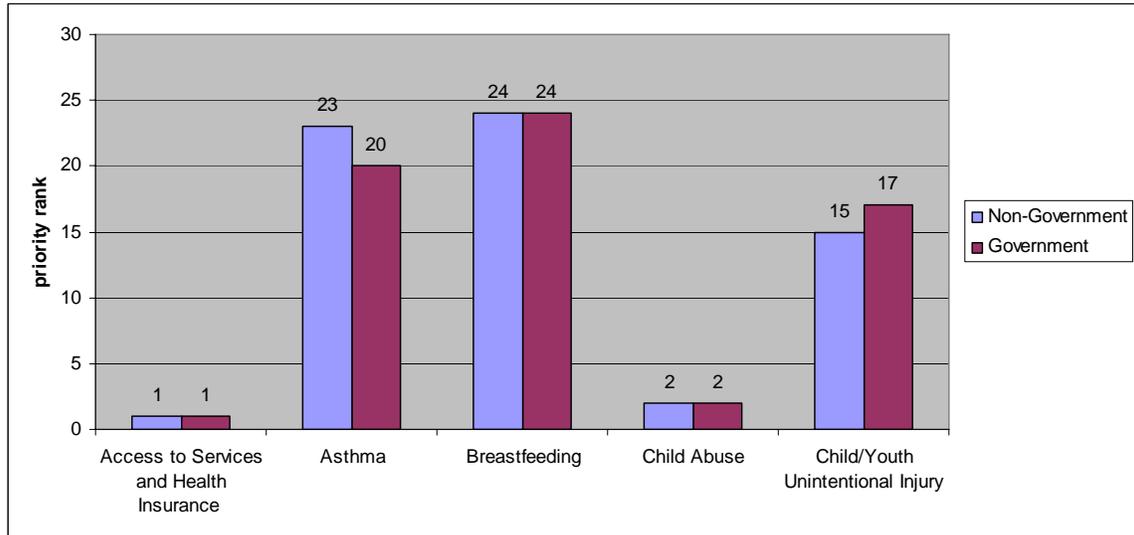


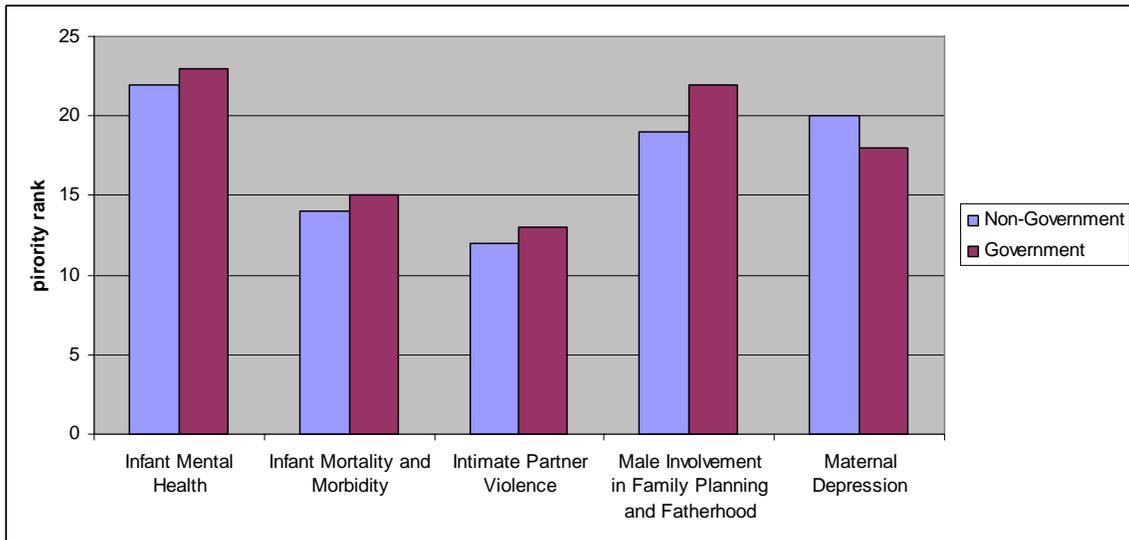
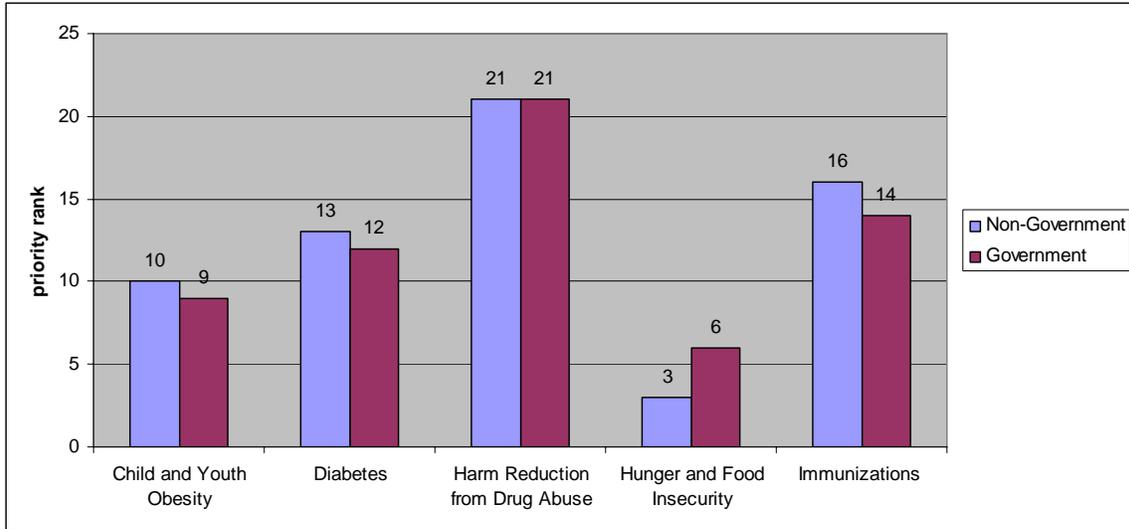
Maternal and Child Health Priority Ranks by Government and Non-Government Employment.

