Maternal and Child Health Services Title V Block Grant

New Mexico

FY 2017 Application/ FY 2015 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

LYNN GALLAGHER, SECRETARY DESIGNATE

July 14, 2016

Lynda Marquardt, M.S.W., ACSW
Social Work Consultant
HRSA/MCHB/DSCH
1301 Young Street, Suite 1030
Dallas, TX 75202

Dear Ms. Marquardt,

The New Mexico Department of Health is pleased to submit the Title V Maternal and Child Health Block Grant report for Federal Fiscal Year 2015 and application for Federal Fiscal Year 2017.

If you have any questions regarding the application and report, please contact Christopher Whiteside, MPH, Title V Block Grant Coordinator, at 505-476-8825 or myself at 505-476-8854.

Sincerely,

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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Background

New Mexico has transitioned from the previous block grant cycle (FFY2011-2015) to the new cycle (FFY2016-2020). New Mexico's previously selected priorities, along with the current National Performance Measures (NPMs) and State Performance Measures (SPMs) from this current cycle, were still under surveillance during the report year (FFY2015), the final year of the previous cycle. This application year (FFY2017) we have added the creation and implementation of unique SPMs and Evidence-Informed Strategy Measures (ESMs). The SPMs are measures developed by the state Title V program to address the unique MCH needs of the state. ESMs are strategy measures that will be used to gauge our progress towards impacting the National Performance Measures (NPMs). Each population domain work group has selected an ESM as a complement to a specific strategy designed to impact the priorities and NPMs that NM has selected.

Maternal Health

2015

The Maternal Health Program, through its involvement with the Collaborative Innovation and Improvement Network, is taking the lead on the strategy to improve Perinatal Regionalization in the state. The Maternal Child Health Epidemiology program is working with the state's Bureau of Vital Records and Health Statistics to gain permission to analyze infant birth and death files by provider of care in order to ascertain if women with high-risk pregnancies are delivering in facilities with appropriate levels of care. New Mexico is utilizing the Level of Care Assessment Tool (LoCATe) that categorizes a hospital's level of risk appropriate care. The Maternal Health Program (MHP) continues to partner with our public health offices, UNM, private practitioners, the NMMA, the NM chapter of the American College of Nurse Midwives, and institutions throughout NM to form agreements with providers or provider sites to provide timely and adequate care to pregnant, birthing, and post-partum women in NM. In October 2014, MHP partnered with state Medicaid authorities to educate the MCOs involved in Centennial Care on the Birthing Options Plan, which includes home births and the services of direct-entry midwives licensed by the MHP.

2017 Application Year Plan

Maternal health is moving forward with the priorities of ensuring that high-risk infants and mothers are receiving care at appropriate level birthing facilities and ensuring that women are receiving and have access to annual preventive medical visits. Maternal health is working together with the Family Planning Program to establish well woman care in postpartum visits.

Perinatal/Infant Health

2015

The Families First (FF) program continued to offer statewide perinatal case management to pregnant women and assess women for tobacco use. Case managers referred women to smoking cessation classes. Family planning assessed women for violence, alcohol and substance abuse. FF, WIC, and Family Planning continued offering assessment education and referral services for pregnant women who use tobacco.

During the transition year of 2015, maintaining and increasing breastfeeding initiation and duration remained a priority in NM. The longitudinal follow-up to PRAMS to measure breastfeeding duration is scheduled to commence in 2016 and we should have data to measure in 2017. WIC provided all pregnant and breastfeeding participants with encouragement, education and support to breastfeed, providing group breastfeeding support sessions and individual counseling to all pregnant and breastfeeding mothers.

2017 Application Year Plan

Moving into the 2017 application year, perinatal and infant health will continue to focus on breastfeeding and will add safe sleep strategies with the goal of integrating breastfeeding and safe sleep messaging. One major strategy is to collaborate with March of Dimes, Children Youth and Families Department (CYFD), and UNM Envision to co-brand messaging around safe sleep and breastfeeding.

Child Health

2015

Immunization, Oral Health, and Child Injury were the major priorities in the final year of the previous block grant cycle. Of these, only oral health will continue into the new cycle as a priority; however, oral health will be now in the Cross-Cutting/Life-Course population domain rather than in Child Health.

At statewide events during "Got Shots? Protect Tots!" weeks held in 2015, participating providers opened their doors on one or more publicized dates and provided immunizations to any child who presented without an appointment, regardless of whether they are a patient or whether they have insurance. 161 0-2 year-olds, 498 3-6 year-olds, and 1503 7-18 year-olds received immunizations at “Got Shots” events in 2015. The Department of Health (DOH) organized the NM School Kids Influenza Immunization Project (SKIIP) with the New Mexico Immunization Coalition.

A total of 7,896 3rd graders received a dental sealant in FY 15. The data on this comes from both the Office of Oral Health (OOH) and Medicaid (1,580 OOH and 4,006 Medicaid enrollees). The OOH contractors are required to provide dental sealant for 3rd graders.

The Office of Injury Prevention (OIP) conducted bimonthly conference calls and meeting notes featuring event announcements for car seat technician trainings, car seat checks and distributions, bicycle helmet distributions and traffic safety events, as well as crib distributions projects. The OIP also publicized home, vehicle and personal safety trainings provided by local nonprofits and community volunteers, DOH clinic staff, the Indian Health Service and the statewide nonprofit Safer New Mexico Now.

2017 Application Year Plan

The Child Health domain priorities moving into the next cycle are: increasing developmental screening and reducing child maltreatment.

To increase the percentage of children receiving a developmental screening, four strategies will be implemented. The first is to expand developmental screening activities in early care and education and increase appropriate referrals among medical homes, early intervention services, child care programs, and families. The second is to

engage pediatric providers, other child health providers, infant mental health consultants, home visitors, and other related professionals in local communities to improve linkages and referrals. The third is to utilize and promote training to early care and education professionals who serve young children. Lastly, the fourth strategy is to promote public awareness of child development.

To decrease abuse and maltreatment of children there are three strategies to be implemented. The first is to identify the most vulnerable families and neighborhoods and utilize “mapping” of data bases to overlay risk factors for identifying areas of highest need (concentrated disadvantaged). The second is to develop policy recommendations based on community engagement and leverage resources to expand the home visitation system to provide services for all families identified as most vulnerable. The third is to expand and fund home visitation services for children and families with three or more identifiable risk factors, including those referred by Protective Services.

Adolescent Health

2015

Adolescent health priorities for 2015 were to reduce teen birth rates, reduce alcohol use, and impact risk factors associated with suicide.

NM Family Planning Program (FPP), Family Health Bureau and PHD/DOH have been working on a multi-pronged approach to decrease the teen birth rate through increasing access to reproductive clinical services, increasing awareness of birth control options, and educational programming. Part of increasing access to services includes working on billing and reimbursement issues and provider training. The NM FPP promotes three population-based strategies: service learning and positive youth development programs, adult/teen communication programs, and comprehensive sex education programs. These strategies complement clinical family planning direct services to prevent teen pregnancy in order to bring about meaningful and measurable reductions in teen births.

The Office of School and Adolescent Health (OSAH) facilitated a Positive Youth Development – Youth Leadership Track at the Annual Head-to-Toe School Health Conference. Over 45 youth participated in various activities & workshops promoting health literacy, teamwork, health education, values and decision making.

2017 Application Year Plan

Adolescent heath had previously identified increasing adolescent well visits, reducing teen birth rates and bullying prevention as priorities. However, during the ongoing Needs Assessment all MCH priority needs are evaluated and the Title V Needs Assessment found that the capacity was not there to impact bullying; therefore, the priority has been dropped. Another priority was added in the Cross-Cutting/Life-Course health domain which will be addressed below.

New Mexico is participating in the Adolescent and Young Adult Health (AYAH) CoIIN collaborative to increase comprehensive well exams among adolescents and young adults. The AYAH CoIIN has brought together Title V, OSAH, and various partners to increase well exams among adolescents. One of the major strategies is for statewide school-based health centers to continue to expand services and supports for Medicaid eligible youth, and to promote the conversion of sports physicals into comprehensive well exams.

The state Title V program will continue to collaborate with FHB/FPP to implement a statewide, comprehensive, and coordinated plan focusing on teen pregnancy prevention/reduction, and to assure continued delivery of safety net family planning services through the strategic alignment of contraceptive services and outreach to schools in counties of high teen birth rates.

Children with Special Health Care Needs (CSHCN)

2015

The Child with Special Health Care Needs (CSHCN) domain priority areas of focus in the previous cycle were: increasing numbers of CSHCN who receive care in a Medical Home, ensuring successful transitions to adult healthcare, and assuring adequate insurance coverage. All three of these priorities remain in the current cycle; however, adequate insurance coverage will now be a part of the Cross-Cutting/Life-Course population domain.

Children's Medical Services (CMS) social workers continued connecting Children and Youth with Special Health Care Needs (CYSHCN) clients to a Medical Home. CMS social workers continued to fax asthma action plans to the primary care provider and the school nurse after each asthma outreach clinic, providing a link to the Medical Home and wrap-around services. CMS social workers empowered parents and youth to partner with their primary care provider in order to ensure their needs are met within the Medical Home.

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

2017 Application Year Plan

Two strategies will be implemented to increase the percentage of families who have access to patient and family centered care coordination and access to a Medical Home. The first strategy is continuing to collaborate with the New Mexico Child Health Improvement program ENVISION to provide training to pediatric providers on care integration and improve cross-provider communications. The second strategy is to collaborate with the National Center for Medical Home Implementation to provide technical assistance to pediatric clinicians.

To increase the amount of services available for CSHCN to make transitions to adult care, several strategies will be implemented. We will continue to collaborate with the Transition Task Force to implement policy and practice recommendations for pediatric practices and collaborate with Got Transition to provide technical assistance to pediatric providers in developing transition policy. Some members of the Transition Task Force plan to contact legislators to see if some of the task force recommendations from 2015 could be proposed in legislation for the 2017 Session.

Cross-Cutting/Life-Course

2015

In the last year of the Title V Block Grant cycle (2011-2015) New Mexico had no activities or priorities directly associated with the cross-cutting or life-course population health domain. New Mexico's Cross-Cutting population domain includes a heavy emphasis on both the Native American and Border populations in addition to focusing on the interplay of risks associated with adverse early life events.

2017 Application Year Plan

The priorities for this population domain are to improve access to care across the life span and to increase and improve access to preventive dental care in pregnant women and children. The latter priority was added due to an increase in need and an increase in the capacity to impact this priority area (and as mentioned in the adolescent health domain, the bullying priority was dropped.) The new priority on Oral health will continue the Title V focus on improving dental care in children but will also add a prenatal aspect to preventive dental care focusing on increasing preventive dental care in pregnant women. Title V will continue to collaborate with the OOH to provide preventive dental services. Title V will also collaborate with the University of New Mexico on the newly developed New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The project will integrate an evidence-based model of inter-professional oral care into primary care delivered to pregnant women and newborns across New Mexico. The Title V Director serves on the Advisory Board for the Oral Health Quality Improvement Project.

Family/Consumer Partnership

Family involvement is a strength in New Mexico; the state benefits from having the national headquarters of Family Voices based in Albuquerque, as well as the Family-to-Family program Parents Reaching Out our F2F, EPICS which focuses on Native American families who have children with special needs and the strong family advocacy component of the Center for Development an Disabilities (CDD) at the University of New Mexico among many others. We also understand the importance of engaging families and youth as partners and as agents of change. NM work with the Family Leadership Action Network (FLAN), a network of families working to promote the voices of families. FLAN sees families as having important and informed perspectives with regards to the policies and programs that affect them.

In New Mexico, the MCH programs are dedicated to the value of family engagement and have embedded family partnership in their overall strategic plans. The Maternal Child Health Collaborative meets quarterly to engage MCH professionals and family leaders to discuss how to work together and support the collaborative efforts to push a family centered agenda in health care policy.

II. Components of the Application/Annual Report

II.A. Overview of the State

POPULATION:

New Mexico (NM) is the fifth largest state in the United States by geographic area but is 36th in population size, with its 2,085,287 people scattered across vast, open spaces (US Census, 2014). NM is demographically a "majority-minority" state where minority groups constitute a majority of the population. According to the University of New Mexico (UNM) Bureau of Business and Economic Research, NM's total population in 2014 was 46% Hispanic, 41% non-Hispanic White, 9% American Indian, 2% African American/Black, and 2% Asian and Pacific Islander (compared, respectively, to the US percentages of 17% Hispanic, 64% non-Hispanic White, 1% American Indian/Alaska Native, 13% Black/African American, and 6% Asian/Pacific Islander). In terms of age distribution, over a quarter (25.0%) of the NM population was younger than the age of 18, almost equal to the population over the age of 44 (28.5%).

NM is bordered by Arizona, Utah, Colorado, Oklahoma, Texas, and the Republic of Mexico and is defined as a frontier state according to the National Center for Frontier Communities. Over 7% of the population resides in frontier or sub-frontier areas (identified by remoteness and geographic isolation, with sparse populations and long travel-times to services of any kind). The average New Mexican aged 16 years and older commutes more than 21 minutes to work. The population of the seven urban counties accounts for 62% of the population. Bernalillo County comprises almost 33% of the state's population. The range of population density is 0.3 persons per square mile in Harding County to 578.0 persons per square mile in Bernalillo County, with a state population density of 17.0. The majority of counties, 25 out of 33, have population densities of less than 15 persons per square mile (US Census, 2010).

POVERTY:

Up to 55% of children live in poverty in the state. In the majority of geographic areas, between 18 and 40% of children experience ongoing poverty. New Mexico is one of the four poorest states in the nation,
with a median household income of $44,927 compared to of US median of nearly $10,000 more. According to 2009-2013 American Community Survey estimates, more than half a million New Mexicans are living in poverty, including 30% of NM's children and 13% of people 65 years old and over. Fourteen percent (14%)
of all families and 40% of families with a female head of household had incomes below the poverty level.
http://quickfacts.census.gov/qfd/states/35000.html

The "children in poverty" rate based on household income in 2012 ranked NM as the third poorest state in the nation, with 29% of children living in poverty (compared to 23% nationally); over 20% of New Mexicans lived below the poverty level in 2009-2013 (compared to 16% nationally). Twenty-five percent of all families and 40% of single-parent families had incomes below the poverty level (Annie E. Casey Foundation, 2014). Over half (52%) of NM births are to unmarried women, as measured by marital status on the birth certificate, but this does not account for paternity, co-habitation or long-term, co-parenting families. http://datacenter.kidscount.org/data/tables/7-births-to-unmarried-women?loc=33&loct=2#detailed/2/33/false/868,867,133,38,35/any/257,258

In 2012's four-year graduation cohort, only 70% of all 9th graders in NM graduated from high school four years later (NM-IBIS, 2014). Eight percent of teens ages 16-19 were not in school and not high school graduates, ranking NM as one of the worst in the nation in this indicator (Annie E. Casey Foundation, Kids Count). In 2011-2012, 16% of NM kids 2-17 years were reported by a parent as having a diagnosis of autism, developmental delays, depression or anxiety ADD/ADHD or behavioral problems. That estimate increased from 14% in 2007. New Mexico struggles to provide comprehensive, wrap-around services to children and adolescents, and this is a significant area of focus for improvement. In addition, women/mothers require support to assure their children receive adequate screening,

identification and referrals to appropriate behavioral and mental health services.

ACCESS TO HEALTHCARE:

Many factors limit access to health care in NM, including provider shortages, lack of affordable insurance, and unawareness of insurance availability. In addition, expansive geographies create long travel distances to primary health clinics and hospitals. Cultural barriers to care include 1) cultural relevance and 2) lack of trust in health providers and systems, which make healthcare utilization a disparity in some areas of the state, most notably among women and children residing on tribal reservations. The number and distribution of health care professionals is a critical and often-overlooked piece of this equation. NM needs more health care providers in nearly every health-related profession. Thirty-two of NM's 33 counties are "health professional shortage areas", demonstrating the need to address this critical access to care problem. Only one of NM's counties, Los Alamos, is designated as neither "Medically Under-served" nor a "Health Professional Shortage Area (HPSA)." The remaining 32 counties are considered either entirely or partially HPSAs (HRSA, 2014). In addition, New Mexico ranks poorly in health insurance coverage and utilization among women, especially the childbearing age population.

More New Mexicans are insured than ever before, which should help increase access somewhat, although having insurance does not guarantee access to a healthcare provider. After ACA implementation, the state's uninsured rate was down to 13.1% in 2015, compared to 20.2% in 2013. In many ways, NM has been a leader in finding innovative ways to improve access to care: promoting the use of midwives and birthing centers; use of community health workers and social workers as care coordinators; utilizing telehealth for training and provider access; and flying pediatric specialists to rural areas to staff one-day specialty clinics for children with chronic medical conditions such as asthma, cerebral palsy, epilepsy, diabetes and congenital heart conditions. NM ranks second in the nation, along with Florida, for the highest percentage of children without health insurance. Through an aggressive outreach and enrollment campaign, the number of children eligible for and enrolled in the State Children's Health Insurance Program (SCHIP) and Medicaid are increasing steadily and enrollment is at an all-time high.

NM Medicaid provides many health care services for children under a federal Medicaid policy which requires that children receive Early Periodic Screening, Diagnostic, and Treatment (EPSDT). This policy includes preventive health services, maintenance health services,and treatment of medical conditions. It also in Enrollment of children 0-18 years in Medicaid of SCHIP increased significantly between 2007 and 2011, prior to ACA implementation http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-mexico.html As of 2015, 363,242 children (birth to age 18) were enrolled in Medicaid or SCHIP. Just under 345,000 children were enrolled in 2009.

NMDOH STATE PRIORITIES:

In 2011, NM Department of Health (NMDOH) engaged its leadership and stakeholder partner organizations to identify a set of priority health issues for agency programs and partners to strategically focus on to improve population health status in NM. The process was outlined in the State Health Improvement Plan (SHIP), May 2014. A State Health Improvement Plan process was established for 2014-2016 to include target-setting, monitoring and evaluation of activities to address the nine selected health priority areas. The resulting State Health Priorities are: childhood obesity, adults who smoke, drug overdose deaths, alcohol-related deaths, diabetes hospitalizations, oral health, adult immunizations, elder falls related deaths, teen births, and access to care. The following sections discuss a few of these priorities and the related activities in which FHB staff have participated and which engage Title V Maternal Child Health populations and programs. In addition, teen births, substance abuse, diabetes and obesity have been designated the Department's four "super-priorities" by the Secretary of Health.

Obesity:

Childhood obesity means that children are developing unhealthy eating and physical activity habits and sedentary tendencies early in life, making it more difficult for them to lead healthy lifestyles as adults. Obese children are more likely to become obese adults and to suffer from chronic diseases such as heart disease, cancer, and diabetes. Obesity is associated with food insecurity, and the NMDOH and Human Service Department (HSD) are collaborating to understand more about this problem and how to address it in New Mexico. The Title V Director has also been working with WIC on a collaboration with the Roadrunner Food Bank and NM State University to teach healthy eating and cooking habits to WIC clients in public health offices. When they attend the classes the participants also leave with produce provided by the food bank. In 2013, 13.7% of kindergarteners and 19.9% of 3rd graders were obese. American Indian children have the highest obesity rates among all racial/ethnic groups in NM. By 3rd grade, nearly one-in-two American Indian students are overweight or obese. Though rates remain high, there appears to be a downward trend in obesity prevalence among 3rd grade students; rates have decreased by 11.9% from 2010 to 2013, going from 22.6% to 19.9%. This pattern is not seen among kindergarteners, where rates have remained more or less level over the four years. From 2010 to 2013, American Indian 3rd graders experienced a large decrease in obesity rates. Rates have dropped from 36.6% to 29.5%, corresponding to a 19.4% change. Hispanic students, however, experienced little change in obesity prevalence between 2010 and 2013.

Smoking:

Cigarette smoking is the number one modifiable health risk in the United States, and its contribution to infant mortality is well-documented. In New Mexico, we estimate that we could reduce infant deaths by up to 30% if we eliminated maternal smoking all together. Cigarette smoking declined among all NM adults from 21.5% (2011) to 19.1% (2014), and from 20.5% to 18.9% among women of childbearing age (18-49 years) for the same period. (NM Behavioral Risk Factor Surveillance System). Among women giving live birth who reported smoking in the three months before pregnancy in 2011-2013 (22.4%), significantly more than half (64.1%) quit during pregnancy. The prevalence of smoking during pregnancy decreased moderately from 9.7% in 2000 to 8.0% in 2013 (NM Pregnancy Risk Assessment Monitoring System). By maternal race-ethnicity, non-Hispanic White women (13.0%) were significantly less likely to smoke during pregnancy compared to Hispanic (5.9%) and Native American women (5.6%) giving birth in NM (2011-2013).

Drug and Alcohol use:

In 2010, NM had the 2nd highest drug overdose death rate in the nation, and nearly double the U.S. rate. In 2012, NM's age-adjusted drug overdose death rate was 24.2 per 100,000 persons. That year, 486 New Mexicans died of drug overdose. Between 1990 and 2012, the overdose death rated in NM increased 300% and by 79.9% since 2001. Prescription opioids have driven the increase in overdose death rates since 2006. Excessive alcohol use (i.e., binge drinking) is the fourth leading preventable cause of death in the US. NM has the highest alcohol-related death rate in the US and NM's rate is nearly twice the US rate. The majority of alcohol-related deaths involve working-age adults. Among women with live birth drinking during pregnancy increased from 5.2% in 2000 to 7.0% in 2009 and slowly tapered to 5.6% in 2013 (NM PRAMS). New Mexico, like many parts of the country experienced a sky-rocketing (about 9 times) increase in neonatal abstinence syndrome diagnosis in infants born between 2000 and 2013. Just between 2009 and 2013, the statewide rate increased by more than two-fold.

	NAS Diagnosis in infants per 1000 live births				
Year	2009	2010	2011	2012	2013
Rate	3.8	4.74	6	7.8	9.1

Diabetes:

Effectively managing chronic conditions, including diabetes and high blood pressure, helps adults stay out of the hospital. People at risk for developing diabetes include those with pre-diabetes; those who are obese, currently smoke, or have a family history of diabetes; and women who have had gestational diabetes. American Indians in

NM had the highest rate of deaths due to diabetes, three times higher than that of Whites. For every 100,000 American Indians there were 73 deaths due to diabetes, compared to 22 deaths due to diabetes for every 100,000 Whites. The Children's Medical Services Program (NM's CYSHCN Program) developed two pilot projects in 2014 to address the issue of diabetes in children and adolescents. In Roswell CMS partnered with the child health improvement program at UNM/ENVISION to provide coaching on the use of motivational interviewing to CMS social workers to help them work with identified families and PCP's. In Santa Fe a partnership developed with the local hospital's diabetes educator, the CMS nutritionist, and CMS social workers, along with a community farm, to provide education, support and access to fruits and vegetables to children with diabetes. Both pilots showed positive outcomes.

Oral Health:

Tooth decay is the most common chronic disease among children, 5 times more common than asthma and 7 times more common than hay fever among 5 to 17 year olds. Access to **oral health** care in NM continues to be largely inaccessible to individuals who are uninsured and are low-income. Tooth decay and other oral diseases are due to: a lack of understanding of the importance of oral health to general health, poor oral hygiene, poor nutritional habits, and general lack of access to care in rural NM. American Indians and Hispanics have the highest rate of tooth decay among all populations. Hispanic and American Indians are less likely to have a dental visit. Less than half of the adults with an annual income of less than $15,000 have had a dental visit within the past year. NM Medicaid provides full dental services for children and limited for adults. In 2012, 40% of adults reported having six or more teeth extracted. Less than 50% of new mothers have had their teeth cleaned. NM has made great strides in its efforts to screen and treat preschool children for dental caries through the many Head Start sites. This work has been strengthened by recent efforts to fluoridate city water in Bernalillo County, NM's largest metropolitan area. In addition, Title V programs and the Epidemiology and Response Division are working together to resume an oral health surveillance system, including a survey of third graders receiving sealants on permanent molars.

Teen Births:

In 2014, there were 25,985 births to NM resident mothers. NM's age-specific fertility rate (typically called 'birth rate' for teens) has declined markedly in the past ten years but remains higher than the national rate. The 2014 NM rate for 15-19 year old females was 37.8 per 1,000, compared to the 2014 US rate of 24.2 of 1,000 (NCHS, 2015).

Disparities persist for Hispanic and American Indian teens. Hispanic teens have the highest birth rates both in NM and nationally. Hispanics constitute almost half of NM's 15-19 year old female population, and their share of teen births is higher, representing almost 70% of the births in this age group. Forty-five point six (45.6) per 1,000 Hispanic females ages 15 to 19 in NM gave birth in 2014, followed by American Indian females (38.0/1,000), Black/African American females (23.3/1,000), and White females (15.5/1,000). Using the majority population (White) as the reference group, Hispanic teens have 2.9 more births and American Indian teens have 2.5 births to every White birth (NM-Indicator Based Information System [IBIS], 2014 births). Higher proportions of young, unmarried, American Indian, and Hispanic women, and those with high school education or less, had unintended pregnancies resulting in live birth. Teen mothers were the most likely to report a mistimed or unwanted pregnancy (75.6% of 15-17 year olds and 69.9% of 18-19 year olds). Among all women with live births who were not trying to get pregnant, 52.3% were using a method of contraception to prevent pregnancy. The three most common reasons for *not* utilizing contraception were: not minding a pregnancy; thinking a pregnancy could not occur when it did; and having a husband, boyfriend or partner who did not want to use birth control (NM Pregnancy Risk Assessment Monitoring System [PRAMS], 2012-2013 births).

Poverty is both a cause and a consequence of early childbearing. Preventing teen pregnancy is an effective and efficient way to reduce poverty and improve overall child and family well-being, and will be a big focus of the Bureau, the Division and the Department in 2016. The NM Legislative Finance Committee (LFC) conducted research on teen pregnancy in NM in late 2014 and summarized this in a report released in May, 2015. Recommendations

include developing a new formula for distributing general fund allocations to school based health centers to prioritize centers with the greatest needs; pursuing public-private partnership opportunities to implement best practices related to the most effective forms of contraception among teens at high risk of becoming parents; and a collaboration between DOH and HSD to develop a plan to increase knowledge and provide technical assistance to safety net providers regarding the most effective forms of contraception as recommended by the CDC. Funding sources such as private foundations are actively being sought, and best practices from other states will be used as models. In particular NMDOH and FHB are looking to replicate the results CO achieved by increasing the use of long-acting reversible contraception (LARC) in teens 15-19 years of age.

ACA/Health Care Reform:

New Mexico MCH staff, including the Title V Director Janis Gonzales, have been monitoring the state and national activities around the Affordable Care Act (ACA) for the past several years. Although the ACA brought several welcome changes to NM, including Medicaid expansion for low-income adults and a 24% decrease in the uninsured rate from 2013 to 2014, there are signs that things are still unsettled and that we may start to see regression or reversal of these trends in the near future. A recent community survey commissioned by the Con Alma Foundation found that 61 percent of people interviewed felt their health care coverage was unaffordable, despite the subsidies available on the Health Insurance Exchange. With even higher insurance costs expected in 2017, it is likely that the uninsured rates may increase again as New Mexicans find it increasingly unaffordable to maintain coverage. In addition, the 2016 state revenue projections are now much lower than previously expected; as a consequence, Medicaid was not fully funded. Provider rate cuts are expected to take effect in August 2016, which will likely present further barriers to accessing care for low-income New Mexicans. In September 2012, 68% of children in New Mexico were enrolled in Medicaid, and an estimated 705,730 New Mexico residents are covered by Medicaid as of May 2015, approximately a third of the entire state population.

NM also has a Health Insurance Exchange (HIX) that was developed as a state-federal partnership, utilizing the federal portal (HealthCare.gov) for individual enrollment and the NM portal (BEWELLNM.com) for the state-run Small business Health Options Program (SHOP) exchange. Over 54,000 people enrolled in private plans through the NM HIX during the 2016 open enrollment period, including renewals and new enrollees. This is an increase of nearly 5% over the 52,358 people who enrolled during the 2015 open enrollment period. Half of the people who were enrolled through the exchange in 2015 were on the Blue Cross Blue Shield plans that were discontinued at the end of the year, causing something of a scramble with assistors and navigators trying to help people move to other plans. In July 2016 Presbyterian Health Plan announced that they were pulling out of the HIX starting next year and will not offer any individual or family plans on the exchange. This will put even more of a burden on the remaining carriers. One of the problems is that the HIX has not attracted enough healthy people to balance out the high claims of those with high cost conditions.

NM Health Connections, one of the four carriers offering plans for 2016 in the NM HIX, is a CO-OP (consumer oriented and operated plan) established with funding provided by the ACA. By March 2015, total enrollment in NM Health Connections had reached nearly 40,000, and by February 2016 enrollment had grown to more than 50,000 members. The long term viability of the CO-OP remains in question, however; they are required by law to offer plans on the exchange, whereas other carriers can choose to drop out of the HIX if they feel it is not financially viable for them. This puts a higher burden on the CO-OP financially.

The NM Medical Insurance Pool continues as a safety net for those with high cost medical conditions who are not eligible for other insurance or who choose not to buy insurance on the Exchange during open enrollment. However, there has been a lot of talk about the possibility of closing the Pool, and the Legislature will probably be discussing this again in the coming session in 2017 as a way to save the state money. Currently the state provides the carriers with tax credits to offset their losses from the Pool.

Although the percentage of uninsured in NM has decreased from 20.2% in 2013 to 13.1% as of June 30, 2015, there were still 233,000 uninsured residents in 2015. Of those remaining uninsured, 47% are Medicaid eligible, 13% are tax credit eligible, and 40% remain ineligible for either (Con Alma Health Foundation Report 2016).

INPUT and NEEDS ASESSMENT PROCESS:

The Title V Director and other FHB staff continually seek feedback from our partners around the state, including clients and families, to determine the magnitude and priority of competing issues impacting health services delivery in the state. The Children's Medical Services Program, Newborn Genetic Screening Program, Early Hearing Detection and Intervention (EHDI) program, Maternal Health Program, Family Planning Program and PRAMS program all have advisory boards that meet regularly to and discuss issues impacting the work of the program on the ground level. Families are always included in the advisory boards as their real-life experience is critical for program planning. The Title V Director, CSHCN Director, and others from FHB participate in a quarterly MCH Collaborative with other MCH programs in the state including Leading Education in Neurodevelopmental Disabilities (LEND), Parents Reaching Out (PRO), Family Voices, Education for Parents of Indian Children with Special needs (EPICS), and others. The Child Health program manager also has monthly meetings with child health partners and stakeholders through the ECCS grant, where current issues impacting child health and wellness are discussed. These stakeholders were engaged early in the process of the needs assessment and assisted the Title V program in evaluating existing performance measures by subcategory and prioritizing the top measures which then moved on for further evaluation and discussion.

CURRENT and EMERGING ISSUES:

Public Health Changes:

In late 2014 a visioning meeting was held with public health/DOH leadership from around the state to begin envisioning new roles and opportunities for public health in the coming decade. These discussions are ongoing, especially in relation to what services should be offered in the public health offices. In addition, NM DOH/PHD received public health accreditation in 2015, a huge accomplishment!

State Innovation Model (SIM) Grant:

NM DOH, in conjunction with the Human Services Dept. (HSD), received a $1 million State Innovation Model (SIM) planning grant in 2015, which is a cooperative agreement with the Centers for Medicare and Medicaid. The SIM Initiative provides financial and technical support to States for the development and testing of State-led, multi-payer health care payment and service delivery models that address the Triple Aim of improving health system performance, increasing quality of care, and decreasing costs of care for Medicaid, Medicare and Children's Health Insurance Program (CHIP) beneficiaries and for all other residents of participating states. The planning year ended and the resulting state health system innovation plan was submitted to CMS in April 2016. However, no further funding is expected. DOH and HSD are continuing to discuss the plan with stakeholders and trying to discern what might be possible even without federal funding.

Data improvements:

Several programs in the FHB are or will soon be undergoing major changes in their IT and client data collection systems. Children's Medical Services (CMS) has an antiquated system that broke down suddenly several times in 2014. The new IT system will be rolled out in 2015-2016 and will replace both the older case management system (InPHORM) and the newborn screening system (currently in ChallengerSoft) and will contain a billing component that will track the entire revenue cycle, something the program has never been able to do. WIC is partnering with Texas and Louisiana in a three-state IT solution to be rolled out in 2017. Families FIRST, a perinatal case management program, will be utilizing the same system as CMS. Additionally, the DOH as a whole is looking at newer and better ways to utilize technology to share information within the Department. Development and testing of the new CMS

database system has occurred over the past year. The system, called CACTUS, will integrate the Children with Special Health Care Needs program, the Newborn Hearing Screening program and the Newborn Genetic Screening program in the hopes of improving the coordination of care and increasing tracking and surveillance. The Go-Live was set for June 2016 but there have been some delays.

CHALLENGES:

In addition to the constant challenges of high poverty rates, health care provider shortages, and cultural barriers, MCH staff in 2015 faced internal challenges including significant turnover of staff and state general fund shortfalls in other areas of the DOH, which put financial pressure on our programs. The challenges inherent in a multi-layered bureaucracy include lengthy and complicated contracting and hiring processes that can make the programmatic work more difficult.

Insurance coverage for all New Mexicans remains a significant challenge. NM has a large population of immigrants, many of whom are undocumented or reside in mixed-status families. Insurance coverage for the undocumented is a major challenge, as the undocumented are not eligible for subsidies to buy insurance on the Health Insurance Exchange, and even on the open market we found there was only one insurance carrier that was accepting applications from undocumented clients during the most recent open enrollment period beginning in the fall of 2015. Currently the only affordable insurance coverage for the undocumented is through the Low Income Premium Plan, which is part of the NM Medical Insurance Pool (High Risk Pool). However, it is unclear how long the Pool will continue to exist; the Board members have frequent discussions about whether or not the Pool should continue and if so, for how long. Since all the carriers in NM follow the same open enrollment period as the HIX, even for off-exchange plans, the only way the uninsured can obtain insurance outside of the open enrollment period is through the high-risk pool. The Pool, at least for now, continues to be the safety net for coverage of critically ill people who are not eligible for other coverage. Title V, Children's Medical Services' funds are used to procure insurance for children with chronic conditions who are not eligible for any other coverage. The Title V program has been asked by DOH leadership to try to find alternative funding for this population, although it is still unclear whether there will be any viable options.

STATUTES and REGULATIONS RELEVANT to TITLE V:

In the 2015 New Mexico State Legislature session, a bill was introduced and passed to revise current statute to allow for the licensure of birth centers in the state. The bill added freestanding birth centers to the list of types of health facilities in the public health act section 24-1-2 NMSA that the Department of Health has the authority to license. Creating licensure for birth centers also allowed facility reimbursement by Medicaid.

Licensure will address four goals that are important to the delivery of prenatal and obstetrical care in New Mexico:

1. expand the options for safe, high-quality prenatal and delivery care in New Mexico for birthing families,
2. provide a recruitment incentive, allowing another option setting for birth providers in the state to practice,
3. grant the Department, through Division of Health Improvement, the opportunity to monitor the operations of such facilities to protect the public's health, and
4. allow the birth centers to receive federal reimbursement which promotes their existence and enhances their sustainability.

In the 2015 Legislative session, another statute which created the Birthing Workforce Retention Fund in 2008 was revised to expand criteria for eligibility of funding to birth provider applicants. The Fund supplements liability insurance premiums for birth providers or their practices. Past awards supported OB-Gyn physicians and certified nurse-midwives in rural practices around the state. Eligibility criteria was made more manageable and tail coverage was explicitly denied – both changes to improve the application process and the selection of in-state practicing providers.

II.B. Five Year Needs Assessment Summary

Needs Assessment Update (as submitted with the FY 2017 Application/FY 2015 Annual Report)

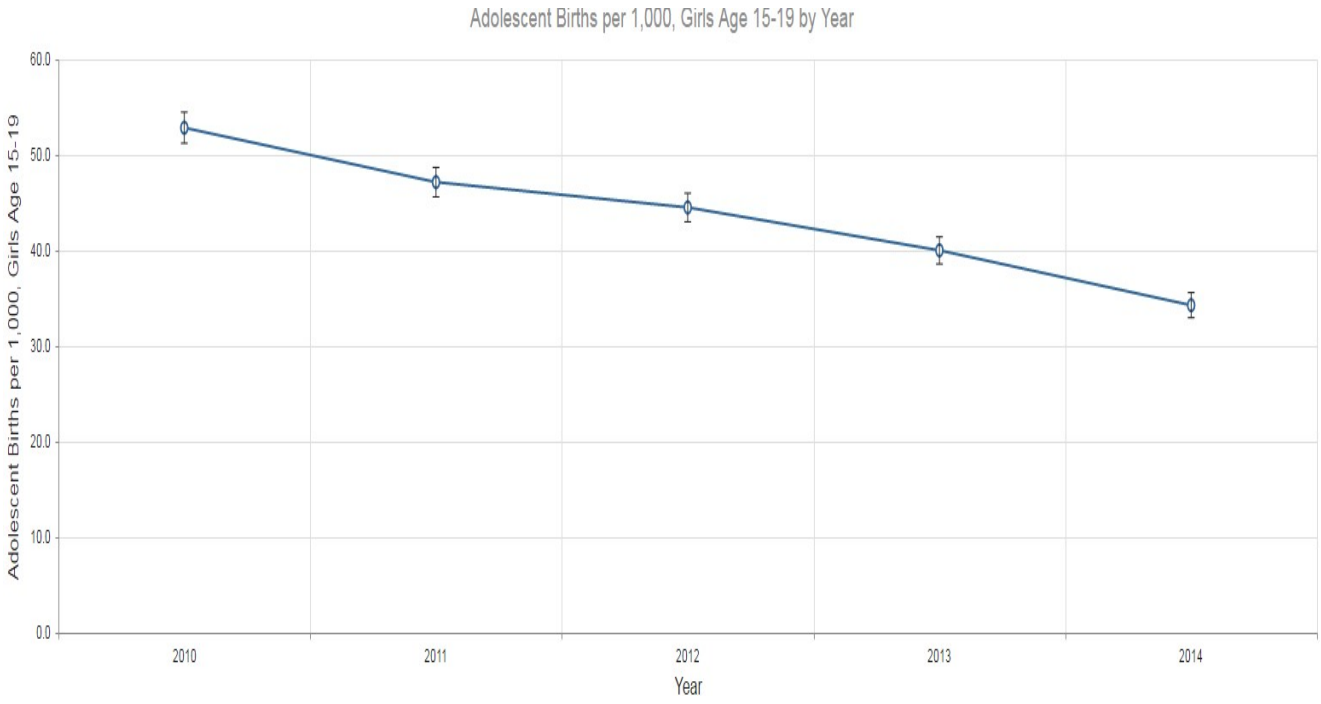
Needs Assessment Annual Update

MCH Population by Domain Group:

Maternal and Women's Health

New Mexico continues to explore and measure the degree to which insurance access and utilization among women of childbearing age has changed. Though we hypothesize the Affordable Care Act is changing these rates positively, population data show mixed results for sub-populations among women of childbearing age and among those giving live birth. We are approaching this question with quantitative population data analysis and with client and community discussions and assessments in select areas of the state. Of particular concern is how we measure availability of contraceptive options and reproductive life planning. Several initiatives in school-based health centers and birthing facilities seek to measure the postpartum insertion or prescription of long-acting reversible contraceptives (LARCs) and to understand how this will impact inter-conception spacing, teen birth rates, and birth outcomes such as pregnancy intention, preterm delivery, and low birthweight.

Though the fertility rate did not drop significantly among women of all ages between 2010 and 2014, the drop in fertility rates among females aged 15-19 declined by 44% from 2005-2014 (62.0 per 1000 to 34.3 per 1000) and by 25% just between 2010 and 2014. This indicates gains among the target population and evidence that interventions are successful. Poverty continues to be one of the most important contributing factors to teenage pregnancy. In 2014, New Mexico ranked 1st among all states in percentage of children living in poverty, and continued success in birth outcomes hinges on programs that address both access and knowledge of contraceptive options, in addition to increasing educational and economic opportunities for girls and women of all ages.



The New Mexico Department of Health continues its partnership and leadership with the New Mexico Perinatal Collaborative. The Title V Director currently serves as Vice President of the Perinatal Collaborative. The collaborative has prioritized improving access to long-acting reversible contraceptives for women immediately after delivery. This aligns with the Title V priority of addressing teen pregnancy prevention in NM and with well-woman care and reproductive life planning among all women of childbearing age. Title V also collaborates with UNM faculty and the Perinatal Collaborative on addressing Neonatal Abstinence Syndrome (NAS). The Perinatal Collaborative group is working to develop NAS diagnosis and treatment protocols for birthing facilities across the state. Additionally, the collaborative is seeking to reduce maternal mortality and morbidity from postpartum hemorrhage complications, a leading cause of preventable maternal mortality. There were 163 hospitalizations due to complications of maternal hemorrhage in NM in 2014. New Mexico Title V team members are also renewing partnerships with the March of Dimes, which has a new national, regional and local structure aligning more closely with ASTHO infant mortality objectives, particularly addressing prematurity.

Infant Health

New Mexico's infant mortality rate decreased from 6.9 infant deaths per thousand live births in 2012 to 5.4 in 2013 and remained at 5.4 in 2014. The decrease between 2012 and 2013-2014 rates was initially attributed to fewer infant deaths among Hispanic mothers within the neonatal period (0-28 days), but there was some discussion related to changing definitions and certification of live births among some facilities (pulse v. breathing) and this is still being explored as a possible contributor to the change in rates. In the past five years perinatal conditions, including low birth weight and preterm birth, account for more than half of all infant deaths in NM.

New Mexico continued its involvement in the national Infant Mortality CoIIN, focused on: Safe Sleep, Smoking Cessation, and Perinatal Regionalization. This has provided an additional platform for Title V related infant health priorities and the establishment of partnerships outside of Title V and collaborations across programs.

Neonatal abstinence syndrome (NAS) persists as an epidemic problem throughout New Mexico. In 2014, New Mexico's opiate overdose death rate led the nation. The state has organized in a cross-sector manner to address the continuing problem. As one measure, Governor Martinez signed 2016 legislation authorizing licensed prescribers to write standing orders to prescribe, dispense, or distribute naloxone to community-based overdose prevention and education programs, first responders, and individuals at risk of experiencing or witnessing an opioid-related overdose.