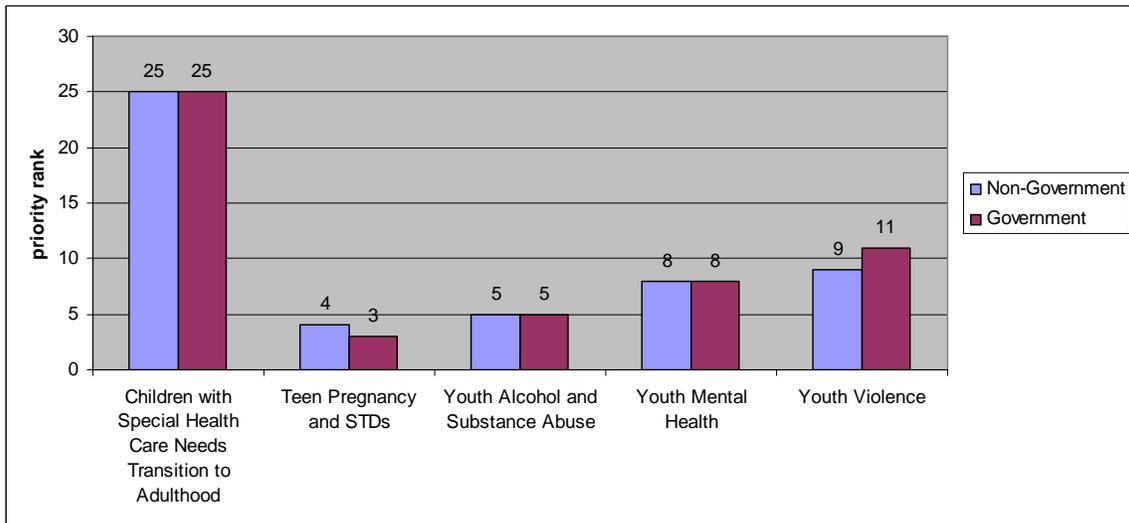
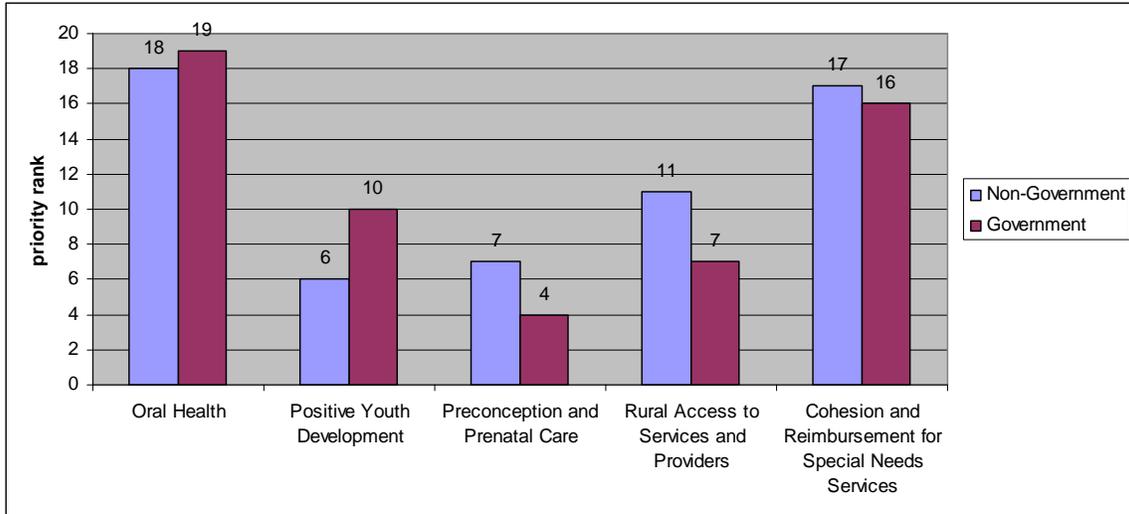
A lower rank number indicates that respondents felt the priority was more important, and a higher rank number indicates that respondents felt the priority was less important. For example, 1 = most important, 25 = least important.

Priorities are presented in alphabetical order.

221 of the respondents were government employees, and 278 were not.