The Title V program is working in partnership with the Perinatal Collaborative and the March of Dimes to develop and expand programs aimed at providing prenatal, maternity and postpartum care for mothers and babies impacted by NAS. The NM Substance Abuse Epidemiology Team works closely with the March of Dimes Program Services Committee and MCH Epidemiology staff to monitor and prevent NAS-affected babies. In addition, community advocates led by Young Women United (YWU), based in Albuquerque, NM, continued a media campaign to encourage pregnant substance-addicted women to seek help without fear of losing their children or facing prosecution/incarceration for their addiction. NM PRAMS staff and YWU leaders developed PRAMS surveillance questions to assess the prevalence of substance use in the preconception/early pregnancy period and have been collecting this data since 2014. Those estimates are expected to be available for analysis and program planning in Fall, 2016.

Child Health

As in previous years, more New Mexican children live in households with income below federal poverty level (28.5%) than the national average of 21.6%. The children of New Mexico (NM) are in the dismal rank of 49th on the KID'S COUNT measures of well-being (early infant birth outcomes, child maltreatment, and poverty or systemic barriers to care) (http://www.aecf.org/m/databook/2015KC_profile_NM.pdf).

The Child Health program continues its partnership with New Mexico Early Childhood Comprehensive System (ECCS) group gathering various early childhood stakeholders. Additionally, the Child Health domain remains engaged with the New Mexico Public Health Association, the Health Alliance of Health Councils and the Health Equity Partnership. These partners continue to provide valuable feedback to New Mexico's Child health priorities and efforts. Unfortunately the ECCS grant ends in June 2016 and our new application was not funded.

Increasing developmental screening and deceasing child abuse and maltreatment remain the most important priorities in Child Health. The ratio of victims of child abuse has steadily increased from 2003-2014 from 9.9 to 16.7 per 1,000 children. Title V is working along with the Office of Injury Prevention and Children Youth and Families Department to address these issue of abuse, neglect and maltreatment as feasible.

CSHCN

Children's Medical Service (CMS) continued its established partnership with the MCH Collaborative to convene a panel of twelve experts to assess the Children and Youth with Special Health Care Needs (CYSHCN) population needs. The MCH Collaborative is comprised of CMS, Family Voices, Parents Reaching Out, the Pediatric Pulmonary program at UNM, the UNM LEND Program, the Developmental Disability Planning Council (DDPC), and the organization Education of Parents of Indian Children with Special Needs (EPICS). The collaborative comprises program representatives who share the personal dedication and commitment to Title V and has been supportive and innovative. It 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 Care Reform process. 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, CMS social workers, the CMS Advisory Board which is part of the New Mexico Medical Society.

Increasing access to care in a family-centered Medical Home for children with special healthcare needs and without, enabling the child population to make transitions to adult care, and addressing behavioral health needs and access to care remain priorities.

Cross-Cutting

New Mexico Department of Health MCH Epidemiology participation in a Technical Assistance opportunity with the Association of Maternal and Child Health Programs (AMCHP, 2015-2016) on Life Course Indicators reinforced the need to understand the upstream contributors to disadvantage. NM has a colonial history of trauma which manifests in different ways among diverse sectors of our population, not the least which impact women and infants. Adverse Childhood Experiences and stress events which people of color disproportionately bear must be understood before we can effectively terminate discrimination in healthcare, limited access or utilization of care among minority populations, and the experiences of families living in areas of concentrated disadvantage. Racism and historical trauma can and should be addressed directly and within community conversations to change our course. We propose that perinatal outcomes can and should be experienced more equally if we address the social and cultural situations of families experience the most challenging conditions. Our recent analysis geocoding births by quartiles of disadvantage showed that among the NM birth population:

• Bernalillo County had the highest percentage of census tracts (26.6%) with "high" Concentrated Disadvantaged, followed by Dona Ana (17.6%), McKinley (11.4%) Counties

• Santa Fe Co. had the highest percentage of census tracts (47.5%) in "low" Concentrated Disadvantaged category, followed by Bernalillo Co. (40.0%)

As an example, teen birth rates are three times higher in geographies of high social disadvantage compared to those in the lowest quartiles of concentrated disadvantage. This indicates there is a community-related aspect to

early child-bearing rather than or in addition to an individual behavior (additional data in attachment 1).

A major emphasis in the needs assessment indicated that access to insurance, insurance navigation and healthcare utilization are areas of top priority. Title V team members collaborated with Dona Ana County Health Services, federal Healthy Start sites, NM Alliance of Health Councils, and the RWJF Center on Health Policy at UNM to address some of the disparities experienced around coverage and access to care. We participated in a Maternal Child Health summit in December, 2015 to update stakeholders on our needs assessment findings, plan next steps and align goals around the infant mortality CoIIN. At that summit, we presented on infant mortality, prenatal and inter-conception insurance coverage, and we heard how we can work together to improve healthy pregnancy spacing and delayed pregnancy through reproductive life planning efforts. As a result of this summit we recommended to University of New Mexico colleagues at the Center on Alcoholism Addiction and Substance Abuse that we frame existing efforts to improve preconception health and behavioral health education with a reproductive life planning curriculum delivered to young men and women throughout the state.

We also expanded our effort to understand challenges with healthcare access through a cross-sector collaboration on the Affordable Care Act Assessment Project, sponsored by the Con Alma Foundation. This included survey data collection among NM families to understand challenges and barriers, as well as secondary analysis of major Census and surveillance system data. Initial activities included:

· Monitoring how ACA is being implemented in NM, with focus on vulnerable children in vulnerable communities

· Focus on equity of ACA implementation: access, process

· Identifying HOT SPOTS: communities of vulnerable children

· Assessing what public use data sets will allow us to measure where the kids are, who they are, and how to help their families to access insurance options

In 2015 there was an increase in the capacity to impact oral health in the child and maternal populations due to a higher level or partnership and collaboration around oral health. Oral health has been a priority in the previous five-year cycle (FFY 2010-FFY 2015). Children of poorer families have 2.5 times more untreated and un-prevented tooth decay. The New Mexico Department of Health oral health survey estimated that 64.6% of New Mew Mexico third graders had caries experience (the Healthy People 2020 goal is 42%), and 37% had untreated decay (the Healthy People 2020 goal is 20%). A 2009-2010 pregnancy risk assessment model system survey (PRAMS) found that only 37.5% of women went to a dentist during pregnancy, and 16.7% reported a dental problem. The Maternal and Child health programs are collaborating with the Center for Development and Disability, the College of Nursing and the Dental Medicine Program in University of New Mexico's Health Sciences Center on the New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The goal of this project is to apply a focus on systems building and theory-based clinical change to build a MCH primary care oral health care delivery model with statewide reach.

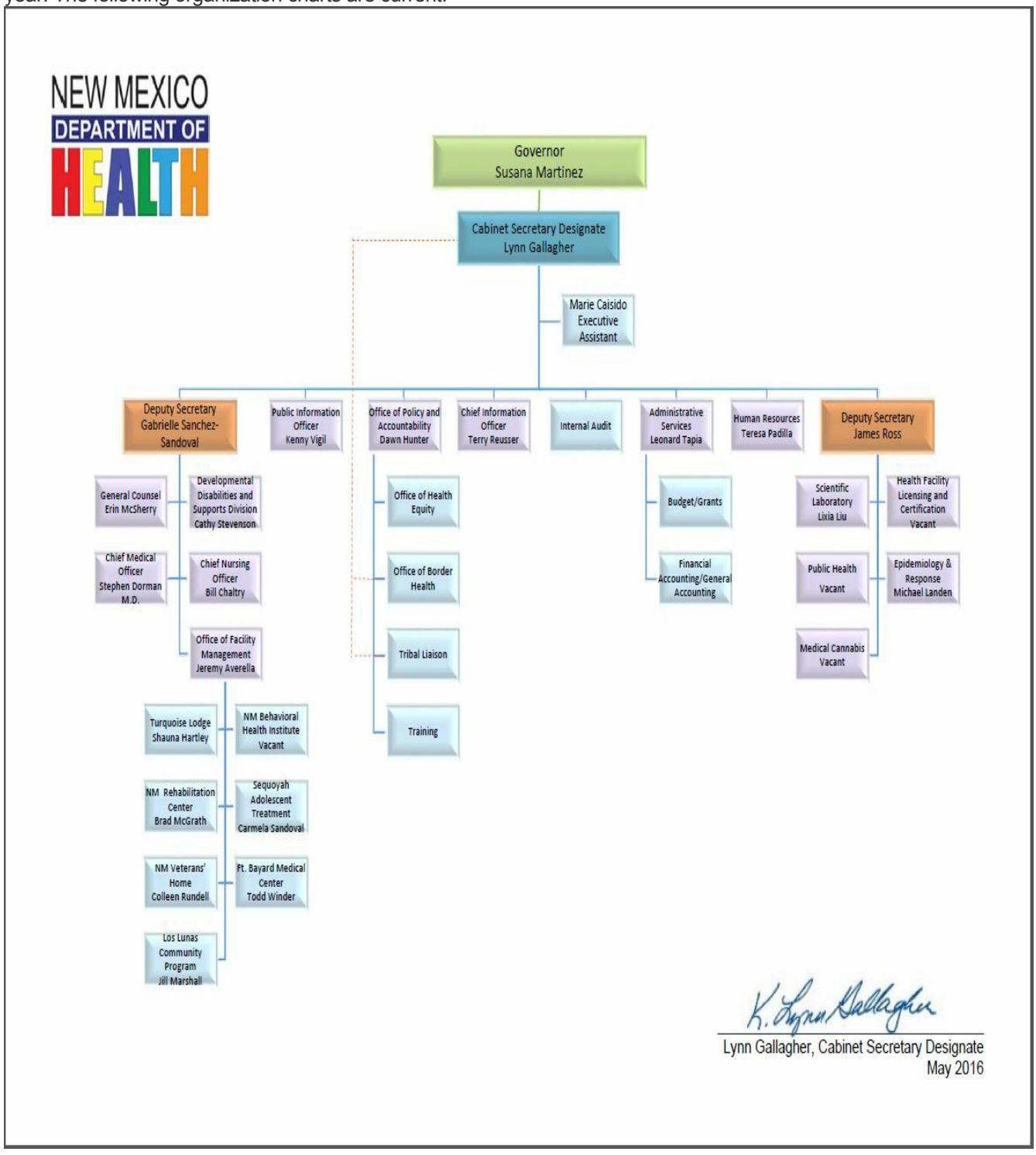
Adolescent Health

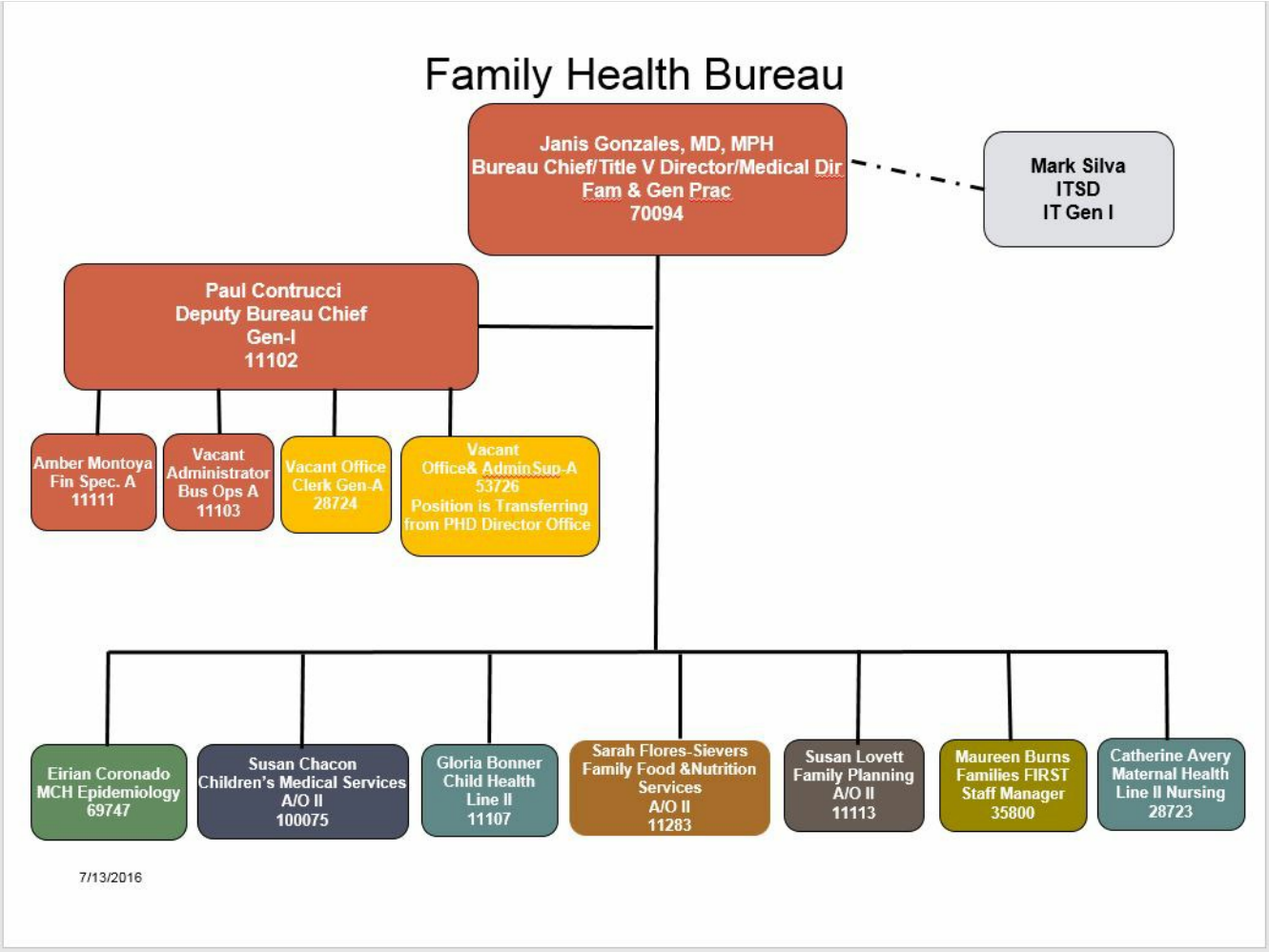
Bullying remains a priority in adolescent health and in the Office of School and Adolescent Health; therefore, there will still be some effort to reduce impact of bullying on adolescents because the programs will continue the efforts that have already been put in place.

Adolescent well visits remain a priority. After the Title V 5-year Needs Assessment indicated a need to address adolescent well visits, New Mexico applied and was accepted to the Adolescent and Young-Adult CoIIN where the primary focus is to increase comprehensive well exams in the adolescent and young adult population. This has brought together individuals from Title V, the Office of School and Adolescent Health, Medicaid, the University of New Mexico, and health care providers to work with four other states in the collaborative.

Organizational Structure

The New Mexico Department of Health experienced a significant change in organizational structure over the past year. The following organization charts are current.




Family Health Bureau
Janis Gonzales, MD, MPH
Bureau Chief/Title V Director/Medical Dir
Fam & Gen Prac
70094
Mark Silva
ITSD
IT Gen I
Paul Contrucci
Deputy Bureau Chief
Gen-I
11102
Amber Montoya
Fin Spec. A
11111
Vacant
Administrator
Bus Ops A
11103
Vacant Office
Clerk Gen-A
28724
Vacant
Office& AdminSup-A
53726
Position is Transferring
from PHD Director Office
Eirian Coronado
MCH Epidemiology
69747
Susan Chacon
Children's Medical Services
A/O II
100075
Gloria Bonner
Child Health
Line II
11107
Sarah Flores-Sievers
Family Food &Nutrition
Services
A/O II
11283
Susan Lovett
Family Planning
A/O II
11113
Maureen Burns
Families FIRST
Staff Manager
35800
Catherine Avery
Maternal Health
Line II Nursing
28723
7/13/2016

Five-Year Needs Assessment Summary
(as submitted with the FY 2016 Application/FY 2014 Annual Report)

II.B.1. Process

Overview

The Title V Needs Assessment process began in February, 2014 by identifying an Executive Leadership Team. That team was comprised of former Bureau Chief, Denita Richards, Deputy Chief and Medical Director, Janis Gonzales, Children's Medical Services Program Manager, Susan Chacon, MCH Epidemiology Program Manager, Eirian Coronado and Maternal Health Program Manager, Katie Avery. In June, 2014 Garry Kelley joined the team as the lead epidemiologist for the assessment of Children and Youth with Special Healthcare Needs, and Christopher Whiteside completed the team in September, 2014 as the Title V MCH Epidemiologist and grant coordinator. The Executive Team convened monthly internal stakeholder members from the Department of Health Family Health Programs, the Office of School and Adolescent Health, the Oral Health Program, Tribal Epidemiologist, community and regional epidemiologists, the Environmental Epidemiology Bureau, the Office of Injury Prevention, and the Health Systems Bureau. This group met for fifteen months, and engaged external stakeholders by population domain team assignments.

In June, 2014 the internal stakeholders completed an environmental scan of existing databases, assessments and surveillance resources by population domain. During the June-August, 2014 time period domain teams identified the gaps in knowledge for NM MCH assessment, and determined that there were three primary areas of concern: 1. Lack of existing information on the impact of ACA / Affordable Care Act provisions on the NM MCH population; 2. Lack of focus on the U.S.-Mexico border region health, and 3. A desire to be more inclusive of tribal communities and health organizations as it pertains to the assessment and planning for the Maternal Child Health population. The process for the entire needs assessment period required that domain teams actively engage with their respective community and partner organization stakeholders through advisory committees, conferences, professional and clinical association meetings, focus groups and surveys. The six population domain teams worked with partners such as the New Mexico Public Health Association (NMPHA), the New Mexico Alliance of Health Councils, March of Dimes, the NM Health Equity Partnership, and the University of New Mexico and government agencies including the Human Services Department-Medicaid, and the Children Youth and Families Department. These partners provided direct access to consumers, families and experts in MCH. Both quantitative and qualitative methods were employed to assess, describe, and begin to identify priorities for each population domain group. Stakeholders from a variety of health-related organizations provided qualitative data, family input and survey responses for prioritization, which were reported back to the Executive Team. The population domain teams each recommended two to three state priority needs for consideration. The final priorities were determined through a series of Executive Team meetings held between April and June, 2015 taking into account agency priorities, community input, and the solicited prioritization through surveys of stakeholders, including professional associations, service organizations, and independent health experts.

Framework

We took a health systems and capacity approach to the needs assessment. Priorities identified as important were viewed within that framework to assess our ability to impact and change the direction of those that need improvement.

Data Sources

Each of New Mexico’s six domain work groups had a specific data table constructed from various resources to help the state initially assess strengths and weaknesses. Each indicator in the tables consisted of three data points that allowed each domain work group to compare New Mexico’s past performance or outcome (last four to

five years), New Mexico's current performance or outcome, and a nationwide indicator or outcome estimate. National data sets used in compilation of the data table included: American Community Survey/U.S. Census, Centers for Disease Control and Prevention (CDC) WONDER, CDC Youth Risk Behavior Survey, CDC WISQARS, CDC Sexually Transmitted Diseases Surveillance Special Focus Profiles, CDC Pregnancy Risk Assessment Monitoring System (PRAMS), CDC Breastfeeding Report Card/National Immunization Survey (NIS), CDC Pregnancy Mortality Surveillance System, National Immunization Survey, FBI Crime and Arrests Statistics, U.S. Bureau of Labor Statistics, Child Maltreatment and Foster Care Statistics, Centers of Medicaid and Medicare, National Center for Education Statistics IDEA Data Center, National Highway Traffic Safety Administration, National Survey of Child Health, FDA Food and Nutrition Program Statistics, Primary Health Care Center Statistics, National Vital Statistics' Mortality data, National MCHB Center for Child Death Review, HRSA Child Health U.S.A., and the National Survey of Children with Special Health Care Needs. New Mexico data sets included: Vital Records and Health Statistics, Juvenile Justice Statistics, Medicaid's Annual EPSDT and Enrollment reports, WIC client participation data, Office of Injury Prevention reports, Behavioral and Substance Abuse data warehouse, School Based Health Center Statistics, Family Planning client data (Title X), NM Child Fatality Review,NM Asthma program, NM PRAMS, NM YRRS, FIT developmental screening (Part C), Emergency Department and Hospitalization data, Safe Kids NM, and Children's Medical Services program data. Additional data sources are described below.

Maternal Health

The domain team started with a list of over 150 indicators and was able to reduce those to 15 based on what stood out from the data and program expertise. A survey based on these indicators was constructed and made available between 1 March 2015 and 15 April 2015 to women's health professionals.Surveys were administered to the NM Chapter of the American College of Obstetricians an Gynecologists (ACOG) in March, 2015, the NM Association of Nurse Midwives (March, 2015), the New Mexico Public Health Association (April, 2015) and an email survey distributed to and including participation from the Association of Women's Health, Obstetricians and Neonatal Nurses (AWHONN), SFM, NMMA , and AAFP.

Ninety-nine responses were collected from a Nursing Supervisor meeting, a Women's Health Conference, the New Mexico Public Health Association, as well as professional and state list-servs. The majority of respondents were CNMs (certified nurse midwives) (46%), followed by registered nurses (17%), students (13%), and OB-Gyns and physician assistants and nurse practitioners (both at 10% of respondents), with some responses from new mothers. In addition, the infant health domain team collected survey input on women's/maternal health priorities, and received input which was shared with the maternal health domain team. Additional data sources included a qualitative analysis of PRAMS data, WIC client/customer satisfaction surveys, and input from community health councils and regional DOH epidemiologists.

The maternal health priorities were also determined based on the cross-cutting surveys conducted among U.S./Mexico border health stakeholders and the tribal health organization survey.

Infant Health

The infant and maternal health domain groups worked with some crossover during the assessment process, and those shared inputs are described in the attached matrix 'public input'. The primary stakeholder organizations are by definition maternal and infant (or early childhood, 0-3) providers or advocates, so the input points were not usually limited to one domain vs. the other. As described in the needs assessment overview, the process began by engaging internal and external stakeholder over the process of fifteen months in advisory committee meetings, foundation grantee meetings, and statewide gatherings. Active stakeholders included Family Health Bureau programs, the statewide perinatal collaborative, the PRAMS steering committee, Santa Fe, San Juan, Bernalillo

and Rio Arriba County Health Councils, perinatal case management and home visiting programs including First Born, Families FIRST, Family Spirit, Tribal Epidemiology Centers, Navajo WIC, and a WK Kellogg foundation consortium of birth to 3 advocacy and service programs (ie Tewa Women United, Envision NM, Share NM, Young Women United and the NM March of Dimes).

In addition, the cross-cutting population surveys- US/Mexico border and Tribal Health Organizations- both made important contributions to the maternal and infant health domain realms. A survey of these populations revealed priorities around access to health insurance and care which was corroborated by a qualitative analysis of PRAMS comments indicating significant barriers to health insurance for women who did not qualify Medicaid or subsidized health insurance but could not afford private insurance before or during pregnancy. The final priorities selected incorporated meeting discussion, existing initiatives, and a final survey of ranking to all stakeholders. The survey tied together important concepts and initiated action planning to be followed in the next 5 years.

Child Health

The Child Health Needs Assessment team was led by Gloria Bonner, the Child Health program manager, and included John McPhee, Childhood Injury Prevention Coordinator/Office of Injury Prevention, Crystal Begay, Health Educator/Environmental Health Epidemiology, and Christopher Whiteside (Title V epidemiologist). The Child Health Needs Assessment domain group began its Needs Assessment by considering the over 200 indicators and health priorities paying close attention to the magnitude and trend of each. The group then narrowed the list to priority areas. The methods used to assess the needs of the child health domain varied between the evaluation of quantitative data and the collection of qualitative data.

The Child Health program used it partnership with the New Mexico Early Childhood Comprehensive System (ECCS) State Team to gather stakeholders into an initial stakeholder meeting that included clinicians, educators, family advocates, and public health professionals. In this meeting, the initial indicators identified as significant were discussed and stakeholders were asked to choose the three most important indicators/health priority areas. The results of the stakeholder group yielded three priority areas that were explored further.

Following the stakeholder meeting the child health needs assessment continued with more stakeholder engagement by the way of surveys conducted distributed via email. The surveys were disseminated to an even larger body of stakeholders using the Child Health program's listserv of over 350 child health advocates and consumers. This survey intended to address various health outcomes within child health and the impact of ACA. The survey collected over 120 responses.The Child Health domain groups continued the Needs Assessment by engaging with the New Mexico Public Health Association (NMPHA), the Alliance of Health Councils, and the Health Equity Partnership. These partners helped inform the domain groups on emerging child health issues within communities by providing feedback and informing the group on consumer/family health issues. The Child Health domain group then honed in on 10 priority areas that emerged as most important both quantitatively and qualitatively. Another survey was developed and sent out to the same group of stakeholders to gauge how actionable each of the priority area were. This was mainly to gauge and develop actionable priorities.

Finally, a list of 8 indicators representing health priority areas was developed and ranked using a criteria based prioritization matrix to help the group hone in on one to three priorities. The criteria considered were: magnitude, trend, severity, preventability, capacity, and community support. Each internal stakeholder in the group was given this matrix along with external stakeholders selected from the larger group. This matrix allowed the Child Health domain group to settle in on two priority areas that were recommended to the large Needs Assessment team as state selected priorities.

CYSHCN

Children's Medical Service (CMS) utilized an established partnership, the MCH Collaborative, to convene a panel of twelve experts to review the Children and Youth with Special Health Care Needs (CYSHCN) data table, which included over 180 data points. The MCH Collaborative is comprised of program representatives from CMS, Family Voices, Parents Reaching Out, the Pediatric Pulmonary program at UNM, the UNM Lend Program, the Developmental Disability Planning Council, and the organization Education of Parents of Indian Children with Special Needs (EPICS) who share the personal dedication and commitment to Title V. The collaborative 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. 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, CMS social workers, and the CMS Advisory Board which is part of the New Mexico Medical Society.

The panel was asked to select up to three priority areas on October 29, 2014 through a facilitated process. The panel settled on three priority areas-behavioral health, medical home, and transition- after two iterations of open discussions and anonymous voting. All participants agreed or strongly agreed that: the materials provided were useful; the panel represented the needs and barriers serving CYSHCN, all members were involved in decision making process and the decisions reached accurately reflected the consensus of the group.

Direct family input is important and critical to the CYSHCN needs assessment. A survey was used to collect additional family/consumer input on the three areas selected by the expert panel. Questions regarding ACA, insurance coverage and gaps was also included. Paper and electronic versions of the surveys were made available to families being served in Children's Medical Services Clinics (CMS) and CMS's partners between March 9, 2015 and May 1, 2015. CMS social workers provided the survey to families after participation in pediatric outreach clinics. CMS staff solicited family input during two Family Leadership conferences one hosted by the NM Family to Family Health Information Center at PRO and another by the Education of Indian Parents with Special Needs (EPICS) who focus on the needs of Native American families. The survey was available in English and Spanish. Two hundred eighty-one individuals provided feedback on the CYSHCN Needs Assessment (CYSHCN NA) Survey concerning their children's health insurance, quality of medical care, and the ranking of selected health needs. Of those who answered the survey, 22% had a special needs family member that was in transitioning age (teens). Families indicated that for both children and teens with special needs that their top concern was improving the behavioral health care of their children.

Current initiatives underway are striving to address priority areas identified by the survey. The National CSHCN survey demonstrates a clear need for improvement in providing a medical home for youth with special health care needs in New Mexico, since only 34.9% of CYSHCN in New Mexico receive coordinated, comprehensive care within a medical home, compared to 43% nationally. In New Mexico, over 70% of Hispanic CSHCN, and over 73% of those below the Federal Poverty Level receive coordinated, comprehensive, ongoing care within a Medical Home. This is especially significant given the fact that almost a third of NM children live in poverty and over a third of the NM population speaks a language other than English at home. All this points to the fact that New Mexican children are at higher risk for not receiving coordinated, comprehensive, culturally competent care within a Medical Home compared to U.S. children in general. The New Mexico Pediatric Society's Pediatric Council has been working with the NM Quality Improvement Partnership (ENVISION New Mexico), the FHB/CMS Medical Director, and the Medical Directors of the four state Medicaid managed care plans to develop a consistent set of Patient Centered Medical Home (PCMH) standards. Having this clear and consistent set of standards will encourage physicians to embrace the medical home model and enable practices to more easily make the transition to becoming certified medical homes. With the support of the D70 funding the CMS program has been addressing 4 goals regarding improving the transition/transfer process for youth with special health care

needs (YSHCN) in coordination with the Medical Home.1)Increase knowledge, skills and capacity of medical and social work providers statewide to provide effective transition services to YSHCN and their families; 2) Develop sustainable systems to provide support and information to YSHCN and their families during the transition process; 3) Build infrastructure to improve access to accurate, reliable information on Medical Home and transition issues for providers and families; 4) Collaborate with other state agencies and entities to promote policy and/or legislative changes that will improve transition services for YSHCN and their families in New Mexico.

Adolescent Health

The Family Health Bureau used an established partnership with the Office of School and Adolescent Health (OSAH) to facilitate the adolescent health needs assessment. The adolescent health domain group was led by Tessa Medina-Lucero the Adolescent Health Coordinator, Jim Farmer the health services manager and Christopher Whiteside the Title V epidemiologist. The OSAH utilized its various partnerships and program resources to engage a diverse group or stakeholders that included educators, clinicians, social workers, researchers, peer leaders and teens. The Needs Assessment commenced with an adolescent health development summit of 45 stakeholders. The group invited experts in the areas of social work to discuss areas of child development and the impact of social determinants on adolescent health. The extensive list of health indicators and priority areas considered gave rise to resiliency indicators. The suggestion by the group was that resiliency was as important if not more important than risk factors.

Following that meeting the Adolescent health group decided to conduct a survey geared to a wider range of stakeholders addressing health priorities and the impact of ACA on adolescent health. The survey had a response of 124 stakeholders including family/consumer input. The Adolescent Health group followed that survey up with a teen focus group of 16 teens. The age range of teens was from 13-18 and discussion questions centered on the most pressing teen health areas established from the larger survey: bullying support, teen pregnancy, substance abuse, mental/behavioral health and physical activity. The teens were able to voice concerns and provide actionable ideas to impact adolescent health.

The Needs Assessment group used an established partnership with Organizing Youth Engagement (OYE) New Mexico's largest grassroots youth engagement conference which brings together youth from all over New Mexico organized by the New Mexico Youth Alliance (NMYA). The conference addressed a multitude of issues surrounding and impacting youth. Of those issues of discussion were social determinants and their impact on health. The conference conducted focus group led by adolescents and attended by adolescents. Using the social-ecological model as its basis, the Needs Assessment group perused the published results from the conference to understand how these determinants are impacting adolescent health and assisted in the development of priority areas of focus.

The Adolescent Health Needs Assessment group utilized input from various stakeholders to hone in on 20 priority areas of needs. Weighing qualitative data heavily into the decision with quantitative data, the group used a prioritization matrix utilizing trend or prevalence, disparities, currently addressed, capacity and community support as criteria to rank the priorities. Capacity and if it is currently being addressed where weighted more heavily into the ranking process. Using these methods the group was able to narrow the list of priorities down to three. These three priorities were ranked and recommended to the larger Needs Assessment group as state selected priorities.

Cross-cutting/life-course

The cross-cutting domain group was incorporated into the other domain where life-course health determinants,

concentrated poverty and disparities or barriers to care were explored. New Mexico has a very diverse population with both a large border and immigrant population and Native/American Indian population. Because of this we chose to assess the MCH health needs of both populations/areas. We surveyed health organizations/providers with series of questions about: aspects of the Affordable Care Act, access to care, maternal heath, infant health, adolescent health, child health and perceived priorities. The results from these investigations fed into the five other health domains in various capacities. For example, the questions in the survey were selected to collect input from particularly vulnerable segments of the MCH population from a systems capacity perspective. Rather than starting with the consumers to understand barriers to care, health priorities and opportunities to improve access, the two surveys sought to understand how we could improve health status from a health organization and health systems perspective.

II.B.2. Findings

II.B.2.a. MCH Population Needs

Infant Health

New Mexico enjoys relatively healthy birth outcomes despite endemic poverty, rural geography and barriers to healthcare. The infant mortality rate in New Mexico remains lower than the national rate, with 5.4 deaths per 1,000 live births in 2013. However, for 2012-2013 the rate of death for infants was 6.2 (5.5-6.8) per 1,000 live births. The primary causes of infant death in 2012-2013 were perinatal conditions such as low birthweight, prematurity (and their drivers like hypertension and restricted intrauterine growth), birth defects, and other and undetermined causes, including injury.

Disparities by maternal race-ethnicity persist, as in previous reporting periods, with Black women experiencing the most concerning infant mortality rates (10.9 per 1,000 live births), Hispanic women next with a rate of 6.8 per 1,000, and Native American, Asian, and White women with the lowest rates. Further analysis is required, however, since the race-ethnicity classification of American Indian women changed between 2012 and 2013 which significantly changed the racial distribution of women who identified as both Hispanic and Native American to just Hispanic. This shifts the infant mortality rates into the Hispanic category and away from American Indian, creating a less than perfect picture of infant mortality disparities. New Mexico is working with the Navajo Epidemiology Center, the DOH tribal epidemiologist, and the Albuquerque Area Southwest Tribal Epidemiology Center to address this issue.

Data Table 1.0, 2012-2013

Race/Ethnicity	Deaths Per 1,000 Births	95% CI LL	95% CI UL	Number of Deaths	Number of Live Births	Statistical Stability
Overall	**6.2**	**5.5**	**6.8**	**329**	**53,234**	-
American Indian or Alaska Native	4.9	3.2	6.6	32	6,554	-
Asian or Pacific Islander	4.5	0.6	8.5	5	1,106	Unstable
Black or African American	10.9	4.2	17.6	10	919	Unstable
Hispanic	6.8	5.9	7.8	196	28,682	-
White	5.5	4.3	6.6	85	15,508	-

There was a an uptick in IMR in 2012 from 2011, and that increase, in part, spurred the application for a National Governor Association (NGA) learning network on improving birth outcomes. The Family Health Bureau led this application and eventually coordinated the implementation of a perinatal collaborative in the New Mexico, the first effort to coordinate obstetric, pediatric, public and private practice and advocacy into one organized and communicative body.

The first year of the perinatal collaborative (2013) corresponded with New Mexico's participation in the National Collaborative Improvement and Innovation Network (CoIIN) which had commenced in 2012 with five regional HRSA strategies for reducing infant mortality: 1) Reduction in Early Elective Deliveries, 2) Perinatal Regionalization (%VLBW infants born in level III or IV hospitals), 3) Interconception Care (increased coordination and payment models among insurance, clinicians ,and public health), and 4)Safe sleep.

For New Mexico entry into these strategy areas made sense, based on existing Vital Records, Pregnancy Risk Assessment Monitoring System (PRAMS) and available Medicaid claims data. Preliminary analyses indicated that although New Mexico's C-section rate was significantly lower than rates in much of the United States, there were significant disparities and barriers to improving those rates. C-section and VBAC among Indian Health Service facilities are an indicator and model of evidence-based practice in New Mexico. But among women with private insurance payers C-section and induction rates are higher, and even those practitioners and facilities serving the Medicaid population struggle to uphold evidence-based practice. The perinatal collaborative and Hospital Engagement Network set out to engage in quality improvement (QI) and further analysis. This effort contributed to the needs assessment of both maternal and infant health population domains. With regard to perinatal regionalization, NM first applied for and received placement of a post-doctoral HSIP fellow in 2014; however, that fell through when that fellow took a different fellowship the same week she was to start in NM. The perinatal regionalization is of interest to NM MCH and MCH Epidemiology staff who met with Dave Goodman in September, 2014 to explore avenues to promote this work.

Safe Sleep in New Mexico has been an area of significant program and public health investment between the Family Health Bureau and Office of Injury Prevention Epidemiology, a cross-divisional effort since 2011. The two

programs have worked together over the past five years to expand awareness around 2011 AAP recommendations for infant sleep safety and to help birthing facilities develop appropriate protocols for safe sleep education during prenatal visits and delivery. The SUID rate for 2008-2013 was .8 deaths per 1,000 (n=134) , and the number of annual deaths decreased from 30 to 16 during that period. The 2014 death review is not complete, but preliminary numbers indicate a return to the more average rate of 20 deaths per year. The SUID (sudden unexpected infant deaths) in New Mexico are unequally distributed by race-ethnicity and geography with the largest share experienced in the NW quadrant of our state and by Native American families.

With regard to intentional injury and related morbidity, child maltreatment is seeing a significant increasing trend. Among all children the ratio of victims of child abuse per 1,000 increased from 9.9 in 2005 to 16.7 in 2013. https://ibis.health.state.nm.us/indicator/view/ChildAbuse.Victims.Year.html The share of infants in this population is notable and is indicated by hospitalization rates for intentional injury victims under the age of one year, which was 2.2 per 10,000 population from 2011-2013.

Strengths and improvements in the infant population include a lower proportion and rate of teen birth rates and increasing breastfeeding initiation. Although these are strengths and New Mexico sees marked improvement it is also an area of disparities and sub-level indicator concern. For example, though the teen births have declined significantly, women of all ages report inconsistent access to contraception and health insurance coverage. This is seen in the unintended pregnancy rates, still over 40% of all NM live births, and in the percentage of women using contraception when they conceived (just over half). Access to health care prior to and during pregnancy is far from adequate in New Mexico.

With regard to breastfeeding, although New Mexico continues to see in gains in initiation, disparities among Hispanic mothers, especially those native-born, persist. In addition, we have not seen the potential increases in duration which are required to establish optimal breastfeeding in the first six months of life.

Maternal Health

The live birth rate for females aged 15-44 years of age has steadily decreased from 2008 to 2013. Between 2000 and 2013, the average live birth rate is 35.1 per 1,000. The year with the highest rate (38.0 per 1,000) was 2007. The year with the lowest rate (32.2 per 1,000) was 2013. Since 2011, the rate has been steadily declining. Reasons for the steady decline in the live birth rate include improved preventive care and increased reliance on contraceptive methods (such as long-acting reversible contraceptives).

i. Pregnancy spacing
   The spacing of pregnancies tends to be, on average, 48.8 months between pregnancies. When looking at data from an age-group perspective, the interpregnancy interval increased as the maternal population aged, from 20 months' interval in the 15-17 year old age-group to 92 months' interval in the 40-44 year old age-group.

   Resources available to Title V clients include Title X contraceptive supplies (such as long-active reversible contraceptives).

ii. Unintended births
   The unintended pregnancy rate has been fluctuating between 42.3% and 45.8% between 2000 and 2008. More than half of the pregnancies each year in NM are reported as "intended" on the PRAMS survey.

A survey on assessing women's health needs was disseminated via conference and e-mail to groups mentioned above (April 8, 2015). The majority of respondents were CNMs (certified nurse midwives) (46%), followed by registered nurses (17%), student attendees (13%), and OB-Gyns and physician assistants and nurse practitioners (both at 10% of respondents). Almost 50% of respondents felt that ACA has made maternal health

services more affordable and more accessible, prenatal care more accessible, and contraceptives more accessible.

Respondents to the above-mentioned survey ranked issues that they felt needed the most improvements:

1. Maternal population without health insurance (68%)
2. Delivery care of high-risk infants (60%)
3. Getting routine health check-ups (50%)
4. Smoking in pregnancy (50%)
5. Receiving adequate prenatal care (43%)

Respondents to the above-mentioned survey ranked issues that they felt needed some improvements:

1. Birth spacing (67%)
2. Postpartum depression (50%)
3. Physical abuse during pregnancy (45%)
4. Non-medically-indicated cesarean sections (45%)
5. Mother's age at child's birth (42%)

Respondents to the above-mentioned survey ranked issues that they felt needed the least improvements:

1. Sexually transmitted diseases or infections (67%)
2. Health complications (diabetes, hypertension, etc.) (61%)
3. Breast-feeding duration (59%)
4. Non-medically-indicated cesarean sections (45%)
5. Birth spacing (33%)

CYSHCN

With the help of external partners and the CMS specialty clinics, a family survey was administered to assess unmet needs of CYSHCN and their families. Assuming that those who answered the survey were representative of the general CYSCHN population in New Mexico, the survey suggests that out of 281 respondents

- 71.9% of the survey respondents with private insurance as compared to 89.5% of families with private insurance from the National Survey reported that their health insurance usually or always lets them see the health care provider that their child needs.

- 48.1% of the survey respondents with private and 58.4% of respondents with public health insurance reported receiving help arranging or coordinating their child's among different doctors or service their child uses. These results are higher than what the National Survey reports for families with private (19.3%) or public (36.2%) health insurance.

- 34.9% of the survey respondents whose child had emotional, behavioral, or developmental needs as compared to 51.8% of parents from the National Survey were very satisfied with their child's doctor's communications with other providers.

- 75.3% of the survey respondents as compared to 84.0% of parents from the National Survey reported that their child's doctors and other healthcare providers usually or always make them feel like partners in their child's care.

- 75.5% of the survey respondents as compared to 87.0% of families from the National Survey reported that their child's doctors and other healthcare providers are usually or always sensitive to their family's values and customs.

- 49.4% of the survey respondents as compared to 21.0% of families from the National Survey reported that their child's doctors talked with their child about eventually seeing doctors or other health care providers that treat adults.

Cross Cutting

Thirty-two health providers answered the tribal needs assessment survey and represented or served all of the federally recognized tribes in New Mexico. Over half of health providers somewhat agreed that their MCH services were culturally appropriate. About half of health providers somewhat agreed that there was sufficient coordination between the tribal community health programs and the New Mexico Department of Health. Tribal health providers reported that the three most common barriers were: availability of transportation services, excessive out-of-pocket expenses, and a lack of trust in the health care system. The most common areas that tribal health providers identified for improving the health of the tribes was: better coordination of health services, better patient education and navigation around health insurance, and improving or expanding the accessibility of safety net care services.