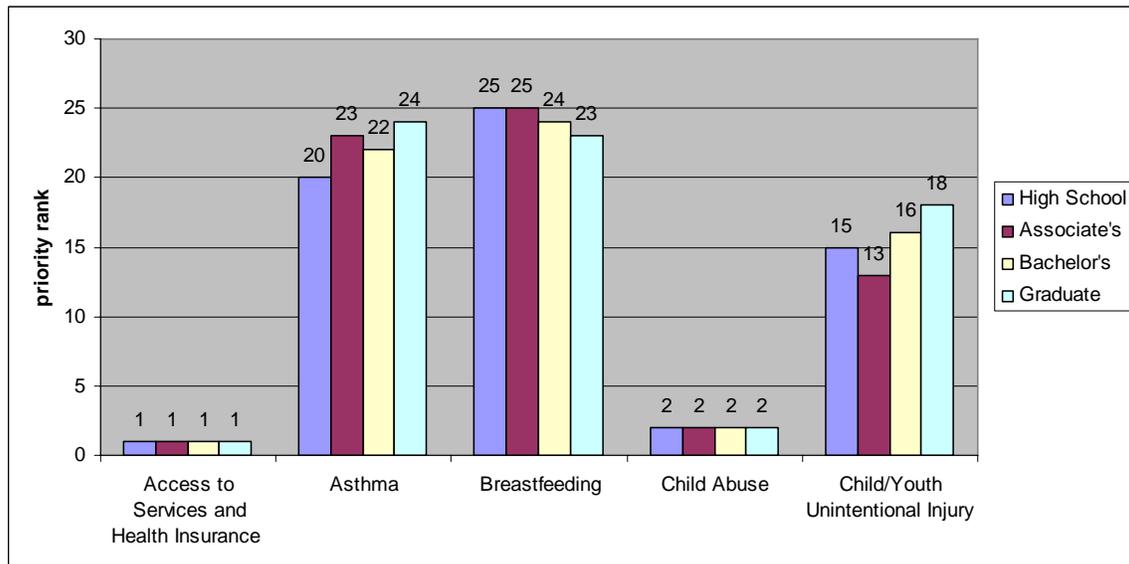


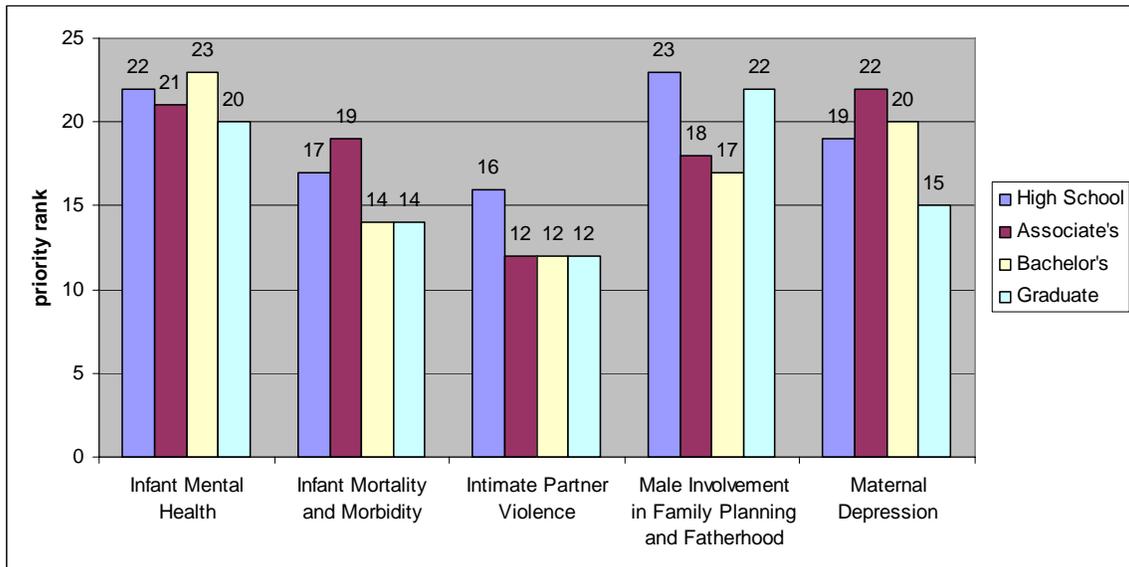
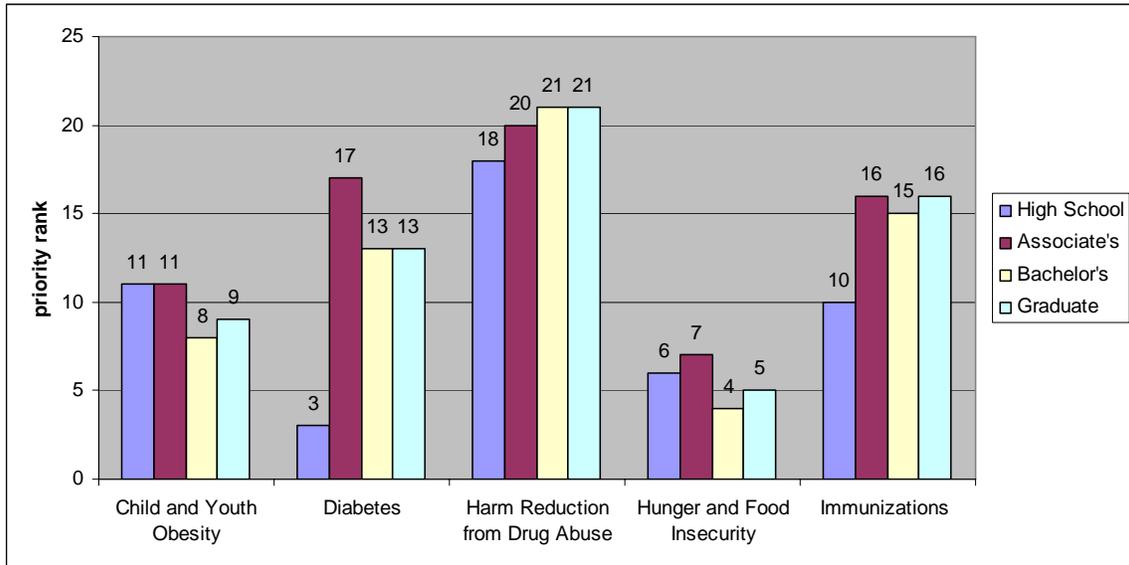
Maternal and Child Health Priority Ranks by Education.

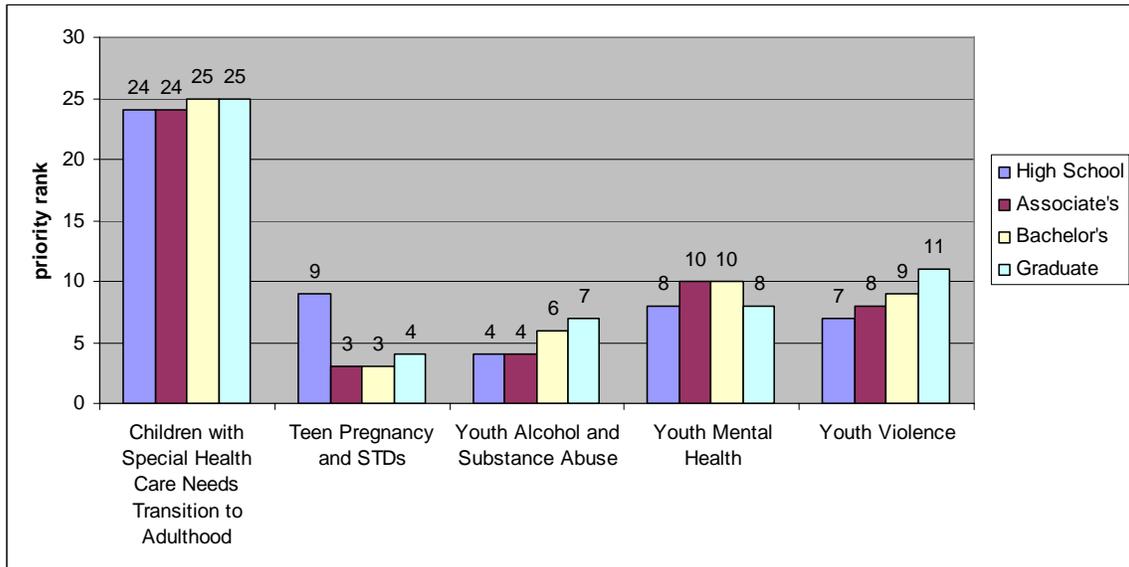
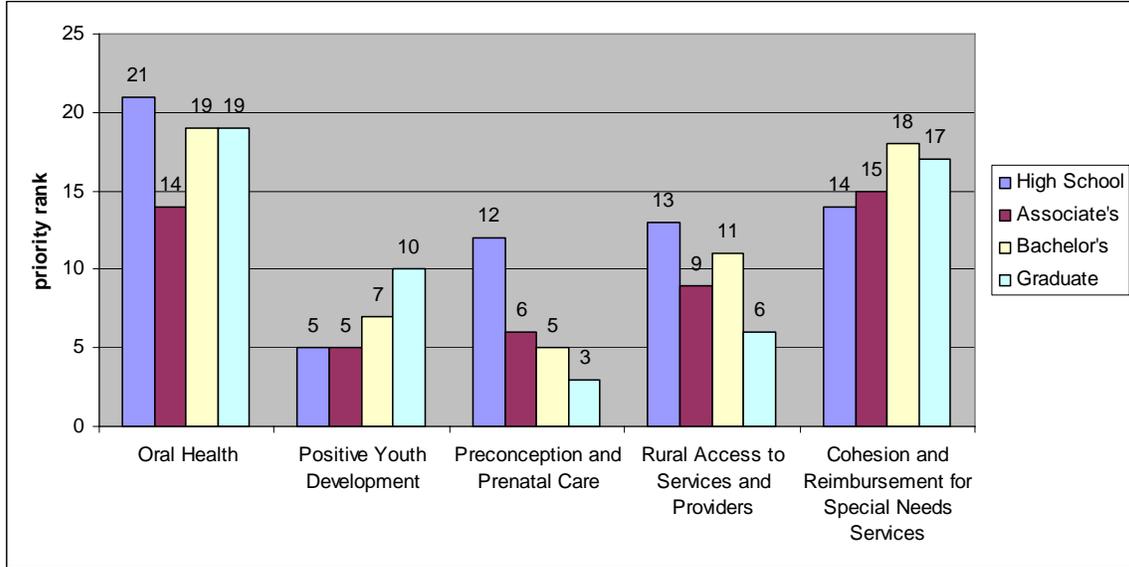
A lower rank number indicates that respondents felt the priority was more important, and a higher rank number indicates that respondents felt the priority was less important. For example, 1 = most important, 25 = least important.