Qualitative feedback in the survey and echoed at community presentations and focus groups indicated that New Mexico needs to focus on including tribal communities in the roll out and implementation of Centennial Care navigation plans. The survey participants felt like initially tribes were not included in the plans to ensure Native American clients could enroll in Centennial Care. It will take a lot of work to keep up with the confusion that enrollment poses for many Native American families.

The border survey participants (n = 101) included staff of community health centers, Healthy Start sites, mental health and substance abuse clinics, health promotions organizations, medical facilities, and state and county health offices. There were also a significant number of respondents from clinics in schools. The largest number surveyed felt there has been an increased demand for their services over the past 5 years. Similarly, access to professional/ medical language interpretation was reported with the largest responses in "somewhat agree" and "completely agree" categories. The largest number of respondents (n = 30) reported services available were culturally appropriate. Respondents reported adequacy of cultural competency training as "somewhat" or "completely agree" (n = 45), "somewhat" or "completely disagree" (n = 14). Respondent "somewhat agreed" (n = 22) with sufficiency of coordination between border region organizations and state department of health.

A series of questions asked about various aspects of the Affordable Care Act. The majority of participants (n = 52) reported they understood how the Affordable Care Act (ACA) impacted their services to the public. However when asked if ACA made health care more affordable, responses centered over "neither agree nor disagree". When asked if ACA had improved quality of health care, the majority (n = 32) rated neither agree nor disagree. Participants responded similarly (n = 37) about language translation services provided through the ACA.

Relating to maternal and women's health, participants surveyed were asked to rate relative importance of several health needs; the highest need is prenatal care (63%); the lowest, elective C-section (25%). Relating to infant health, the highest need was treatment referrals for infant drug exposure (56%); the lowest Sudden Infant Death (SID) Syndrome/ sudden unexpected infant death (42%). Child abuse rated as highest need (62%) and childhood injuries as lowest (32%) in child/ youth health. When asked about adolescent health, two areas rated

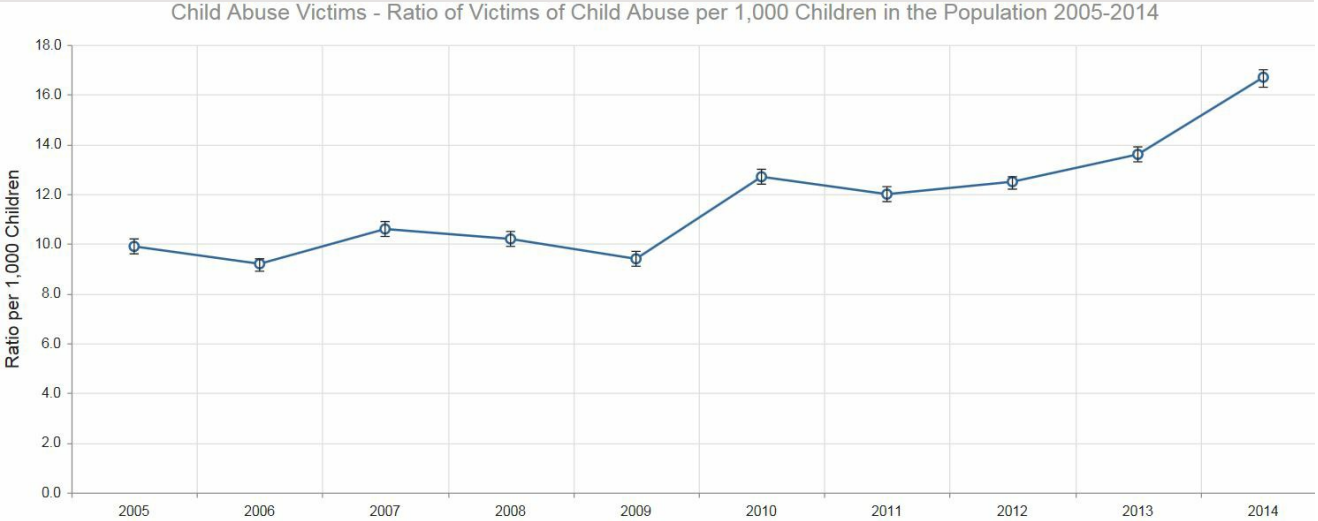
equally as the highest concern: adolescent pregnancy prevention and adolescent pregnancy parenting support services (59%). The lowest is adolescent injuries (32%).

New Mexico chose the cross-cutting issue of improving access to health care based on feedback from the six domains, including surveys of two special and vulnerable populations (tribal and US/Mexico border). According to the U.S. Census's Small Area Health Insurance Estimate, 26.8% of women of reproductive age were without health insurance and 9% of children under 19 were without health insurance. Both these values are above the national average. Lack of health insurance was also frequently cited in top four concerns for: maternal health domain (a third of consumers and providers), children (third of parents and providers), adolescents (a third of consumers and providers), tribal health (a quarter of health providers), and border health (over half of health service providers).

Child Health

Meetings and surveys given to stakeholders identified developmental screening (63%) and child maltreatment (72%) as child health population needs. Both were also identified as preventable and actionable based upon their knowledge of current capacity.

The ratio of victims of child abuse has increased significantly since 2005.



Adolescent Health

In a survey of 124 respondents or stakeholders involved in adolescent health, bullying/cyber-bullying was identified as a priority that would be both actionable and supported by the community at large. Additionally a youth focus group identified bullying as need.

% of public high schoolers who were bullied on school property at least once in the past year (2013)	
NM	18.2%
US	19.6%

U.S. Department of Health and Human Services. Centers for Disease Control and Prevention (CDC)

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

Susana Martinez was elected Governor of New Mexico in November, 2010 and re-elected November 2014. The Lieutenant Governor is John A. Sanchez. Retta Ward, Cabinet Secretary for the Department of Health was reappointed in 2014. The current administration of Governor Susana Martinez consists of 22 State Departments, including the Department of Health. Cabinet members serve at the Governor's discretion and together form a constructive advisory board in assisting the Governor in running the affairs of state, with reporting duties based on their respective agencies. Currently, the Governor's Cabinet is comprised of Secretaries and Directors of nearly thirty agencies each of who deal with particular issues the Governor deems as an important part of the overall health of our state and its
people. The NM Department of Health (DOH) is a statewide agency organized into 5 Regions with each of the 53 loc

The Secretary of the Department of Health, Retta Ward MPH, is a Cabinet Secretary and reports directly to the Governor. The Deputy Secretaries are Lynn Gallagher, responsible for Programs, and Brad McGrath, responsible for finance and facilities management , including five hospitals and healthcare centers. The Secretary's Office houses the Public Information Officer, Chief Medical Officer, Chief Information Officer and the Chief Privacy Officer (HIPAA and related functions), as well as the Office of General Counsel. The Deputy Secretary of Programs oversees three major divisions which include: Public Health Division, Developmental Disabilities Support Services Division, and Health Certification and Licensing.

The Public Health Division (PHD) consists of 5 Region Offices, an Office of Border Health, a Pharmacy Office, and 5 Bureaus: Program Support, Health Systems, Chronic Disease, Infectious Disease, and Family Health. The Family Health Bureau is the largest bureau in the Public Health Division. The Family Health Bureau Chief is Janis Gonzales and the Deputy Bureau Chief position is currently vacant. The Family Health Bureau (FHB) is located in the Colgate Building at 2040 South Pacheco, about six blocks from the Harold Runnels DOH building. Organizational charts for the Family Health Bureau and the Public Health Division of the Department of Health are in the Appendices. Susan Lovett is manager of the Family Planning. Family Food and Nutrition (WIC) Program director is Sarah Flores. Susan Chacon is the Children's Medical Services program manager. The Maternal Child Health Epidemiology program is overseen by Eirian Coronado; Gloria Bonner manages the Child Health program; and the Maternal Health program is overseen by Catherine Avery.

The MCH Epidemiology Program serves the data and information needs of the FHB and its many partners. It has inc
genetic

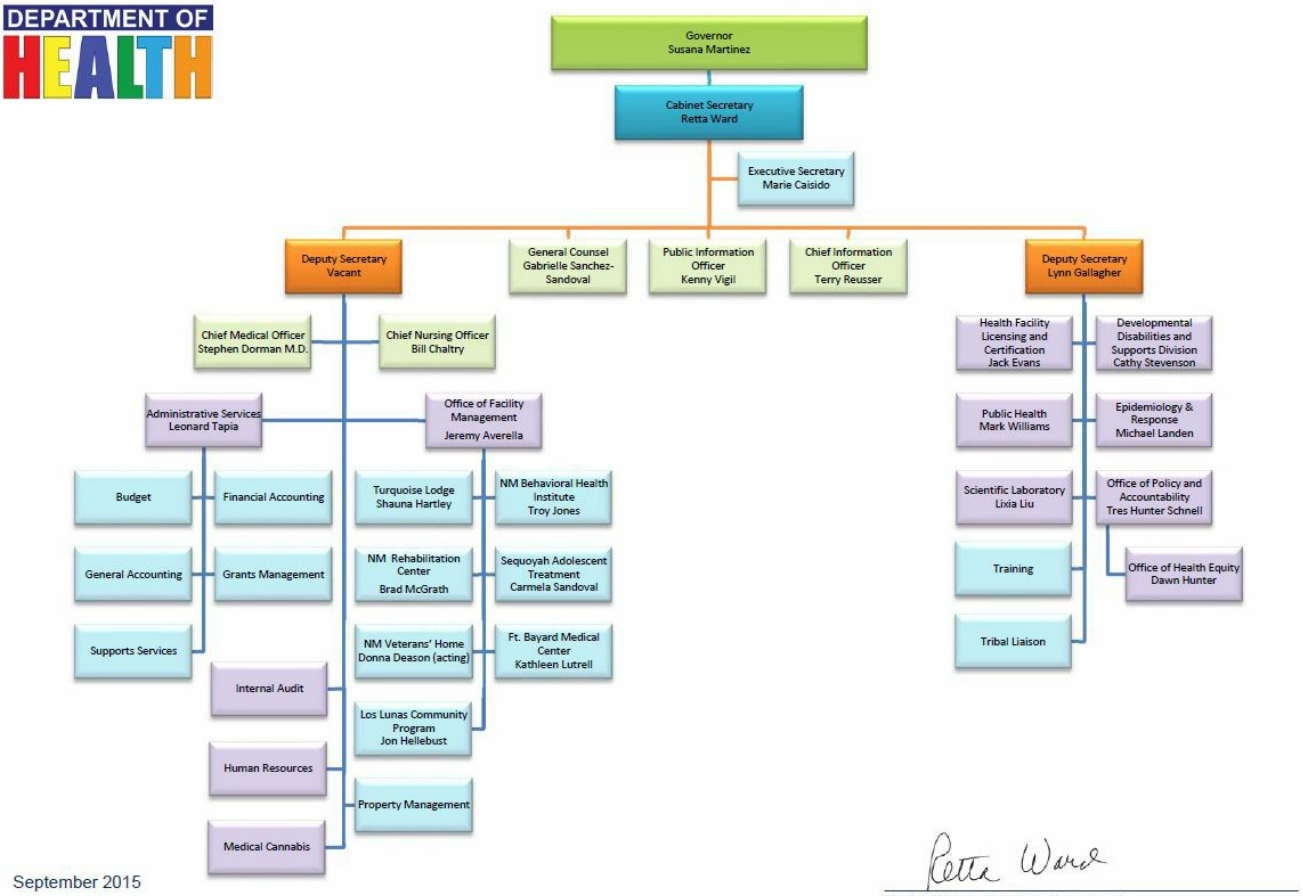
sreening, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group staff, including a position funded by SSDI, aid in the data collection and evaluation of MCH data, and work on Title V MCH specific data and assessment tasks. This includes data synthesis and assessment related to the MCH Block Grant and analysis of WIC data for selected priority topics. This section is also responsible for coordination of the Collaborative Improvement and Innovation to prevent infant mortality in New Mexico.

The FHB is organized into five programs: 1. MCH Epidemiology, 2. Family Planning/Title X, 3. Children's Medical Services, 4. WIC Food and Nutrition and, 5. Maternal and Child Health, and 6.Families FIRST perinatal case management. The FHB is responsible for carrying out the majority of Title V programs. The Office of School and Adolescent Health, the Office of Oral Health and the Injury Prevention/ Child Fatality Review Program receive some Title V funds but are located within other DOH bureaus. In addition, the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) programs were awarded to the Children Youth and Families Department (CYFD) rather than the Department of Health. The Office of School and Adolescent Health (OSAH) is housed within the Health Systems Bureau in the Public Health Division (PHD). The Office of School and Adolescent Health manages services for school based health centers and engages youth in policy making for those centers. The Office of School and Adolescent Health promotes quality accessible student and community health services through the development and support of School-Based Health Centers. These centers provide comprehensive primary care and behavioral health services by using a multi-disciplinary health team to provide reproductive health care and education. For communities where teen birth rates are high, School-Based Health Centers can be supportive partners in teen pregnancy prevention.The New Mexico SBHC initiative is a collaborative partnership among the following state agencies: New Mexico Department of Health, Public Education Department, Human Services Division, and Children, Youth & Families Department.

The Office of Oral Health and dental program is located in the Health Systems Bureau, with easy access to the FHB/Title V MCH Agency for consultations on oral health in mothers and children. In addition, the Health Systems Bureau houses the Office of Community Health Workers and the Northern Tribal Liaison, Diana Abeyta.

Title V Programs located and funded by Title V within the Family Health Bureau, where the Block Grant is administered, include: Children's Medical Services , the Maternal Health Program/ Child Health Program, and the MCH Epidemiology Program. Other partner programs administered within the same bureau are: the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the WIC Farmer's Market Nutrition Program, the Commodity Supplemental Food Program, the Title X Family Planning Program, the state-funded Families FIRST Perinatal Case Management Program.

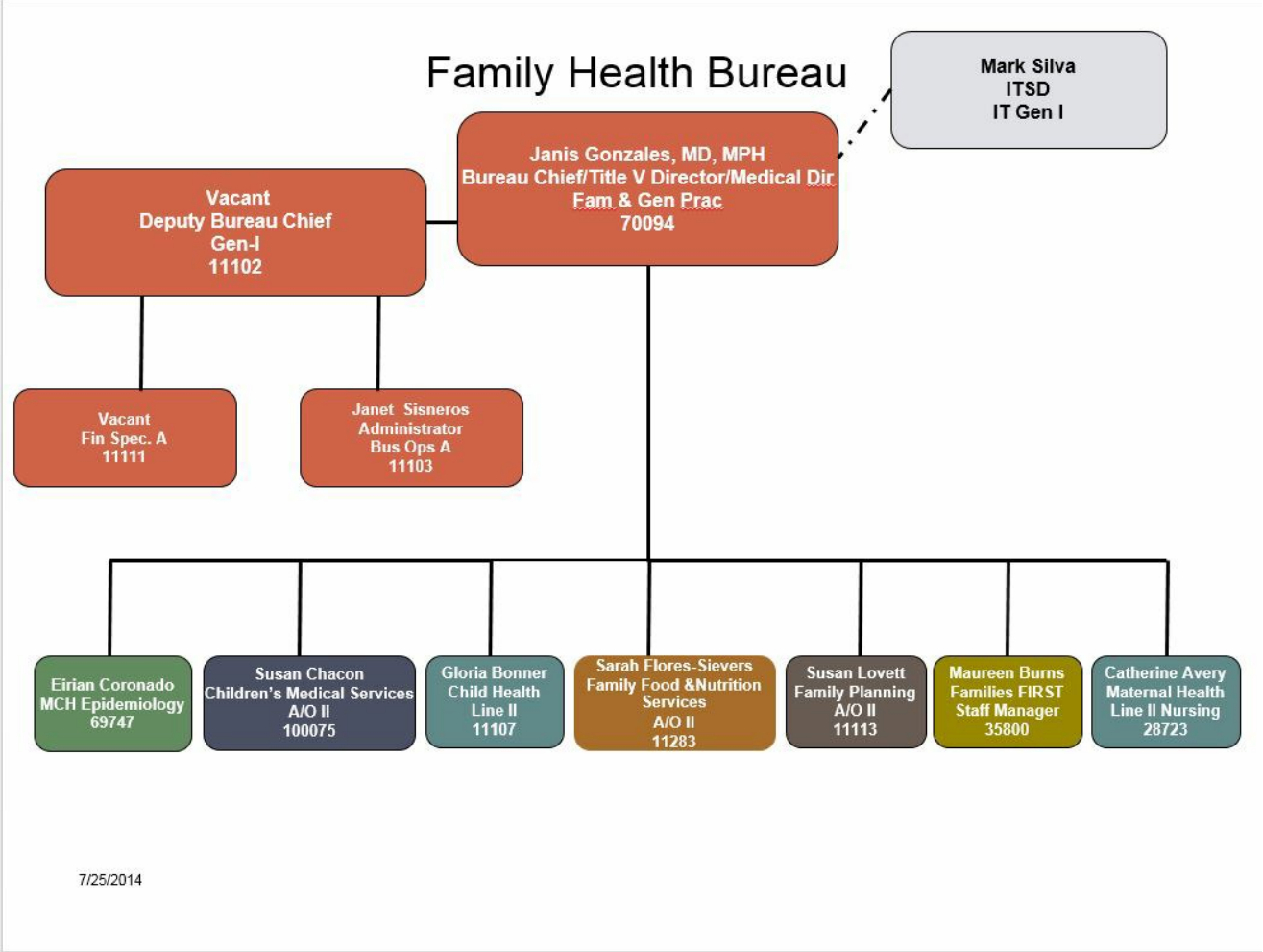
NEW MEXICO DEPARTMENT OF HEALTH



September 2015

Retta Ward

Retta Ward, Cabinet Secretary



II.B.2.b.ii. Agency Capacity

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

The Maternal Health program administers the High Risk Prenatal Care Fund (HRF) contracting with 21 qualified private care providers, clinics and hospitals throughout the state to care for more than 1200 medically indigent women with high-risk perinatal conditions per year. The HRF also contracts with the University of New Mexico Hospital (UNMH) to provide prenatal care to high and low-risk medically indigent women in Albuquerque, and to any patients referred to them from providers throughout the state. The program indirectly provides for prenatal care through the licensing and regulation of midwifery care in NM. MH regulates both Licensed Midwives (LM) and Certified Nurse Midwives (CNM).

In 2008 the legislature approved the Birthing Workforce Retention Fund which is administered by the Maternal Health Program. This fund provides up to $10,000, per provider, to help defray the cost of malpractice insurance for some qualified rural perinatal health care providers.

The Families FIRST Program (FF) provides case management for Medicaid-eligible pregnant women and

children 0-3 years. Its goals are to improve birth outcomes, to decrease high-risk pregnancies and identify children with special health care needs for referral to CMS and Early Intervention.

CYSHCN

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.

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; The NM Sickle Cell Council provides education, screening and follow-up for sickle cell and other hemoglobinopathies. CMS worked with Medicaid to reimburse midwives for expanded Newborn Genetic Screening. Medicaid and CMS work together to increase enrollment of children due to expanded eligibility requirements. CMS staff are trained in enrolling clients through presumptive eligibility and Medicaid on site application services. CMS is working with the Commission for the Deaf and Hard of Hearing and the Commission for the Blind and Visually Impaired to address unmet needs for children in these communities. CMS continues to collaborate with Medicaid, WIC, UNM, the Commission for the Blind and the Commission for the Deaf and Hard of Hearing to address needs of CYSHCN and children identified on newborn genetic screening and newborn hearing screening. /The MCH Collaborative meets monthly to support Title V activities in the state and to address issues as a collaborative. Participants include the Title V CYSHCN program, Family Voices, Parents Reaching Out, EPICS, the LEND program and the Pediatric Pulmonary Program. All participants receive MCHB funding. CMS works with Hands & Voices NM Chapter to increase family involvement of CYSHCN in Title V activities.

State Program Support for Communities:

CYSHCN who are covered by CMS, Medicaid/SCHIP and private insurance can receive clinic services in multidisciplinary CMS/UNM/Presbyterian pediatric specialty outreach clinics, and care coordination by CMS social workers. 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 UNM pediatric cardiology and in 2015 added 12 cardiology clinics statewide to address unmet needs.

Coordination with Health Components of Community Based Systems:

CMS's network of 60 social workers is located and co-located with other health services in NM.. They coordinate health care for CMS CYSHCN statewide. CMS works with community councils and services with the Title XVIII Medicaid and Title XXI SCHIP program, the largest providers of medical care, in an effort to provide and model family centered, community based, culturally competent coordinated care. CMS social workers provide a statewide system of oversight and care coordination for infants identified through the Newborn Genetic Screening and Newborn Hearing Screening state mandated programs.

CMS is working with the Center for Development and Disability (CDD) to improve the system of care for YSHCN, provide training to CMS staff and other providers on transition issues, and strengthen outreach of the Transition Consultative clinic to rural areas of the state. Transition activities with the CDD include the development of a peer mentorship with help from the Governor’s youth council. A curriculum committee with CMS, CDD and PRO has started to develop trainings which are available online, and a task force has been legislatively required which will look at policies and recommendations to improve the system of care for YSHCN transitioning from pediatric to adult medical care. The task force will present its findings to legislative committees beginning in the fall of 2015.