Priorities are presented in alphabetical order.

- 74 Respondents had up to high school education or GED
- 79 had an associate's degree
- 151 had a bachelor's degree
- 206 had a graduate degree







Appendix 5 -- Responses to ongoing assessment of need in New Mexico

Mothers and Infants

New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS) data indicated a high rate of Maternal Depression in New Mexico. A Maternal Depression work group was created.

Families First sought funding to address the high NM incidence of Maternal Depression and obtained funding from HSD to do a 10 month pilot project in Santa Fe and San Miguel counties.

ECAN partnered with Governor's Women's Health Advisory Council to host Women's Health Forum on Pre-conceptional and Perinatal Care which developed recommendations to improve outcomes for women that was submitted to the Governor's Office for the 2009 legislative session.

The 2009 legislature passed House Memorial 58 to create a workgroup to study whether or not schools are supporting breastfeeding students. The Governor's Women's Health Office headed that workgroup which created a report that was presented to the legislature.

The New Mexico Breastfeeding Task Force is currently trying to get all NM hospitals to become baby-friendly, or at least to eliminate formula discharge packs.

Early Childhood Action Network (ECAN) partnered with many key stakeholders, including key legislators, to establish funding to Children, Youth, and Families Department (CYFD) to create a Home Visitation Task Force to develop a statewide plan for voluntary newborn home visitation. FHB staff participated in the Task Force and development of recommendations for the report: Building a System of Home Visitation in New Mexico: 2009-2012, published by Children, Youth, and Families Department.

Children

Injury data showed that there was a high rate of ATV injuries among children and youth. A law was passed to set age limits and helmet requirements for children using ATVs.

Injury data indicated high rates of child injuries when using bicycles, skateboards and other non-motorized vehicles. Safety advocates successfully supported childhood injury prevention during the 2007 legislative passage of the Child Helmet Safety Act requiring helmet use while using non-motorized recreational vehicles used on public property.

Awareness of the increased rates of autism resulted in more funding for autism services

Low national rates of influenza immunization for children with special health care needs prompted CMS to conduct targeted outreach and showed a rate almost twice the national average.

The Asthma epidemiologist detected high pediatric asthma ER and hospitalization rates in the Southeast part of the state. As a result, Children's Medical Services coordinated asthma summits in each region.

In 2005 the prototype for the Children's Report Card and later the Children's Budget Report were created to allow for review and informed discussion of strategic investment on behalf of children. Since that time the Children's Report Card and Budget Report have been published annually.

The introduction of the Head Start DVD, *In Harm's Way: Traumatic Brain Injury in Young Children* last fall provided an unanticipated opportunity in the development of safety curriculum for early childhood teachers, daycare providers, and child development specialists. It was apparent from the first showing that it is **an exceptional tool for linking injury detection, developmental intervention, and injury prevention**. The synergistic effect of this video in combination with the NM Department of Health prevention curriculum has significant potential.

The first trial integration of *In Harm's Way* with a prevention program was provided to Public Health Office employees, who work directly with new, young parents and their small children, aged 0-3 years. This training approach was well received, and it will now be utilized in every Public Health Office in the State of New Mexico.

New Mexico is one of five states funded by the Centers for Disease Control and Prevention to pilot the development and maintenance of a Sudden Unexpected Infant Death Case Registry (SUIDCR).

The NM Child Fatality Review, facilitated by the NMDOH Office of Injury Prevention, partners with the Office of the Medical Investigator to maintain the NM-SUIDCR. New Mexico SUID cases are reviewed by a multidisciplinary panel of experts, who then develop recommendations for prevention. A primary recommendation is for a "Safe Sleep" Campaign to be integrated into home safety curricula and health promotion education for anyone home daycare providers, Early Head Start daycare providers, public health educators, clinic counselors, and home visitation specialists.

Consistently alarming annual statistics for fatalities and serious injuries among youth and children on all terrain vehicles (ATV's) in New Mexico resulted in passage of the Revised Off Road Vehicle Regulations in the 2005 Legislature.

Equally poor statistics regarding the incidence of traumatic brain injury among children and youth when riding bicycles, skateboards, scooters, skates and tricycles led to the passing of the Child Helmet Safety Act in the 2007 Legislature, requiring helmet use by

children while using any non-motorized vehicles used on public property, which includes sidewalks.

Children with Special Health Care Needs

The Developmental Screening Symposiums formed the foundation for New Mexico's Developmental Screening Initiative (DSI), with a published report in 2006: *Improving Developmental Care for Young Children and Their Families in New Mexico*.

Children's Medical Services provided information and recommendations that resulted in 2007 legislation requiring insurance companies to cover hearing aids for children. Also, Medicaid reimbursement was increased and the gross receipts tax on hearing aids was eliminated. This change took place based on numbers of children requiring hearing aids, and stories from families and providers of the lack of access to this service.

Appendix 6: New Mexico
Home Visiting Indicators
Rates, Percents and Ranks
by County