Coordination of Health Services with Other Services at Community Level:

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

II.B.2.b.iii. MCH Workforce Development and Capacity

Title V Director's Office

The Family Health Bureau houses 10 separate programs. The Bureau Chief, the Medical Director and program support staff work collaboratively as a team to use resources strategically to meet identified needs within this population depending on program focus. The Bureau Chief/Medical Director/Title V Director, Dr. Janis Gonzales, oversees all programs and works with each of the 8 program managers for direct oversight of each program. Dr. Gonzales is Board Certified in Pediatrics and has a Masters Degree in Public Health. She previously spent 9 years in private practice and then worked in hospice and in Early Childhood Developmental Screening before joining CMS. She also had a daughter with special needs. Dr. Gonzales serves as the AAP Chapter Champion for the EHDI program and works closely with the newborn hearing screening coordinator and served as Medical Director for CYSHCN in New Mexico. She served as the CMS Medical Director for 5 years and as the Family Health Bureau Medical Director for the past 2 years. She was promoted to Title V Director in Feb. 2015.

The programs in the Bureau consist of Women Infants & Children (WIC), which includes two Farmers Market programs and the Breastfeeding program; Children's Medical Services (CMS) which includes the Newborn Genetic Screening and Newborn Hearing programs; the Child Health program; the Maternal Health program; the Families FIRST perinatal case management program; the Maternal Child Health Epidemiology Program; the Family Planning Program which includes the Teen Pregnancy Prevention program and the Teen Outreach program.The Bureau administrative staff consists of an HR Administrator, a Financial Specialist, a Clerk Supervisor, and a General Clerk/receptionist who provide overall Bureau program support, as well as the Bureau Chief and Deputy Bureau Chief.

Maternal & Child Health, Title V Funded Staff

Katie Avery, RN, CNFP is the Maternal Health Manager, responsible for the High Risk Prenatal program, Midwife Licensure and Regulation and the Maternal Health program.The Child Health Manager, Gloria Bonner, is responsible for the Early Childhood Comprehensive Systems (ECCS) Grant, Las Cruces Home visiting

contract, and program activities that focus on child health with a focus now on developmental screening. Health Educator, Diane Dennedy-Frank, MSW, assists with segments of the ECCS grant and the child health component of the program including training on Ages and Stages. She also assists the Maternal Health Program Manager with special projects. Amber Montoya Clerk Specialist, provides office support for MCH staff and performs budget operation processes for MCH program.

The Families FIRST Program is revenue driven program obtaining reimbursements negotiated through Managed Care Organization (MCO) contracts and Medicaid (JPA). Maureen Burns, Program Manager, supervises 5 state staff and oversees 4 Regional Coordinators, 24 Care Coordinators, and 5 Clerks. Bonnie Hargrove, Registered Nurse Consultant, provides programmatic direction to 4 Regional Coordinators. She also monitors the Families FIRST Provider network and provides oversight of quality improvement for the perinatal case management population.Care Coordinators provide care coordination for pregnant women and children, assist clients with Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) and the MCO process. They also assist with establishing medical homes, community resources & referral networks. Families FIRST Care Coordinators are located in 23 sites throughout the state. Regina Sena, Management Analyst, maintains financial processes & budget operations. Jessica Tapia, Medical Secretary, maintains client & claim-processing databases.

CYSHCN Children's Medical Services

Ms. Susan Chacon, LISW is the Title V CYSHCN Director. Ms. Chacon has 10 years of program management within the Maternal &Child Health Program. The Title V CYSHCN Director position is the Statewide Program Manager for Children's Medical Services, under which fall the CYSHCN Program, The Multidisciplinary Specialty Outreach Clinic Program; the Newborn Genetic Screening Program; the Newborn Hearing Screening Program. Dr. Janis Gonzales remains as the CMS Medical Director since 2008. Dr. Janis Gonzales who is a pediatrician with many years of experience working with CYSHCN. CMS has 90 staff in 29 field offices throughout the state along with 10 state office staff for a total of 100 staff presently. All staff are involved in the Title V CYSHCN programs.

The state office staff consists of the Title V Statewide CYSHCN Program Manager, two nurse consultants who work with Newborn Genetic Screening Ms. Brenda Romero and Carla Oritz, a Newborn Hearing Screening Coordinator whose position is funded by a HRSA/MCHB grant (currently vacant), a clinic coordinator Executive Secretary Michelle Quintana, a financial specialist Mary Lewis, a training &development specialist Elaine Abhold, Finance Manager Paul Frey and general clerk Lydia Sanchez A second financial specialist position is vacant. The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, regional program managers &key state office staff. The management team meets monthly to review policy issues related to the implementation of the CMS programs.

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

Maternal & Child Health Epidemiology

The Maternal & Child Health Epidemiology program coordinates the Title V Block Grant &Needs Assessment, the State Systems Development Initiative (SSDI) grant, and the Pregnancy Risk Assessment Monitoring System (PRAMS), including a CDC-Kellogg Foundation collaboration to over-sample Native American women in New Mexico. Currently, there are four epidemiologists, a data manager, two data collection staff and a program clerk. Eirian Coronado, MA, MPH candidate, coordinates the PRAMS survey and is the Program Manager. Chris

Whiteside MPH, coordinates the Title V grant & Needs Assessment. He also coordinates and leads New Mexico in the Collaborative Improvement and Innovation Network to prevent infant mortality. Garry Kelley, MPH provides advanced analytic support for the CMS and WIC programs. Glenda Hubbard, MPH,RN, is the PRAMS analyst and SSDI data linkage project director. Dorin Sisneros is a data manager and provide fiscal oversight to the program. Oralia Flores and Nicole Hernandez provide data collection, data entry and general program support.The CMS program works in collaboration with the MCH Epidemiology program in data collection & analysis of the newborn screening program.

The Family Planning Program (FPP):

There are 51 Family Planning Program staff in Public Health Offices throughout the state &12 State Office staff. The field office staff consists of nurses, clinical nurse practitioners, &clerks who provide direct services to clients. The Program Manger Susan Lovett in the State Office manages the statewide Family Planning Program including oversight of budget, personnel, and Federal Grant requirements. Dr. Wanicha Burapa is the Medical Director.

Other Workforce capacity:

There is a new MCH certificate program through New Mexico State University that is designed to help increase capacity in the MCH workforce. The Graduate Certificate program is designed for MCH professionals working in rural, border and under-served populations and can lead to a Masters of Public Health

II.B.2.c. Partnerships, Collaboration, and Coordination

Maternal Child Health partnerships with internal and external stakeholders played a key role in the needs assessment process. These groups were involved in the selection of the state's priorities, informing staff of gaps in services, identifying health issues, and providing feedback on the five year needs assessment priorities as well as quality of services rendered by MCH programs. Children's medical services drew on their partnerships with Family Voices, Parents Reaching Out, the Pediatric Pulmonary program at UNM, the UNM Lend Program, the Developmental Disability Planning Council, NM Family to Family Health Information Center, Newborn Hearing Screening Advisory Council, the Newborn Genetic Screening Advisory Council, the Pediatric Council and the CMS Advisory Board, Education of Parents of Indian Children with Special Needs (EPICS) and parents to help them in the selection and feedback of their domain's priorities. The infant domain and child domain teams worked with the Office of Injury Prevention/Child Fatality Review, Environmental Health Epidemiology, DOH, CYFD, HSD, PED, NM Children's Cabinet, ECCS, NM Act Early State Team, Essentials for Childhood, Youth Development Inc., NM Association for the Education of Young Children (NMAEYC), Presbyterian Medical Services, Collective Action Strategies, NM Pediatric Society, Alliance of Health Councils, Early Childhood Accountability Partnership, J. Paul Taylor Task Force, Safe Kids, Parents Reaching Out, Educating Parents of Indian Children with Special Needs (EPICS), Center for Development & Disability, County Health Councils, LEND, Project ECHO, NM Association of Infant Mental Health, Brindle Foundation, LANL Foundation First Born Program, St. Joseph Health Care, Early Learning Advisory Council (ELAC), and the Interagency Coordinating Council (ICC).

II.C. State Selected Priorities

No.	Priority Need
1	To maintain and increase breastfeeding initiation and duration
2	To increase the percentage of children receiving a developmental screen
3	Increase access to care to a family-centered comprehensive medical home for children and adolescents
4	To increase the amount of services available to assist adolescents to make successful transitions to adult health care services
5	To reduce birth rates among teens 15-19
6	To improve access and quality of comprehensive well exams for adolescents
7	Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.
8	To improve safe sleep practices among home visiting participants and birthing facility medical staff
9	To decrease abuse and maltreatment of children
10	To increase and improve access to preventive dental care in pregnant women and children

Priorities Identified in the initial Five-Year Needs Assessment

The identification of state priorities began with a comprehensive list of possible priorities as health indicators that were either selected by our population domain teams through community meetings, existing community and health assessments or from those compiled by our epidemiology team. The Needs Assessment team presented those final indicators both in the large meetings and in small work groups, organized into teams according to the mandated population domain groups: infant, maternal, child, children and youth with special health care needs, adolescents and cross-cutting/life course. The domain group teams were given prioritization ranking tools to assist the Needs Assessment analysis.
In our ongoing Needs Assessment we systematically collected and examined information to identify and prioritize health problems in the MCH population. We started by collecting data and creating a data list that included a list of over 800 health indicators organized by domain group from nearly 50 data sources. The indicators sets included risk factors, resiliency factors, mortality and morbidity. Each domain team explored indicators that had the greatest magnitude or prevalence and appeared to be significant with regard to disparities, persistence/trend or impact on population health. Each domain group used various methods such as surveys and stakeholder meetings to collect qualitative and survey data ultimately used to rank and identify any additional indicators that may be linked to emerging priorities.

The domain groups were given ranking tools to rank and choose the priorities. Some domain group teams used Q-sort with internal stakeholder and other used variations of criteria-based rating. Q-sort is a ranking technique where a panel of stakeholders or experts choose and rank the priorities and provides some understanding of subjective viewpoints. Criteria-based rating uses standard criteria and each priority is scored by that criteria. Most domain groups used the latter and when each domain group settled on two to three priorities, this is how the priorities were

finalized. The criteria that were given consideration were: trend or prevalence, disparities, currently addressed, capacity and community support for change. In some of the domain groups criteria weighted heavier on ranking priorities.

The initial list of indicators from each domain group before we ranked and discussed were:

- Child safety/injury
- Child Maltreatment/abuse prevention
- Developmental screening
- Physical Activity/healthy weight
- Bullying
- Well-Child Visits
- Medical Home
- Teen Pregnancy/births
- Reproductive life planning/access to contraception
- Safe Sleep/SUID prevention
- Behavioral Health and wrap around services
- Adequate Insurance (all MCH domains)
- Perinatal Regionalization
- Smoking Cessation
- Neonatal Abstinence Syndrome and prenatal substance use
- Substance abuse (adolescent)
- Early Elective Delivery and inductions
- Poor Medical Transitions (CYSHCN and adolescent)
- Oral Health

The executive Needs Assessment team discussed all priorities and utilized the criteria-based ranking method. Other factors that came into the process were political will and having to address the required National Performance Measures. The executive team recommended and the Title V director accepted the final 13 priorities and determined which of the 13 will be submitted on form 9 of the TVIS.

Those identified as the final priorities in the initial Five-Year Reporting Period:

- Maintain and increase breastfeeding initiation and duration
- Increase the percentage of children receiving a developmental screen
- Increase access to a family-centered comprehensive medical home for children and adolescents
- Increase the amount of services available to adolescents to make successful transitions to adult health
- Reduce birth rates among teens 15-19 years
- Improve access and quality of comprehensive well exams for adolescents
- Improve access to care across the life span, from prenatal to well-woman care, via adequate insurance options for populations across the state
- Increase access to resources and increase awareness on bullying prevention
- Improve safe sleep practices among home visiting participants and birthing facility medical staff
- Decrease abuse and maltreatment of children

Updated Priorities 2015 Report and 2017 Application

The MCH priority need to increase access to resources and increase awareness on bullying prevention was removed and replaced with the MCH priority need to increase and improve access to preventive dental care in

pregnant women and children.

The decision to make this change was made after the MCH Title V program was encouraged by state public health leadership to align our MCH efforts with broader state priorities in New Mexico around oral health. Bearing in mind the capacity to collaborate our MCH oral health efforts from the previous 5-year cycle and being engaged by public health leadership and academic partner, the recommendation was made by the Title V director to explore the possibility of reevaluating our MCH priorities. This required the Title V Needs Assessment workgroup, comprised of MCH programs and partners, to reassess our findings on the 5-year Needs Assessment.

The results of our findings while reassessing and updating our 5-year Needs Assessment indicated an increased Title V program capacity to impact oral health due to a higher level of partnership and collaboration around oral health. The increase in capacity can be partly attributed to the implementation of the New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The project will integrate an evidence-based model of inter-professional oral care into primary care delivered to pregnant women and newborns across New Mexico. Expected project outcomes include improved oral health for pregnant women and their newborn children, as well as new standards of care for treating oral health conditions as part of primary care for this population.

There is an ongoing priority to improve MCH oral health outcomes. More New Mexican children live in households with income below federal poverty level (28.5%) than the national average of 21.6%. Children of poorer families have 2.5 times more untreated and un-prevented tooth decay. The New Mexico Department of Health oral health survey estimated that 64.6% of New Mew Mexico third graders had caries experience (the Healthy People 2020 goal is 42%), and 37% had untreated decay (the Healthy People 2020 goal is 20%). According to 2012-2013 PRAMS survey estimates, while 46.6% of women went to a dentist or hygienist for a teeth cleaning during pregnancy, only 14.5% visited a dentist for a dental problem during pregnancy. That indicates that many women may be aware they can or should visit a dentist during pregnancy, but they may not have adequate insurance coverage to do so. More analysis is required to explore the possible barriers.

The increased capacity and the ongoing priority to improve MCH outcomes made oral health a renewed priority that could engage multiple partners and programs. Nevertheless, the Title V director did not want to make a change to the National Performance Measures selected unless there was a marked decrease in the capacity to impact one of the priorities selected. After carefully reviewing all of the MCH priorities, the bullying priority was evaluated even further and the results indicated a significant decrease in the capacity to impact bullying. Bullying remains a priority in adolescent health and in the Office of School and Adolescent Health, therefore there will still be some effort to reduce impact of bullying on adolescents because the programs will continue the efforts that have already been put in place.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 11 - Percent of children with and without special health care needs having a medical home
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year
- NPM 15 - Percent of children ages 0 through 17 who are adequately insured

NPM 4-A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
NOMs:
• Infant mortality rate per 1,000 live births
• Postneonatal mortality rate per 1,000 live births
• Sleep-related SUID per 100,000 live births
This National Performance Measure is linked to maintaining and increasing breastfeeding initiation and duration. Work on increasing breastfeeding initiation and duration has been successful in New Mexico and the plan is to continue the trend of improvement. The agency has initiatives in place to impact all of the National Outcome Measures.

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
NOMs:
• Percent of children in excellent or very good health
• Percent of children meeting the criteria developed for school readiness
This National Performance Measure is linked to increasing the percentage of children receiving a developmental screen. Developmental screening is one of New Mexico's top priorities, the linkage to this NPM reflects the state's commitment to continue this trend of improvement.

NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

NOM's:
• Percent of children in excellent or very good health
• Percent of children ages 6 months through 17 years who are vaccinated annually against seasonal influenza
• Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
• Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
• Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
• Adolescent mortality ages 10 through 19 per 100,000
• Adolescent motor vehicle mortality ages 15 through 19 per 100,000

• Adolescent suicide ages 15 through 19 per 100,000
• Percent of children with mental/behavioral health condition who receive treatment or counseling
• Percent of adolescents who are overweight or obese (BMI at or above the 85th percentile)
• Severe maternal morbidity per 10,000 delivery hospitalizations
• Maternal mortality rate per 100,000 live births
• Low birth weight rate (%)
• Very low birth weight rate (%)
• Moderately low birth weight rate (%)
• Preterm birth rate (%)
• Early preterm birth rate (%)
• Late preterm birth rate (%)
• Early term birth rate (%)
• Infant mortality per 1,000 live births
• Perinatal mortality per 1,000 live births plus fetal deaths
• Neonatal mortality per 1,000 live births
• Postneonatal mortality rate per 1,000 live births
• Preterm-related mortality per 100,000 live births

This NPM is linked to improve access and quality of comprehensive well exams for adolescents. The Adolescent health Needs Assessment domain group linked this priority to many health outcomes. The NOMs also reflect the linkage of this NPM with many NOMs. The Office of School and Adolescent Health (OSAH) is making this priority the center of a grant initiative.

NPM 11-Percent of children with and without special health care needs having a medical home
NOMs:
• Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
• Percent of children in excellent or very good health
• Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations
• Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
• Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
• Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
• Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine.

This National Performance Measure is linked to increasing access to care to a family-centered comprehensive medical home for children and adolescents. Medical home is also a top priority in New Mexico.

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
NOMs:
• Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
• Percent of children in excellent or very good health

This NPM is linked to increasing the amount of services available to assist adolescents to make successful transitions to adult health care services. The objectives associated with this priority are to ensure that not only the percentage of children are making transitions to adult care but also the system well-functioning. The linkage to the first NOM should assist in the development of ESMs.

NPM 1-Percent of women with a past year preventive medical visit &

NPM 15-Percent of children ages 0 through 17 who are adequately insured
• Severe maternal morbidity per 10,000 delivery hospitalizations
• Maternal mortality rate per 100,000 live births
• Low birth weight rate (%)
• Very low birth weight rate (%)
• Moderately low birth weight rate (%)
• Preterm birth rate (%)
• Early preterm birth rate (%)
• Late preterm birth rate (%)
• Early term birth rate (%)
• Infant mortality per 1,000 live births
• Perinatal mortality per 1,000 live births plus fetal deaths
• Neonatal mortality per 1,000 live births
• Post-neonatal mortality rate per 1,000 live births
• Preterm-related mortality per 100,000 live births
• Percent of children without health insurance
• Systems of care for children with special health care needs (Percent of children and youth with special health care needs (CYSHCN) receiving care in a well-functioning system)

Both of these NPMs are linked to improving access to care across the life span, from prenatal to adult well-woman care, via adequate insurance options for the maternal child health populations across the state. Since both NPMs have a relation to access to care and insurance they were both linked to this priority. The NOMs are all related to maternal/infant outcomes and insurance coverage.

NPM 13- A) Percent of women who had a preventive dental visit during pregnancy and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

- Percent of children in excellent or very good health

This NPM is linked to improving the overall health and well-being of children. Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

- SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
- SPM 2 - Percent of infants placed to sleep on their backs
- SPM 3 - Ratio of Victims of Child Abuse per 1,000 Children in the Population
- SPM 4 - Teen Birth Rate, ages 15 to 19 years

The State Performance Measures(SPM) selected reflect New Mexico's unique MCH priority needs as identified in the Five –year Needs Assessment. The State priorities also reflect the MCH priorities of the New Mexico Department of Heath strategic plan.

State Performance Measures

SPM1 -"Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)"

This SPM reflects the goal and priority of the state to ensure higher risk mothers and newborns deliver at appropriate level hospitals.

National Outcome Measures that should be impacted by this measure are:

· Infant mortality per 1,000 live births

· Perinatal mortality per 1,000 live births plus fetal deaths

· Neonatal mortality per 1,000 live births

Preterm-related mortality per 100,000 live births

SPM2- "Percent of infants placed to sleep on their backs"

This SPM reflects New Mexico's priority of improving safe sleep practices among home visiting participants and birthing facility medical staff.

National Outcome Measures that should be impacted by this measure are:

- Infant mortality per 1,000 live births
- Postneonatal mortality per 1,000 live births
- Sleep-related SUID per 100,000 live births

SPM3- "Ratio of Victims of Child Abuse per 1,000 Children in the Population"

This SPM reflects New Mexico's priority to reduce the physical, psychological, behavioral impact of child maltreatment on not just the child and family, but society as a whole.

National Outcome Measures that should be impacted by this measure are:

- Child mortality ages 1 through 9 per 100,000
- Adolescent mortality ages 10 through 19 per 100,000

SPM4- "Teen Birth Rate, ages 15 to 19 years"

This SPM reflects New Mexico's priority to reduce birth rates among adolescent females 15 to 19 years of ages.

National Outcome Measures that should be impacted by this measures are:

- Maternal mortality rate per 100,000 live births
- Low birth weight rate (%)
- Very low birth weight rate (%)
- Moderately low birth weight rate (%)
- Preterm birth rate (%)
- Early preterm birth rate (%)
- Late preterm birth rate (%)
- Early term birth rate (%)
- Infant mortality per 1,000 live births
- Perinatal mortality per 1,000 live births plus fetal deaths
- Neonatal mortality per 1,000 live births
- Postneonatal mortality rate per 1,000 live births
- Preterm related mortality per 100,000 live births

II.F. Five Year State Action Plan

II.F.1 State Action Plan and Strategies by MCH Population Domain

Women/Maternal Health

State Action Plan Table

State Action Plan Table - Women/Maternal Health - Entry 1

Priority Need

Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.

NPM

Percent of women with a past year preventive medical visit

Objectives

The adequacy and accessibility of the delivery of care for pregnant women will be increased in 5 years

Strategies

In the capacity of the licensing authority for midwives, MHP will continue to promulgate regulations and guidelines, and explore improvements to the licensing process, for the midwifery workforce.