Needs Rank	Community/County	Adolescent Births/1000	Adolescent birth rank	Percent Preterm Births	Preterm rank	%LBW <2500g	LBW rank	Infant Deaths/100,000	IMR rank	Residents Below FPL	Poverty rank	Juvenile Arrests/100000	Juvenile Arrest rank
1	Quay	56	16	10.20%	15	7.10%	22	11.08	1	19.9	15	7329	2
2	Alb.S.Valley	95.5	1	10.40%	13	9.63%	7	*	*	25.09	5	*	*
3	Grant	60.9	11	13.60%	1	11.30%	4	6.96	7	19	16	5676	9
4	Guadalupe	48.6	21	10.10%	16	8.80%	12	*	*	23.7	8	6585	4
5	Lea	91.5	3	12.80%	4	9%	11	6.63	8	15.5	25	6117	6
5	Luna	92.8	2	12.10%	6	8.40%	14	7.60	5	28	2	3991	17
6	Cibola	74	7	10.70%	11	9.40%	9	7.22	6	24.2	6	2104	29
7	McKinley	55.3	17	13.50%	2	8.70%	13	9.47	3	30.8	1	2032	30
8	Hidalgo	58	14	12.90%	3	9.40%	9	*	*	21.3	12	6869	3
9	Chaves	73.8	8	10.70%	11	7.90%	17	6.69	7	21.2	13	5174	13
10	Sandoval	43.3	26	11.30%	10	12.60%	1	4.74	19	25.6	4	1334	32
11	Socorro	59.8	12	11.90%	8	8.70%	13	*	*	27.3	3	6092	7
12	Dona Ana	76.9	5	10.30%	14	7.30%	21	4.70	20	23.3	9	5495	11
13	Curry	89	4	11.80%	9	8.70%	13	6.38	9	17.9	20	6294	5
14	Colfax	51.5	19	12%	7	11.50%	3	*	*	16.6	22	5313	12
15	Eddy	76.1	6	11.30%	10	7.70%	19	7.80	4	15.3	27	5991	8
16	San Miguel	59.6	13	9.80%	17	7.70%	19	5.98	15	14.4	29	13479	1
17	Taos	50	20	10.10%	16	11%	5	5.44	17	18.1	18	5667	10
18	Rio Arriba	71.1	9	10.40%	13	10.70%	6	4.13	21	17.2	21	3118	24
19	Lincoln	46.7	24	12.30%	5	9.60%	8	6.16	13	15.4	26	5119	14
20	Valencia	58	14	10.30%	14	7.60%	20	5.47	16	15.7	24	2449	27
21	Union	41.5	27	12.90%	3	6.70%	24	*	*	16	23	3956	18
22	Bernalillo	57.2	15	10.70%	11	8.80%	12	6.17	12	14.3	30	4189	16
23	Torrance	41.4	28	8.60%	21	6.60%	25	10.48	2	21.4	11	3577	22
24	Otero	45.8	25	9.20%	20	8%	16	6.37	10	18	19	4410	15
25	Sierra	51.7	18	10.30%	14	7.80%	18	*	*	23.9	7	3931	19
26	Roosevelt	68	10	10.20%	15	6.80%	23	6.10	14	21.2	13	3923	20
27	Mora	33.8	30	9.70%	18	12.30%	2	*	*	23	10	2615	26
28	San Juan	36.6	29	10.50%	12	7.90%	17	6.20	11	11	32	3756	21
29	De Baca	46.8	23	*	*	*	*	*	*	18	19	*	*
30	Santa Fe	47.8	22	8.50%	22	9.20%	10	5.43	18	12.3	31	3055	25
31	Catron	28.2	31	*	*	*	*	*	*	20.7	14	*	*
32	Harding	*	*	0%	23	*	*	*	*	15.2	28	*	*
33	Los Alamos	8.5	32	9.40%	19	8.30%	15	*	*	3.1	33	2267	28
	Total NM	60.1		10.7		8.6		6.16		17		4227	

Appendix 6: New Mexico
Home Visiting Indicators
Rates, Percents and Ranks
by County

Community/County	DV Rate/1000	DV rank	Percent hs drop-outs grades 9-12	Dropout Rank	Percent Unemployed	Unemployed rank	Combined Abuse/1000 Children	2008 Combined Abuse rank	Rank 1	Rank 2	# Indicators in top 5 for need
Quay	30.54	2	7.5	3	8	13	84.26	1	9.00	1	5
Alb.S.Valley	*	*	*	*	5.13	24	*	*	10.00	2	2
Grant	7.64	19	3.25	15	11.4	3	13.51	22	10.70	3	3
Guadalupe	10.57	11	3.25	15	9.6	8	40.90	2	10.78	4	2
Lea	11.77	9	2.24	25	8	13	32.83	6	11.00	5	2
Luna	1.11	29	3.9	13	19	1	15.19	21	11.00	5	4
Cibola	9.02	14	16	1	8	13	18.14	17	11.30	6	2
McKinley	13.19	6	6.2	8	9.8	7	9.01	28	11.50	7	3
Hidalgo	6.88	20	3.15	16	7.1	15	23.23	12	11.56	8	2
Chaves	7.96	18	2.9	18	8	13	37.98	4	12.20	9	1
Sandoval	9.88	12	8.2	2	8.7	9	28.71	8	12.30	10	3
Socorro	9.00	15	7	5	6.2	19	6.32	29	12.33	11	2
Dona Ana	14.50	4	3.1	17	8.2	12	18.42	15	12.80	12	2
Curry	8.52	17	2.7	20	5.1	25	32.60	7	12.90	13	2
Colfax	4.92	26	5.3	9	7.5	14	20.96	13	13.89	14	1
Eddy	9.16	13	2.5	22	6.1	20	24.85	10	13.90	15	1
San Miguel	12.15	7	4.6	12	9.9	6	11.20	26	14.50	16	1
Taos	8.54	16	2.8	19	10.3	5	15.54	20	14.60	17	2
Rio Arriba	6.44	21	6.7	6	8.4	11	18.26	16	14.80	18	0
Lincoln	14.82	3	1.6	26	6.4	17	19.70	14	15.00	19	1
Valencia	6.42	22	4.8	10	10.4	4	33.98	5	15.60	20	2
Union	31.38	1	2.5	22	5.4	22	39.18	3	15.89	21	3
Bernalillo	13.52	5	2.4	24	8.5	10	11.91	24	15.90	22	1
Torrance	5.84	23	7.3	4	9.8	7	17.89	18	16.10	23	2
Otero	11.86	8	2.45	23	7.5	14	15.61	19	16.90	24	0
Sierra	4.95	25	6.5	7	5.9	21	11.75	25	17.11	25	0
Roosevelt	5.49	24	1.1	28	6.3	18	24.48	11	17.60	26	0
Mora	2.76	27	1.45	27	15	2	*	*	17.75	27	2
San Juan	9.00	15	4.7	11	9.6	8	5.13	30	18.60	28	0
De Baca	*	*	2.6	21	5.2	23	26.32	9	19.00	29	0
Santa Fe	10.72	10	3.3	14	6.9	16	9.71	27	19.50	30	0
Catron	*	*	*	*	8	13	12.52	23	20.25	31	0
Harding	*	*	0	29	4.3	26	*	*	26.50	32	0
Los Alamos	1.94	28	1.6	26	3.6	27	3.93	31	26.56	33	0
Total NM	11.31		3.8		8.2		16.47				

County	adolescent births	ad birth z	% preterm births	preterm z	%LBW (<2500g)	LBW z	% below FPL	poverty z	% un-employed	un-employ z	Combine z
Luna	0.0928	1.7755	0.1210	0.8692	0.0840	-0.2972	28	1.521323	19	3.5649258	7.43
Grant	0.0609	0.1130	0.1360	1.9735	0.1130	1.5165	19	-0.060612	11.4	1.0141422	4.56
McKinley	0.0553	-0.1789	0.1350	1.8999	0.0870	-0.1095	30.8	2.01348	9.8	0.4771351	4.10
Sandoval	0.0433	-0.8043	0.1130	0.2802	0.1260	2.3295	25.6	1.099473	8.7	0.1079428	3.01
Mora	0.0338	-1.2994	0.0970	-0.8977	0.1230	2.1419	23	0.64247	15	2.2224081	2.81
Lea	0.0915	1.7078	0.1280	1.3846	0.0900	0.0781	15.5	-0.675809	8	-0.1269978	2.37
So Val/Central	0.0955	1.9162	0.1040	-0.3824	0.0963	0.4721	25.09	1.00983	5.13	-1.0902543	1.93
Cibola	0.074	0.7957	0.1070	-0.1615	0.0940	0.3282	24.2	0.853394	8	-0.1269978	1.69
Hidalgo	0.058	-0.0382	0.1290	1.4582	0.0940	0.3282	21.3	0.34366	7.1	-0.4290643	1.66
Socorro	0.0598	0.0556	0.1190	0.7220	0.0870	-0.1095	27.3	1.398283	6.2	-0.7311308	1.34
Colfax	0.0515	-0.3769	0.1200	0.7956	0.1150	1.6416	16.6	-0.482462	7.5	-0.2948126	1.28
Rio Arriba	0.0711	0.6446	0.1040	-0.3824	0.1070	1.1412	17.2	-0.377	8.4	0.0072539	1.03
Curry	0.089	1.5775	0.1180	0.6483	0.0870	-0.1095	17.9	-0.25396	5.1	-1.1003232	0.76
Taos	0.05	-0.4551	0.1010	-0.6032	0.1100	1.3289	18.1	-0.218806	10.3	0.6449498	0.70
Chaves	0.0738	0.7853	0.1070	-0.1615	0.0790	-0.6099	21.2	0.326083	8	-0.1269978	0.21
Dona Ana	0.0769	0.9469	0.1030	-0.4560	0.0730	-0.9851	23.3	0.695201	8.2	-0.059872	0.14
Guadalupe	0.0486	-0.5281	0.1010	-0.6032	0.0880	-0.0470	23.7	0.765509	9.6	0.4100092	0.00
Lincoln	0.0467	-0.6271	0.1230	1.0165	0.0960	0.4533	15.4	-0.693387	6.4	-0.6640049	-0.51
Eddy	0.0761	0.9052	0.1130	0.2802	0.0770	-0.7349	15.3	-0.710964	6.1	-0.7646937	-1.03
Bernalillo	0.0572	-0.0799	0.1070	-0.1615	0.0880	-0.0470	14.3	-0.886734	8.5	0.0408169	-1.13
Valencia	0.058	-0.0382	0.1030	-0.4560	0.0760	-0.7975	15.7	-0.640655	10.4	0.6785128	-1.25
Sierra	0.0517	-0.3665	0.1030	-0.4560	0.0780	-0.6724	23.9	0.800663	5.9	-0.8318196	-1.53
Roosevelt	0.068	0.4830	0.1020	-0.5296	0.0680	-1.2978	21.2	0.326083	6.3	-0.6975679	-1.72
Quay	0.056	-0.1424	0.1020	-0.5296	0.0710	-1.1102	19.9	0.097581	8	-0.1269978	-1.81
San Miguel	0.0596	0.0452	0.0980	-0.8241	0.0770	-0.7349	14.4	-0.869157	9.9	0.5106981	-1.87
Union	0.0415	-0.8981	0.1290	1.4582	0.0670	-1.3603	16	-0.587924	5.4	-0.9996343	-2.39
Otero	0.0458	-0.6740	0.0920	-1.2658	0.0800	-0.5473	18	-0.236383	7.5	-0.2948126	-3.02
San Juan	0.0366	-1.1535	0.1050	-0.3087	0.0790	-0.6099	11	-1.466777	9.6	0.4100092	-3.13
Torrance	0.0414	-0.9033	0.0860	-1.7076	0.0660	-1.4229	21.4	0.361237	9.8	0.4771351	-3.20
Santa Fe	0.0478	-0.5698	0.0850	-1.7812	0.0920	0.2032	12.3	-1.238275	6.9	-0.4961902	-3.88
Los Alamos	0.0085	-2.6180	0.0940	-1.1186	0.0830	-0.3597	3.1	-2.855364	3.6	-1.6037673	-8.56

Average 0.058732258 0.10919355 0.088752 19.34484 8.3783871
Standard Dev. 0.019187451 0.01358288 0.01599 5.689235 2.97947657

Catron, De Baca and Harding counties were not included in this analysis due to insufficient data.

Appendix 8 -- New Mexico Maternal and Child Health Data and Linkage Capacity

DATA SOURCES	Availability
Vital Statistics	Yes
Pregnancy Risk Assessment Monitoring System (PRAMS)	Yes since 1997. Two Navajo-specific PRAMS reports are available through the Navajo Epidemiology Center. Years 1998-2007 PRAMS indicators are queriable on the NMDOH IBIS and the CDC PONDER systems.
Women, Infants, & Children (WIC) program	Yes An annual download to examine selected health indicators. Linkage of WIC to birth files and PRAMS is in development stages
Medicaid	Yes Aggregate reports available upon request to Medicaid.
Birth defects registry/program	Yes Birth defects surveillance is currently supported by the New Mexico Environmental Public Health Tracking System in the Epidemiology & Response Division, DOH. Active & passive surveillance w/record review is done for 5 birth defects.
Newborn screening program (NB Genetic Screening)	YES The New Mexico Newborn Screening Program offers screening for 27 disorders. New Mexico Newborn Screening Program continues to partner with Mountain States Genetic Network and has also contracted with Oregon State Public Health Laboratory for expanded screening. http://www.health.state.nm.us/nbs/index.html

DATA SOURCES	Availability
Hospital discharge data	Yes NM Health Policy Commission – as of 2009 can provide data files for use by Dept Health Epidemiologists
Home visiting records	Yes Data collection for state sponsored programs began spring 2009
Newborn hearing screening program	Yes Screening follow up records are merged with birth file to estimate screening coverage
Behavioral Risk Factor Surveillance System (BRFSS)	Yes Done in the Behavioral Epi Program within the Epidemiology and Response Division. MCH has had special questions on insurance coverage added. MCH Epi has used data to evaluate youth in transition (age 18-24 years) regarding CSHCN issues
State-specific survey related to perinatal health	PRAMS
Healthy Start program (HRSA funded program)	Healthy Start is sited in southern part of state. They have an electronic record system for clients & selected activities (billing) called Challenger Soft. The same system is used in the FHB Families FIRST perinatal case management.
Family Planning program data	Yes Collected and reported to Title X agency. Used by Title V to evaluate needs and unmet needs; also Guttmacher estimates for NM are used
Immunization data	Yes National Immunization Survey is main source for coverage. WIC collects immunization data in some offices.
Perinatal HIV/AIDS data	Yes HIV and AIDS are reportable conditions. Available from Epidemiology and Response