Restart a Maternal Depression Workgroup model that will address the assessment of the behavioral health needs, and explore adequate treatment options, for maternal/pregnant populations.

Restart a Maternal Mortality Review Committee in the state. Develop committee policy and procedures for case notification, case review, data reporting and recommendations, at the care and policy levels, to stakeholders.

Through collaboration with NM's Title X Family Planning Program, support access to well-women care through the appropriate use and application of NM Family Planning Program clinical protocol.

At health fairs, increase presence/advertising to promote services at Public Health Offices and Federally Qualified Health Centers.

Create and present a training in Spring 2017 to licensed direct-entry midwives who see Medicaid clients in collaboration with the state's Medicaid Division and managed care organizations providing health care coverage to Medicaid clients.

Rates of postpartum visit completion will be measured to assess if completion rates are below, at or above national levels

ESMs

ESM 1.1 - Number of completed postpartum visits by maternal clients followed by Licensed Midwife providers

ESM 1.2 - Number of licensed midwives trained in appropriate medical billing/coding

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

State Action Plan Table - Women/Maternal Health - Entry 2

SPM

Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Objectives

Increase the delivery of higher-risk infants and mothers at appropriate level facilities around the state.

Strategies

Develop educational model for identifying indications for transport of high-risk pregnant women

Complete the assessment of neonatal and maternal Levels of Care (LoCATe) at all birth hospitals in the state.

Develop a key from the LoCATe assessment that will facilitate review of high risk morbidity and mortality cases (maternal and neonatal)

Create an interdisciplinary review committee following an FIMR model that will review, analyze and disseminate recommendations on improving transfer protocols at birth hospitals

Maintain the Maternal Mortality and Morbidity Review process (restarted 7/2016) in the state to carry out the functions of #3 in the maternal population.

Measures

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	58.7	59.9	61.1	62.3	63.5	64.7

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	58.6 %	2.0 %	204,130	348,213
2013	57.5 %	1.8 %	202,217	351,422
2012	53.0 %	1.6 %	188,045	354,589
2011	56.0 %	1.6 %	200,052	357,171
2010	62.5 %	2.1 %	217,904	348,900
2009	61.3 %	1.9 %	217,134	353,971

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 1.1 - Number of completed postpartum visits by maternal clients followed by Licensed Midwife providers

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	150.0	165.0	190.0	205.0	210.0

ESM 1.2 - Number of licensed midwives trained in appropriate medical billing/coding

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	35.0	50.0	65.0	80.0

Women/Maternal Health - Plan for the Application Year

Well-women Care

The Maternal Health Program (MHP) also continues to partner with our public health offices, the University of New Mexico (UNM), private practitioners, the NM Midwives Association, the NM chapter of the American College of Nurse Midwives, and institutions throughout NM to form agreements with providers or provider sites to provide timely and adequate care to pregnant, birthing, and post-partum women in NM. By working to retain providers and promoting public awareness we hope to improve the percentage of women receiving insurance coverage and care in the 1st trimester and throughout pregnancy.

The Maternal Health Program (MHP) manages the High-Risk Prenatal Fund (HRF) which utilizes matched Title V Block Grant (TVBG) funds to provide prenatal care coverage for women who are uninsured and underinsured. Via provider agreements and contracts managed by MHP, in 2015-2016, thirteen provider sites in New Mexico urban and rural areas and along the US-Mexico border received funding to support prenatal care and delivery services. This service serves as a safety net making prenatal care available to maternal clients and optimizing a safer and healthier birth outcome.

In the past year, a new rural hospital site was added to the covered network to provide support to prenatal providers along the border. A change in availability of public health clinical services for prenatal clients in that area necessitated support of providers in the private sector to maintain access to care for uninsured clients. Over the next year, that area (the southwest/border region of the state) will continue to be studied to determine whether other provider sites could be recruited as recipients of high-risk prenatal fund monies to improve access issues. Finally, the population served by high risk funding is monitored for whether postpartum services, as an opportunity for well-women care, are made available and completed by clients.

The MHP also serves as the licensing authority for the midwifery workforce in the state. Indirectly, work done in this arm of program function also supports the use of midwives in the field. This provider workforce contributes to the availability of birthing options in the state including the use of the licensed (or direct-entry) midwives who attend home births, a service that is covered by NM Medicaid. In a partnership capacity, detailed below, the MHP works closely with NM Medicaid and the managed care provider organizations (MCOs) that receive Medicaid monies to recognize midwives as Medicaid-reimbursable providers. MHP continues to receive feedback from licensed midwives in the state that reimbursement delays hamper their ability to practice in rural communities. Over the next year, MHP will work with Medicaid to revise the Birthing Options Plan (a component of the Medicaid-MCO expanded

care services) for updating, and also create a larger meeting with all the MCOs to be re-oriented to the Birthing Options Plan so that the reimbursement issues are resolved.

The Family Planning Program at the Family Health Bureau manages family planning clinical services at the public health offices across the state. It also contracts with federally-qualified health centers as well as independent clinics and practices to provide family planning services (contraception and well-woman health care) to women utilizing all forms of insurance (Medicaid, private, Title X). The FP Program prescribes to a curriculum at the health care visits that covers reproductive life planning and well women clinical needs including physical and behavioral assessments. MHP will work with the FP Program to gather data on women served for Title V reporting purposes.

Activities for which the state Title V program has a partnership role but does not have primary responsibility for implementation:

Recently, MHP sponsored a meeting between Text4Baby (T4B), Medicaid, and Children's, Youth and Families service personnel to learn about T4B's use in NM,and what services could be provided. MHP will spearhead a combined effort with the three agencies (as well as with members of an oral health project based at the academic/clinical center, University of New Mexico) to utilize T4B messaging to promote and educate users on the various prenatal or infant/child-related services available around the state. MHP will pursue customized messaging to remind postpartum clients of upcoming appointments.

MHP will continue work with NMDOH's Office of Community Workers (OCHW) to explore funding sources to expand the doula workforce as well as any legislative initiatives to support continued use and access to doula care for diverse communities and populations. Currently, doula curriculum materials are being gathered to share with the the OCHW so that they can incorporate it into their training curriculum and certification requirements. Recognition as certified professionals in the state will improve later efforts to seek Medicaid reimbursements for doulas.

Perinatal Regionalization

There are three major strategies to promote the availability and accessibility of risk appropriate care for maternal and neonatal populations in the state.

First, a comprehensive assessment of neonatal and maternal levels of care is being conducted and is expected to complete by fall 2016. The assessment will be done at all 30 birth hospitals in the state and will use the CDC LoCATe tool to gather the facility-level information from each hospital. Analysis will be completed with CDC assistance and once identified, a levels of care key will be provided to our Bureau of Vital Records so that any infant death will be linked to LEVEL OF CARE at birth facility as characterized by the birth hospital during the LoCATe survey. Review of appropriate level of care will be possible with use of this key, and regional-based recommendations will be issued stemming from the review of these cases.

Secondly, a current assessment of the level of identification, referral and/or care capacity for substance-using mothers and/or neonates with abstinence syndrome at each of NM's birth hospitals is underway. The work team consists of clinical staff at UNM who are contacting each birth hospital and gathering info on current protocols, level of knowledge and on-site management capabilities. Four pilot sites will be selected from the assessment and specialized on-site training as well as protocol-sharing will be provided by the work team. This same team will also aid in the dissemination and completion of the LoCATe survey project as described above.

Finally, work in the area of maternal morbidity and mortality case review is re-starting in the state. A maternal mortality review committee is meeting in July 2016 and will be primarily a partnership with UNM clinicians in obstetric, perinatal and neonatal care, as well as include other professional members such as the Office of the Medical Investigator and the New Mexico Hospital Association. The goal of the Committee will be adequate case identification, case review and standardized data collection; review of individual cases with a larger multi-professional review group, review of aggregate cases to identify regional trends or issues with a strategic public

health intervention step to address disparities in care by region, race/ethnicity, access to care among other categories.

Women/Maternal Health - Annual Report

Perinatal Regionalization

The Maternal Health Program, through its involvement with the Collaborative Innovation and Improvement Network (CoIIN), continues to take the lead in collaboration with Maternal & Child Health Epidemiology staff on the strategy to improve Perinatal Regionalization in the state. The goal of this CoIIN team is to ensure that women with high-risk pregnancies, by medical conditions or at-risk socioeconomic conditions present in pregnancy, are receiving care in facilities that can provide appropriate levels of care. The plan to update a 2014 neonatal levels of care assessment, this time using the CDC tool continues. The team worked with Wyoming public health personnel to craft an introductory letter which will go out to key staff in New Mexico's birth hospital network accompanying the latest version, now including maternal levels of care assessment of the CDC LoCATe survey. After data collection is completed, the team will work with CDC on data analysis. Findings will be presented to stakeholder groups including members of the NM Perinatal Collaborative (NMPNC). Findings will also be used to drive a strategic effort to address adequate distribution of services as well as adequate transfer protocols to enhance timely accessibility to risk-appropriate perinatal care.

The NMPNC, now 3 years in existence in the state, recently approved a new strategy workgroup to address maternal/obstetric hemorrhage. This workgroup also offered to be a starting core group of clinical expertise members to serve on the charter meeting of a Maternal Mortality Review (MMR) Committee at the state level. The MMR Committee work was active at various times in the last decade but has not met since 2012. Charter meeting of this renewed committee is set for late July 2016. Since February 2016, MHP has also been involved in a reproductive health technical workgroup under the US-Mexico Border Health Commission to study maternal mortality occurrence along the border (US and MX), compare the maternal mortality review methodology in all involved states and give recommendations on how to improve outcomes and coordinate all involved systems.

New Mexico has received permission to use the CDC's Maternal and Neonatal Level of Care Assessment Tool (LoCATe) that would provide a systematic and standardized way of categorizing hospital's level of risk appropriate care. In the process of gathering this information, the Family Health Bureau is contacting its external professional partners such as the New Mexico Hospital Association and the local chapter of the American College of Obstetricians and Gynecologists. The assessment will be completed by the Spring of 2017.

The high-risk prenatal funds provided partially under Title V funding continue to be disbursed to health care sites that service high-risk OB clients who are not eligible for other insurance options including Medicaid.. The funds supplement care and support to uninsured and under-insured pregnant clients. In 2015-2016, funds were disbursed to a tertiary care hospital system (3 levels of service at this site),5 rural outpatient clinics, 2 rural hospital sites, 2 sonogram services and one urban clinic which utilizes the fund to cover prenatal-related lab services for uninsured clients. Over 600 patients received services from this funding stream. The purpose of this funding is to provide prenatal services to clients who are uninsured or under-insured. With its provisions, it allows prenatal care access to a high-risk population and optimized better outcomes at delivery.

Prenatal Care

The Maternal Health Program (MHP) continues to partner with our public health offices, UNM, private practitioners, the NM Medical Society, the NM chapter of the American College of Nurse Midwives, and institutions throughout NM to form agreements with providers or provider sites to provide timely and adequate care to pregnant, birthing, and

post-partum women in NM. By working to retain providers and promoting public awareness we hope to improve the percentage of women receiving care in the 1st trimester and throughout pregnancy.

In 2015 and 2016, the MHP program manager also participated on a review committee at the Department of Health's Office of Rural and Primary Care. The committee reviewed applications for stipend rewards to primary care providers (all provider types including midwives) who indicate willingness to serve in rural and underserved areas of the state.

The MHP worked in this 2015 state legislative session to successfully pass a revision to wording in the current Birthing Workforce Retention Fund statute. The statute provides malpractice insurance premium assistance to MDs and CNMs whose insurance costs jeopardize their ability to practice in NM. The hearing to institute the revision changes in the Birthing Workforce Rule was held earlier this month, and the revised rule is now ready for final publication. It is anticipated that in the next two months, MHP will again be able to recruit applicants and offer this needed service to birthing providers in the state.

In October 2014, MHP partnered with state Medicaid authorities to educate the MCOs involved in Centennial Care on the Birthing Options Plan, which includes home births and the services of direct-entry midwives licensed by the MHP. The work continues, with monthly trouble-shooting conference calls, with Medicaid/Human Services Department personnel as well as with the managed care organizations and licensed midwives to improve reimbursement timeliness for claims to these midwives licensed under MHP. These often rural providers supply a key service to underserved maternal populations in the state and so hindrance to reimbursement is considered a key hindrance to service delivery.

Finally, through the High Risk Prenatal Fund, data are collected on prenatal visits that are completed on pregnant women in the first trimester. The Fund and its implementation was evaluated in Summer 2015 to ensure that its use is appropriately distributed in the state, its use enhances prenatal care accessibility in needed areas and that data collected are contributing to indicator tracking and knowledge on prenatal clients in the state. Findings from the evaluation pointed to data collection issues that will be addressed this summer 2016 with the creation of a standardized data collection form that will be distributed to all the sites.

The MH Program will also continue to provide funding for prenatal-related services at public health offices that serve uninsured clients. In early 2016, prenatal care services ceased at one of the remaining two PH Clinic sites that continued to serve prenatal clients. With the phasing out of this service, additional funding was offered to private clinics and to federally-qualified clinics in the area to continue prenatal services to uninsured clients.

Prenatal Care Health Care Coverage

The Maternal Health Program (MHP) has engaged with its partner Zero to Three (formerly, National Healthy Mothers, Healthy Babies Coalition), to promote *Text4Baby (T4B)* usage in the state primarily through education and information to clients of the Families First (prenatal case management) Program. A meeting in late May 2016 was conducted with the T4B regional representative who presented on NM user statistics, and what battery of services and messaging is available under T4B. Staff from the Human Services Department, the Department of Children, Youth and Families; and from the University of NM Community Dental Services were present. At the conclusion of the meeting, a plan was formulated to combine efforts from all stakeholders present to potentially utilize T4B's services to promote the work from each of the organizations. That planning effort continues.

MHP, in its capacity as the licensing authority for midwives in the state, works closely with the midwife community, the Medicaid Division (Human Services Department) and the managed care organizations that insure Medicaid clients to promote the Birthing Options Plan. The Plan is utilized by clients who opt for home or birthing center birth settings, two options where midwives are primary birth providers. Claims and reimbursement issues continue to exist, and the Medicaid Division has taken on the task of updating the Birthing Options Plan and any letter of direction documents

needed so that the MCO's can be updated on all aspects of the plan which, it is expected, will improve timeliness of reimbursement.

Unintended Births

NM has a high rate of unintended births for both teens and all women. These rates were estimated based on weighted data collected by the NM Pregnancy Risk Assessment Monitoring System (PRAMS) for 2000-2013. Unintended births were those resulting from pregnancies in which women said they did not want to be pregnant then or at any time in the future (unwanted) or they wanted to be pregnant later (mistimed). Over 67% of births in NM between the years of 2000 and 2008 were unintended, while for birth year 2012, 44.5% of all NM mothers experienced an unintended birth (NM-IBIS, 2014).

Higher proportions of young, unmarried, American Indian, and Hispanic women, and those with high school education or less had unintended pregnancies. The majority of counties with high unintended birth rates were also counties with high or increased teen birth rates. By implementing strategies to reduce teen birth rates, the unintended birth rate will also be addressed, because teens have the highest unintended birth rate. While 44% of NM mothers had an unintended pregnancy, 71% of teens 15-17 year olds and 67% of 18-19 year olds had an unintended pregnancy (NM PRAMS, 2009). Strategies to reduce unintended and teen birth rates include promotion of long-acting reversible contraceptives (LARCs) and provision of clinical services at school outreach sites.

Clinical services are provided in most of the state-funded public health offices across New Mexico and in primary health care clinics that are contracted through the NM Family Planning Program. Between 2009 and 2014, the use of long-acting reversible contraceptives (LARCs) increased, from 4% to 10%; during these same years, the use of the IUD and implant (LARCs) steadily increased, whereas the use of the 3-month injection decreased and the use of the oral contraceptive stayed relatively stable (between 27% and 33%). During these same years, the percentage of respondents who are pregnant or seeking pregnancy also remained relatively stable (between 16% and 18%). In 2014, over 22,000 women of reproductive age received services at a Title X-funded clinic. The most popular method of contraceptive remains the oral contraceptive, followed by the 3-month hormonal injection and the IUD. Over 15% of Title X clients report being pregnant or seeking pregnancy.

Information dissemination occurs at Title X clinics through the education process about contraceptives. Title X distributes pamphlets about contraceptive methods, information on services provided, sexual responsibility, dating and partner violence, and sexually transmitted infections to public health offices and clinics across the state. The NM Family Planning Program provides funds to support the BrdsNBz warm-line text-back service that provides medically accurate, age-appropriate sexual health and sexual behavior answers to teens and parents who text questions.

Perinatal/Infant Health

State Action Plan Table

State Action Plan Table - Perinatal/Infant Health - Entry 1

Priority Need

To maintain and increase breastfeeding initiation and duration

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase the number of NM delivery facilities with Baby-friendly status and corresponding mother/self-reported experience

Fill measurement gaps to capture breastfeeding duration in NM

Integrate and define the relationship between SUID/SIDS prevention and breastfeeding promotion

Establish monitoring and reporting on mother-friendly workplaces and employers in NM

Strategies

Utilize PRAMS to measure the correspondence between self-reported experience and the facility identification as baby-friendly

Establish a longitudinal follow up to PRAMS to measure breastfeeding duration in NM

Clearly define and pilot a home visiting curriculum which promotes breastfeeding support while simultaneously promoting safe sleep practices for families and their infants

Collaborate with the March of Dimes, Children Youth and Families Department, and UNM Envision to co-brand messaging around safe sleep and breastfeeding

Collaborate with the NM breastfeeding taskforce and the WIC breastfeeding program to monitor anticipated progress in breastfeeding initiation and duration at baby-friendly facilities in NM

Share data and combine analytic efforts with UNM Envision, the NM Breastfeeding Taskforce and NMDOH to document the return on investment of breastfeeding and supportive workplace policies in NM

ESMs

ESM 4.1 - Percentage of mothers who report a baby-friendly experience at a New Mexico birthing facility

NOMs

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table - Perinatal/Infant Health - Entry 2

Priority Need

To improve safe sleep practices among home visiting participants and birthing facility medical staff

SPM

Percent of infants placed to sleep on their backs

Objectives

Increase the number of NM birthing facilities who have developed safe sleep education protocols and who have policies clearly defining the information given to families at delivery.

Increase the number of home visitation and perinatal case management staff with train the trainer preparation for Safe Sleep/Purple crying and Shaken Baby education in NM.

Develop and test effective safe sleep media messaging for diverse audiences in NM

Strategies

Primary driver: Health care professionals understand, actively endorse and model safe- sleep practices.Strategy 1. Convene statewide birthing hospital summit to share best practices and continuing education for hospital staff, utilizing Cribs for Kids and Dr. Michael Goodstein expertise.

Infant caregivers have the knowledge, skills and self-efficacy to practice safe sleep for every sleep.Strategy: Provide two Public Health and CYFD training opportunities by the end of 2015. Safe sleep brochure will be included in monthly Vital Records birth registration packets in their mailing to all families of infants born in New Mexico.2. Increase the number of Home visitation staff trained in safe sleep education3. Test combined approach to training grandparent caregivers on safe sleep and adult falls prevention4. Pilot culturally tailored safe sleep intervention with Tewa Women United Community Doula Program and Family Spirit (Johns Hopkins University).

Primary driver: Messages activate and drive infant caregivers, community and government to support safe sleep.Strategy 1. Consult with four regional media companies with an emphasis on American Indian/Native audiences and families of all ethnicities, as well as a bilingual families, regionalized for cultural differences across NM.

Measures

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.5	80.0	81.7	83.2	85.0	86.8

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	80.4 %	3.3 %	19,215	23,889
2011	76.9 %	3.5 %		
2010	80.3 %	3.4 %		
2009	75.0 %	3.2 %		
2008	75.4 %	2.8 %		
2007	78.4 %	2.6 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	25.6	27.2	21.0	28.8	30.4	32.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	24.5 %	3.3 %	5,724	23,408
2011	16.1 %	2.6 %		
2010	17.4 %	2.7 %		
2009	21.8 %	2.9 %		
2008	16.9 %	2.1 %		
2007	16.8 %	2.1 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 4.1 - Percentage of mothers who report a baby-friendly experience at a New Mexico birthing facility

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	65.0	67.0	68.5	70.0	71.5

Perinatal/Infant Health - Plan for the Application Year

Breastfeeding duration/Baby-Friendly Hospitals
Progress on the following components and annual plans:

a. Longitudinal data collection and data linkage improvement

The longitudinal follow up survey to PRAMS is near commencement. The study is a survey of PRAMS participants when their infant reaches the age of two. The collaboration involves expertise from the University of New Mexico, Bureau of Business and Economic Research (BBER), independent research consultants and early childhood service program staff. The survey tool is complete and in field testing. The next steps planned toward launch the survey involve survey translation to Spanish and completion of a data collection/data management system. We expect to have these tasks finished and data collected by August, 2016. Data for analysis would not be accessible until May, 2016. At that point, we will merge PRAMS infant survey data (2014 births) with the toddler results for analysis on baby-friendly experiences and their relationship to breastfeeding duration. The plans for a longitudinal follow up are in keeping with Title V priorities and performance measures to monitor breastfeeding duration beyond the early postpartum period, at a state and sub-population level.

b. Newborn genetic screening card data analysis (breastfeeding at hospital discharge)

The NM Breastfeeding Taskforce epidemiologist utilizes the Newborn Genetic Screening breastfeeding data to complete facility-specific report cards to NM birthing hospitals. These report cards are being used in conversation

with those facilities regarding the progress they are making with breastfeeding rates at discharge. While the information is not public, it is useful for hospitals to have their own data for evaluation of their baby-friendly status and pathways to that status. Plans for the TVBG application year are to compare results reported on that card and results from facility-level measures to the PRAMS survey results on baby-friendly hospital measures. All indicator responses will be compared to the self-reported facility responses for the same steps associated with baby-friendly designation.

c. NM Breastfeeding Taskforce employer/workplace initiative

For the application year, NM will continue to collaborate with the NMBFTF on their employer/workplace initiative and with the HM2 paid parental leave workgroup. Our plans will build on earlier collaboration to estimate the economic impact of breastfeeding in NM to evaluate data currently available to explore the following questions:

1. If NM had 6 months of paid maternity, how much would we estimate that breastfeeding duration would increase?

2. Comparing duration rates for employed mothers and unemployed mothers—how does paid maternity leave impact duration?

3. What are businesses doing to comply with the federal regulations for nursing in the workplace? How do employee reports differ from management reports in that regard?