DATA SOURCES	Availability
	Division.
Data from regional perinatal centers	Nothing specific at state level.
Youth Risk Behavior Survey (YRBS) Known as YRRS (Youth Risk and Resiliency Survey) in NM	Yes every other year done in the Behavioral Epi Program within the Epidemiology and Response Division
Child fatality review	Yes Established with regulations by the Title V MCH funded programs. Now placed in Injury Prevention Office of the Epidemiology and Response Division –
Healthcare Cost and Utilization Project (H-CUP) data	Yes Bill passed in NM legislature 2009 session that allows New Mexico Health Policy Commission to participate in H-CUP. NM participating as of FY2010.
Lead poisoning program data	Yes Lead poisoning program in ERD. Lead poisoning is a reportable condition.
National Survey of Children’s Health (NSCH)	Yes
National Survey of Children with Special Healthcare Needs (NSCSHCN)	Yes
State-specific perinatal health program data	PRAMS and Vital Records
Other data sources related to perinatal health.	NM Families FIRST, perinatal case management has an electronic client record used to track clients, evaluate progress on indicators with potential linkage to birth file, & other MCH electronic records
Home visiting	In development. Client based electronic record system developed by the home visiting initiatives in the Children Youth & Families Department.

DATA LINKAGES	
Birth records - Death records	Yes Done annually by NM Vital Records and Health Statistics (VRHS).
Vital records - Medicaid	No Done in past by VRHS. Plans are underway to link these for the SSDI grant
WIC - birth certificate	No The data are available and plans are underway to link these.
Birth defects - Birth certificate	Yes Done in the Environmental Epidemiology Program of ERD
Newborn screening - Birth certificate	No Possibly will be done in the future in ChallengerSoft. Needs to be worked-out and approved by VRHS.
Hospital discharge - Birth certificate	No Not yet. DOH is now set up to be able to do this
Hospital discharge - Death certificate	No Not yet. DOH is now set up to be able to do this
Birth defects - Death certificates	Not yet. Could be done in the Environmental Epidemiology Program of Epidemiology and Response Division
Newborn genetic screening - Death certificates	Not yet
Newborn hearing screening - Birth certificates	Yes
Perinatal HIV/STD data - Birth certificates	No
Perinatal HIV/STD data - Death certificates	No
Agency data - Birth certificates	No In past linked birth certificates with Families FIRST perinatal case management program. Will do this

	again in future, staff resources permitting
Live births - Fetal deaths – Death certificates of 10-54 year old women	No Formerly, when maternal mortality review was functioning. Presently on hold due to lack of staff and funds to support the activity
PRAMS to WIC	Yes Linking has been done of several years' worth of data. Analysis is needed.
PRAMS to Medicaid	No This is in the top linkage priorities for linkage

Appendix 9: Department of Health Strategic Plan Objectives FY 2010

Improving Individual Health

- 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.

- **Under consideration for FY 2011:**
 - Individual Objective 6: Reduce substance abuse, including alcohol and tobacco.

Improving Community Health

- Community Objective 1: Reduce health disparities in New Mexico.
- Community Objective 2: Decrease the transmission of infectious disease and expand services for persons with infectious diseases.
- Community Objective 3: Ensure preparedness for health emergencies, including pandemic influenza.
- Community Objective 4: Identify and reduce environmental exposures harmful to public health.

Improving the Health System

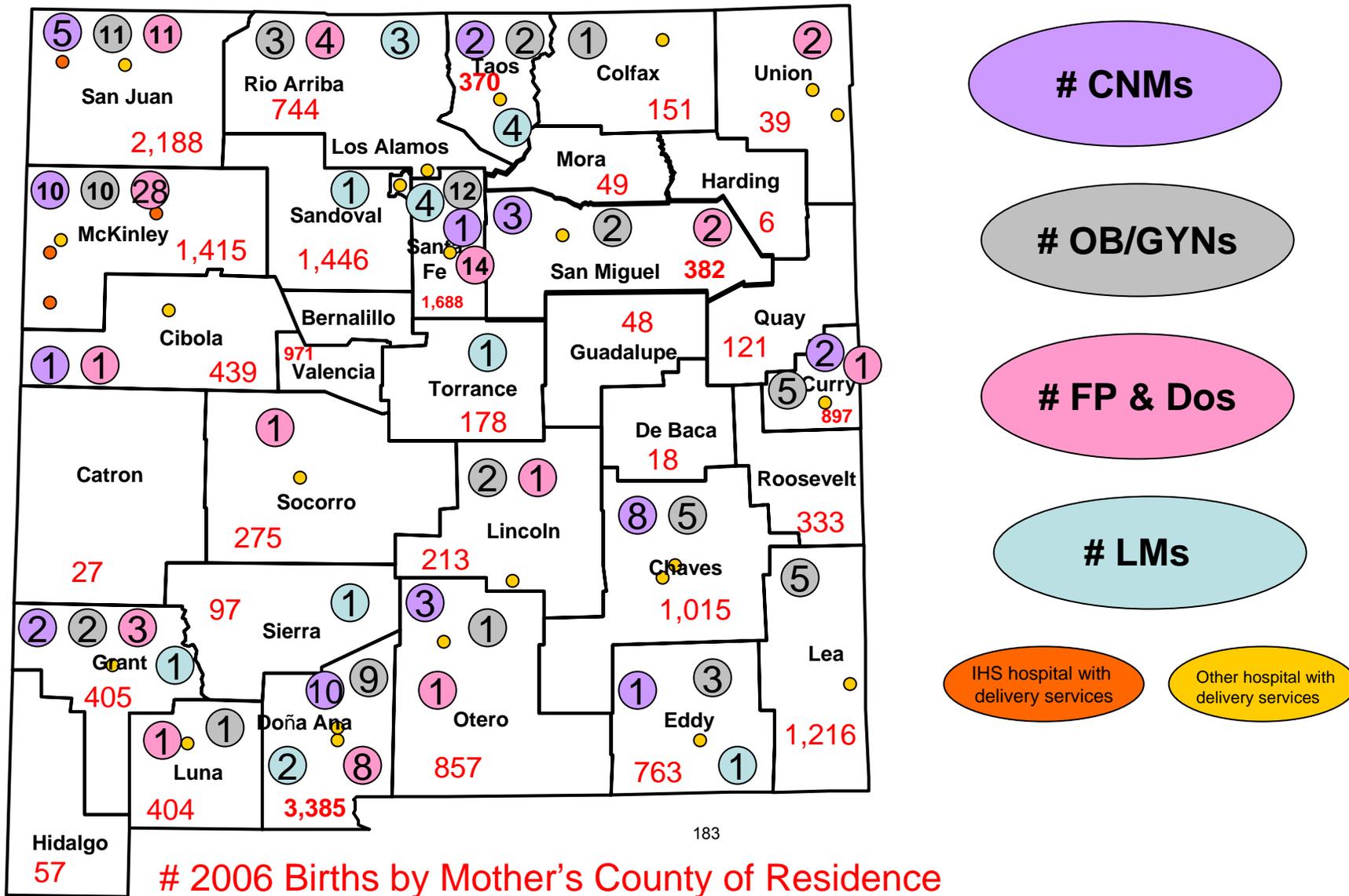
- Objective 1: Improve accountability and responsiveness of our services within the Department of Health.
- System Objective 2: Expand healthcare for school-age children and youth through school-based health services.
- System Objective 3: Create an oral health system that provides children, low-income rural populations and people with disabilities with preventive and restorative oral health services.
- System Objective 4: Improve the EMS and trauma care system across the State.
- System Objective 5: Improve the State Laboratory's ability to provide laboratory analytical services to State programs.
- System Objective 6: Improve resident care and 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 healthcare providers in rural and underserved areas.
 - System Objective 10: Increase use of technologies to improve health outcomes.

Availability of Obstetric Services In 2008

Bernalillo Co. had 9,633 births to residents in 2006, and in 2008 has 70 OB/Gyns, 79 FPs/DOs, 60 CNMs and 7 LMs attending births, and 3 hospitals that provide obstetric services.

Los Alamos Co. had 178 births to residents in 2006, and in 2008 has 1 CNM and 1OB/GYN attending births.



Appendix 11 -- MCH Priorities “Weighting” Exercise

Please read these definitions/concepts carefully and use the worksheet that corresponds to your group to assign a “weight” from one to five for each of the priorities.

1. Criterion Name: Problem has serious health consequences

Definition/Concepts: This means that the problem identified could result in severe disability or death.

- 1= Problem has a high likelihood of death and disability
- 2= Problem can be moderately life threatening but there is a strong likelihood of disability
- 3= Problem can be moderately life threatening or disabling
- 4= Problem is not life threatening but is sometimes disabling
- 5= Problem is not life threatening or disabling to individuals or community

2. Criterion Name: A large number of Individuals are affected by the problem

Definition/Concepts: This criterion considers the absolute number of people (the MCAH population) affected. It includes the concept that targeting a problem affecting a large number of individuals could have a greater impact on the health of the community than one affecting a relatively small number of people. This criterion is intended to provide a balance for a situation in which a few occurrences of a particular problem in a small group can result in a high rate but in reality the condition may only affect a few individuals in the community, e.g., a geographic area with a very small population and few births that has one teenage pregnancy will result in a high teen pregnancy rate for that geographic area.

- 1= Large number of individuals affected across the entire population
- 2= Large number of individuals affected in particular subgroups
- 3= Moderate number of individuals affected across the entire population
- 4= Moderate number of individuals affected in particular subgroups
- 5= Relatively few individuals affected

3. Criterion Name: Disproportionate effects among subgroups of the population (please estimate this, do not worry about the statistical significance for now.)

Definition/Concepts: This means that one or more population subgroups as defined by race, ethnicity, income, insurance status, gender or geography have *statistically* significantly worse indicator values of illness or condition when compared to another group.

- 1= Statistically significant differences exist in one or more groups and at least one of the disadvantaged groups is greater than 1.75 times more likely to have a poor outcome
- 2= Statistically significant differences exist in more than one group
- 3= Statistically significant differences exist in one group and the disadvantaged group is at least 1.25 to 1.75 times more likely to have a poor outcome
- 4= It appears that one or more groups is disproportionately affected by the problem, but differences are not statistically significant
- 5= No group is disproportionately affected by the problem

4. Criterion Name: Problem results in significant economic/ social cost

Definition/Concepts: If problem is not addressed the result will be increased monetary costs, e.g., health care and/or social services costs to society and costs to employers, and or loss of productive individuals because of chronic illness, disability or premature death.

- 1= There will be great economic and societal cost
- 2= There is likely to be substantial increased costs
- 3= There is likely to be moderate increased costs
- 4= There is some potential increased costs
- 5= Economic/ societal cost is minimal

5. Criterion Name: Problem is cross-cutting to multiple issues/ life span effect

Definition/Concepts: Problem at one life stage has long term impact in later life and/or problem is a proxy for a set of other related behavioral or social problems.

- 1= Problem severely impacts entire life course and is associated with multiple problems
- 2= Problem severely affects either entire life course or is associated with multiple problems
- 3= Problem moderately impacts entire life course and is associated with multiple problems
- 4= Problem minimally impacts entire life course and is associated with multiple problems
- 5= Problem limited to one life stage and is not associated with other problems

6. Criterion Name: Potential for prevention/mitigation

Definition/Concepts: Level of capacity/resources available to prevent the problem, or mitigate existing problem.

- 1= Funds, expertise, infrastructure and other resources exist, are well coordinated, and are regularly accessed and employed.
- 2= Funds, expertise, infrastructure and other resources exist, and are coordinated at an adequate level.
- 3= Funds, expertise, infrastructure and other resources exist, but are not coordinated.
- 4= Some, but not all funds, expertise, infrastructure and other resources exist. Those that are unavailable are unlikely to become available within the next five years.
- 5= Funds, expertise, infrastructure and other resources are scarce or non-existent, and unlikely to become available within the next five years.

Appendix 12: Comparison of 2010 and 2005 Priorities

	2010	2005	2005	2005	2005
1	Increase accessibility to care for pregnant women and mothers that provides care before, during and after pregnancy	Reduce barriers and disparities to accessing community-based health and health related services for women, children and youth.	Working with women on preconceptional health issues such as increasing folic acid supplementation, while reducing smoking and drinking	Reduce medical services funding gaps for children in NM	Increase the proportion of women receiving adequate prenatal care
2	Enhance the infrastructure for preventing domestic and interpersonal violence and assisting victims of violence	Reduce fatal and non-fatal family violence	Decreasing the number of women abused in pregnancy		
3	Increase voluntary mental illness and substance abuse screening for the MCH population increase availability of treatment options	Measuring of substance abuse in families with children	Promote youth development strategies to reduce the incidence of substance abuse and mental health disorders and other high-risk behaviors in youth under age 21		
4	Promote healthy lifestyle options to decrease obesity and overweight among children and youth	Promoting healthy weight among parents and their children			
5	Improve the infrastructure for care coordination of children and youth with special health care needs	Establish an infrastructure to support and monitor transition services for adolescents with special health care needs			

	2010	2005
6	Increase awareness and availability of family planning and STD prevention options	Decreasing the teen chlamydia rate
7	Promote awareness of childhood injury risks and provide injury prevention protocols to families and caregivers of children	Promote child safety by focusing on reduction of unintentional injury
8	Decrease disparities in maternal and infant mortality and morbidity	Increasing male involvement in the family and increasing the quality of Fatherhood
9	Maintain specialty outreach clinics for children and youth with special health care needs	
10	Increase the proportion of mothers that exclusively breastfeed their infants at six months of age	