MCH Epidemiology staff will continue to participate in the HM2 paid parental leave work group and work with UNM Economic Research (BBER) to model simulated breastfeeding outcomes using PRAMS data. The analysis plan will be completed by December, 2016 and the target date for reporting out on the results is May, 2017.

d. NM Breastfeeding advisory group to increase breastfeeding duration in NM
New Mexico MCH Epidemiology will continue to work with this data advisory committee which involves the RWJF Center for Health Equity, NM Breastfeeding Task Force, Young Women United, and Nuestra Salud.

Safe Sleep and Sudden Unexpected Infant Death (SUID) prevention

Plans are in place to collaborate in following areas:

1. Tie safe sleep and breastfeeding promotion efforts together.

We are in strategic development with the Office of Injury Prevention, Children Youth and Families Home Visiting Program, NM Office of the Medical Investigator/CDC SUID registry, Tewa Women United, birthing hospital facilities, Navajo Nation and several home visiting programs to promote breastfeeding while including safe sleep education for NM families. With support of Graduate Student Epidemiology Program intern and NICHD safe sleep champion, Dr. Mary Overpeck, NM will proceed to implement the following activities over the next year:

* Conduct an environmental scan of program practice and policy across New Mexico. Logic model and plan to address process measurements and tasks for preliminary team review.

* Convene existing stakeholders from the Child Fatality Review (central OMI); University of NM; NMDOH; NM Children, Youth and Family Department; native tribal entities; home visiting programs; NM Breastfeeding Task Force; Voices for Children; and the March of Dimes to begin strategic planning process.

* Contribute to the analysis of NM SUID registry data and publication.

Outline of analysis: I. Death circumstances of SUID cases reviewed by NM Child Fatality Review team since 2010:
a. Descriptors regarding circumstances by cause of death (age of infant/sleep surface/caretaker relationship at time of death)

b. Cause of death composite for SUID (R99, R95, W75) overview of sleep-related deaths in NM

c. Cross-tabulations of SUIDs by maternal race/ethnicity, regional of residence and medical characteristics

d. Qualitative and statistical results to identify risks associated with sleep-related deaths in NM.

Outline of communication plan: II. What we know about SUID

a. National recommendations from AAP, NICHD, CDC
b. Regional and local efforts (CPS trainings and hospital protocols)
c. National campaign to increase safe sleep
d. Local messaging and cultural adaptability

Engagement strategy plan: III. Child Fatality Review and stakeholders

a. NM Safe sleep campaign/webinars
b. Infant mortality CoIIN
c. March of Dimes program service committee
d. Voices for Children
e. Federal MCVIE home visiting sites

Perinatal/Infant Health - Annual Report

Breastfeeding promotion activities:

a. Longitudinal data collection and data linkage improvement

The longitudinal follow up (toddler survey) to PRAMS is near commencement. Funding was procured through the WK Kellogg Foundation in May, 2016. The survey tool was completed and went into field testing in June, 2016. IRB approvals were obtained and the toddler survey analysis plans were developed. The toddler study coordinator, Chris Whiteside, held advisory meetings and updated the PRAMS Steering committee several times in 2015. He also worked directly with PRAMS staff and WIC breastfeeding program managers to develop the survey section relating to breastfeeding. In 2015 MCH Epidemiology staff consulted with subject matter experts and academicians to develop survey content related to breastfeeding, developmental screening, mental health and adverse child experiences.

b. Newborn genetic screening (NBGS) card data analysis (breastfeeding at hospital discharge)

The NM Breastfeeding Taskforce (NMBFTF) epidemiologist utilized the NBGS breastfeeding data to complete facility-specific report cards to NM birthing hospitals. In addition, the PRAMS epidemiologists and the NMBFTF staff worked together to assure that questions selected for the Phase 8 PRAMS survey were appropriate and complementary to the data obtained on the NM birth certificate and on the NBGS card. A limitation of the NBGS data identified over the past year was that some hospitals are not filling out the field for all births, that they may not be recording whether delivering women attempted to breastfeed, breastfeed during the hospital stay, but rather only recorded if they were breastfeeding at discharge.
The TaskForce worked with several large facilities to address the information gaps and to institute a follow-up to determine breastfeeding status at six months.

c. NM Breastfeeding Taskforce employer/workplace initiative and ASTHO Breastfeeding Learning Community

NM PRAMS and the Breastfeeding TaskForce collaborated on the workplace breastfeeding initiative. We developed some research questions in collaboration with the House Memorial 2 (HM2) Parental Leave Working Group which we said in last year's plan would build on earlier collaboration to estimate the economic impact of breastfeeding in NM. In particular, we explored the following questions: If we had 6 months of paid maternity, how much would we

estimate that breastfeeding duration would increase? Comparing duration rates for employed mothers and unemployed mothers—how does paid maternity leave impact duration? What are businesses doing to comply with the federal regulations for nursing in the workplace? How do employee reports differ from management reports in that regard?

We worked with the HM2 Parental Leave Working Group to answer some of these questions and to explore data gaps we need to fill in order to appropriately answer those and other policy related questions. The House Memorial requests that the University of New Mexico's Bureau of Business and Economic Research convene a parental paid leave working group to develop recommendations for the establishment of a parental paid leave program and a publicly managed parenting workers' leave fund, and would be due on October 1, 2016. The work group was facilitated by the Southwest Women's Law Center and met bi-monthly. There were various strategies used to address the outcomes related to breastfeeding duration. One of those is establishment of the right to work during pregnancy. While there are some federal legal protections in place, New Mexico seeks a strong law that requires employers to provide basic accommodations for pregnant workers. As a first step, SWLC is collecting stories from women who have experienced discrimination in the workplace because of their pregnancy. These stories will be vital in our fight to create legal protections for pregnant workers.

In addition, to this workgroup, NM PRAMS developed an analysis plan to examine the impact of maternity leave policies on the outcome of breastfeeding initiation and early duration. Analysis is not complete, but preliminary findings show that women with adequate paid leave may be more likely to initiate and continue breastfeeding beyond two months compared to women without paid leave.

The ASTHO Breastfeeding State Learning Community 2014-2015

This cross-sector effort focused on improving breast-feeding competent businesses in NM through the following activity measures:

Create a system of support through increasing the number of breastfeeding friendly businesses and fostering a more supportive environment for breastfeeding employees and patrons of those businesses.

Outreach to 60 employers to understand business benefits of supporting employees to breastfeed and the legal requirements of complying with the NM law. (Networking Contracts)

Aid 40 employers to provide support for their breastfeeding employees (technical assistance consults) including developing workplace policies, designating pumping/breastfeeding spaces, arranging flexible break time.

Recognize 20 business as breastfeeding friendly using criteria

1) Inclusion of a supportive worksite accommodation lactation policy; 2) appropriate private space to pump and/or nurse if desired; 3) an adequate system in place to cover milk expression breaks for nursing employees in practice.

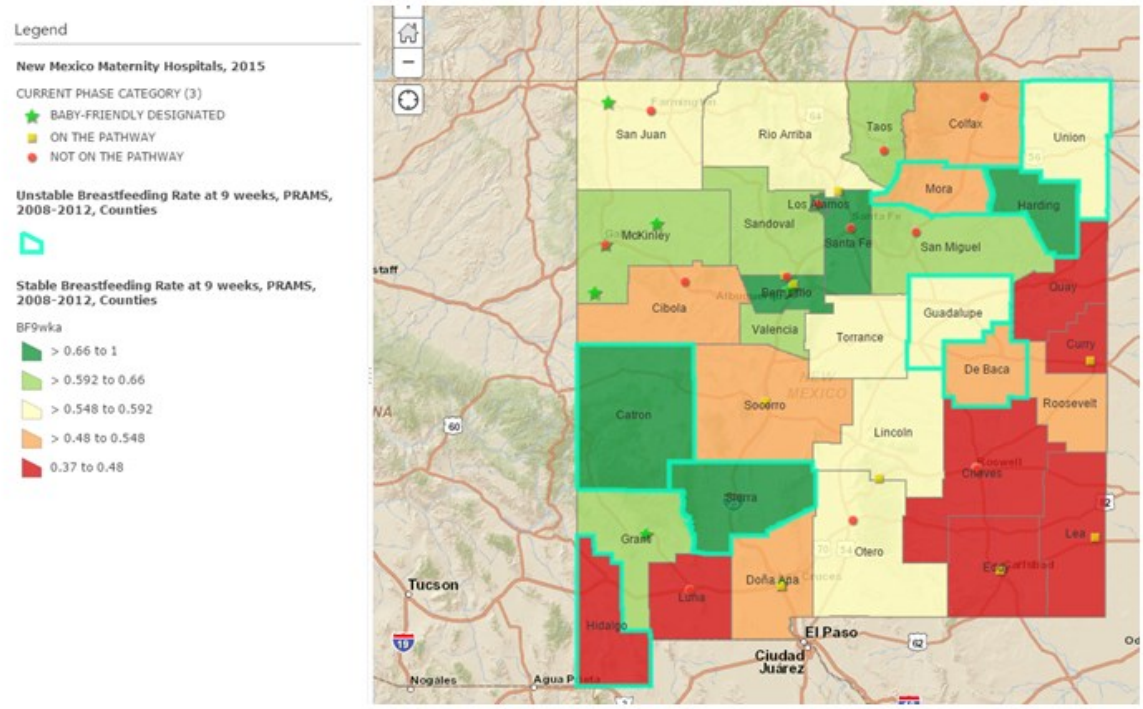
Over the 5 month ASTHO funding cycle the NMBTF successfully worked to aid employers in providing support for their breastfeeding employees and help breastfeeding employees to successfully continue breastfeeding as they return to the workforce. Specifically, the goals included: 1) Educate employers to foster compliance with state and federal worksite lactation accommodation laws; 2) Provide technical assistance to develop worksite policies and implement accommodations for flexible break time and a clean, private space to pump; and 3) Support breastfeeding employees with strategies and resources to help them better negotiate with their supervisors.

Between February 24 and June 23, 2015 the BWL completed 42 networking contacts, 21 intakes for technical assistance, and 25 follow up visits. Evaluation surveys and breastfeeding friendly certificates were distributed between May 31 and June 23, 2015. Eight businesses (38%) completed the evaluation form. A Social Media Campaign was developed, in part as an evaluation strategy, to share with program impact nationwide and inspire similar initiatives in other states.

d. A NM Breastfeeding advisory group worked to increase breastfeeding duration in 2015. The group was convened through Envision New Mexico, a pediatric quality improvement organization which brought together stakeholders from Young Women United, Nuestra Salud, NM PRAMS, March of Dimes, UNM Robert Wood Johnson Foundation Center for Health Policy and pediatric specialists. The team conducted a scan of existing breastfeeding data sources including PRAMS, NM Vital Records, the National Immunization Survey, and the National Survey of Children's Health. The group also collected qualitative data and conducted community conversations through the leadership of the NM Breastfeeding Task Force.

e. New Mexico Maternity Care and Infant Feeding Summit- The goal of the 2015 New Mexico Maternity Care and Infant Feeding Summit for Hospital Personnel was to provide education and support for leaders from the 35+ maternity facilities and birthing centers in New Mexico and to help these leaders facilitate change and thereby offer optimal mother-baby care. NM Title V staff from MCH Epidemiology and the WIC breastfeeding program participated in this important event by presenting data and by offering and moderating training on safe sleep for NM WIC field staff.

f. PRAMS data were shared with stakeholders throughout the state and made accessible on the Community Data Collaborative site:



Safe Sleep/SUID prevention

a. Cribs for Kids initiative and safe sleep books

The MCH Epidemiology program, Child Health Program and the Children Youth and Families Department Home Visiting Program established an agreement to partner with Cribs for Kids and make cribs and safe sleep training materials available to home visiting clients, statewide. The Cribs for Kids agreement was not implemented though funds were made available to CYFD. A change in leadership and transitions in early childhood priorities made the agreement delay, and we re-established goals through a new cross-agency team in March, 2016. At this time we broadened our scope to include poverty, economic and social risk factors associated not just with unsafe sleep but with other adverse early childhood outcomes.

To support the development of a strategic plan, MCH Epidemiology submitted a proposal to host a graduate student epidemiology program intern to support analysis of sudden unexpected infant death data collected in the national child death registry for New Mexico. We were matched with a graduate student in May, 2016 and submitted the following to complete by August, 2016:

Deliverables

5/23-5/27	Review SUID and ASSB classification literature
	NM PRAMS dataset overview, safe sleep and former data products
5/31-6/3	Meet with Office of Medical Investigator
	Meet with Office of Injury Prevention
6/6-6/10	Complete preliminary data anlaysis from SUID registry/CDR
6/12-6/17	Work on select PRAMS surveillance indicators
6/20-6/24	Present preliminary SUID analysis to internal stakeholders
6/27-7/1	Meet with partner programs (Young Women United, home visiting, Families FIRST)
7/5-7/8	Communicate with St Vincent hospital and Hospital Association re: past education and current protocols
7/11-7/15	Complete phase 2 of SUID analysis with demographics and risk factors
7/18-7/22	ARticulate PRAMS safe sleep analysis and GIS mapping (multivariate or logistic models)
7/25-7/29	Prepare communications products from SUID data and complete data tables for paper
8/1-8/5	Work on combined breastfeeding and safe sleep Title V and CoIIN recommendations

In addition, we convened with Injury Prevention and Child Fatality Review panel members to develop actions and recommendations, as well as update the strategies for current and future program outlined here:

Objective One: Infant caregivers have the knowledge, skills and self-efficacy to practice safe sleep for every sleep

Successes/complete:

1. Vital Records approval for safe sleep brochure in their mailing to all families of infants born in New Mexico.
2. Brochure designed and printed for statewide distribution
3. Home visitation staff trained in safe sleep education
4. Combined approach to training grandparent caregivers on safe sleep and adult falls prevention

Next steps:

1. Translate brochure in to Spanish
2. Distribute brochure in Vital Records birth packets

Objective 2. Engage and activate infant caregivers, community and government to support safe sleep

Completed:

1. Collaboration among two DOH Divisions and the Children Youth and Families Department to train over 700 Child Protective Service (CPS) workers in infant safety with a focus on safe sleep

2. Train Santa FE City EMTs on assessing safe sleep environment during any visit

3. Engage new members SUID child fatality review committee and SUID registry

Policies support/facilitate safe sleep practices

1. Hospital engagement and follow up to 2014 birthing facility trainings

2. Creation of a Senate Memorial to form a multisectorial SUID Task Force statewide

3. Pediatric Society endorsement for Senate Memorial calling for SUID Task Force

Implement small tests of change:

1. Work with WIC breastfeeding peer counseling program to measure impact of safe sleep education on post-partum women counseled by lactation peer counselors at delivery and postpartum follow up.

2. Assess grandparent receptivity to implementing/advising on safe sleep practices replicating the 1,000 Grandmothers curriculum or by testing local intervention of grandparent safe sleep infant care curriculum.

3. Work with Tribal Epidemiology Centers and tribal doula or home visiting programs to develop culturally resonant safe sleep education.

4. Develop media plan to raise public awareness on the AAP safe sleep recommendations and most current evidence-based practices for breastfeeding promotion and safe sleep.

Child Health

State Action Plan Table

State Action Plan Table - Child Health - Entry 1

Priority Need

To increase the percentage of children receiving a developmental screen

NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Objectives

Increase the percentage of children receiving a developmental screening

Strategies

Expand developmental screening activities in early care and education, link training and increase appropriate referrals when needed among medical homes, early intervention services, child care programs, and families.

Engage pediatric providers, other child health providers, infant mental health consultants, home visitors, and other related professionals in local communities to improve linkages and referrals

Utilize and promote training to early care and education professional who serve young children.

Promote public awareness of child development.

Outline necessary system enhancements, work flow, financing structures, and policy changes necessary to support the Objective.

Capture and document developmental and behavioral health screening and referral activities across early care and education, health, and early intervention systems.

ESMs

ESM 6.1 - Number of early childhood professionals and medical providers trained to administer and score developmental screening instruments

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table - Child Health - Entry 2

Priority Need

To decrease abuse and maltreatment of children

SPM

Ratio of Victims of Child Abuse per 1,000 Children in the Population

Objectives

Reduce incidence of child abuse and neglect

Provide most vulnerable families and neighborhoods with family support services

Strategies

Identify most vulnerable families and neighborhoods and utilize “mapping” data bases to overlay risk factors for most need.

Develop policy recommendations based on community engagement and leverage resources to expand the home visitation system to provide services for all families identified as most vulnerable

Expand and fund home visitation services for children and families with three or more identifiable risk factors, including those referred by Protective Services

Utilize the AMCHP Lifecourse indicators on concentrated disadvantage and Adverse Child Experiences (ACE) to assess the geographic and population risk areas to address child maltreatment and domestic violence.

Collaborate effectively across state agencies, children's advocacy groups and professional consultants to develop a shared vision and strategic plan to prevent child abuse in NM

Measures

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	39.3	40	41	42	43	45

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.3 %	3.6 %	54,323	141,890
2007	29.7 %	3.6 %	38,679	130,465

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 6.1 - Number of early childhood professionals and medical providers trained to administer and score developmental screening instruments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	300.0	350.0	400.0	450.0	500.0

Child Health - Plan for the Application Year

Developmental Screening

Promoting the appropriate administration and scoring of developmental screening tools contributes to improved health outcomes for young children by identifying developmental and social-emotional delays early. In the US, 17% of children have a developmental or behavioral disability. Less than half of children with developmental delays are identified before starting school. Research shows that when delays are identified and children and families are referred for appropriate early intervention treatment services, the child's development can be greatly improved and the child is better prepared to enter school ready to learn.

For the past 6 ½ years, the Department of Health/Family Health Bureau/Child Health Program, funded by Project LAUNCH and Early Childhood Comprehensive Systems (ECCS) grants, has offered free training to early childhood providers in the administration and scoring of developmental screening tools, the Ages and Stages Questionnaire (ASQ) and ASQ: Social Emotional (ASQ:SE). As of May 2016, 1,087 people have attended the trainings – representing approximately 181 organizations in 56 separate training events. In addition to offering free training, the

program has also provided ASQ and ASQ:SE materials, free of charge, to organizations that did not have the resources to purchase on their own.

One Health Educator has been the primary trainer. In order to sustain the work, build capacity in early childhood-serving organizations, and continue to promote appropriate developmental and behavioral screening and referral for young children, a cadre of 25 new Trainers, all from local community-based or county entities, were selected to attend the Brookes On Location ASQ Training of Trainers Seminar (TOT), May 18-20, 2016. The TOT was funded by the ECCS grant with contributions from the Children, Youth & Families Department/Office of Child Development and the Brindle Foundation, a small family foundation based in Santa Fe, NM with a focus on early childhood.

The new trainers, and their supervisors, have agreed to provide trainings annually for the organization's employees and/or the early childhood staff the agency serves, to administer and score the ASQ-3 and ASQ:SE-2. The Trainers will also be available to provide, at no charge, at least two (2) training sessions per year to other community-based organizations, including physician offices and medical clinics, within the agreed upon geographic area. An annual report of trainings conducted will be reported to the Family Health Bureau/Child Health Program. All participants will also agree to provide annual screening and referral data (e.g. number of unduplicated children screened with ASQ-3 and ASQ:SE-2, number of children flagged, and number referred) to the New Mexico Department of Health, Family Health Bureau/Child Health Program.

Child Maltreatment

Through public and private networks, initiatives, and collaborative partnerships, New Mexico will work to decrease the incidence of child maltreatment. One of the key groups that will be addressing this issue is the J. Paul Taylor Early Childhood Task Force (JPT). The JPT is a legislatively authorized group of public and private partners tasked with:

· Creating a public health driven early childhood mental health action plan for infants and children to age eight (8) and their families;

· Developing a system to identify unserved and underserved at-risk children and families; promoting evidence based local community programs in New Mexico; and

· Identifying how current systems can be used for the prevention of child abuse and neglect.

The JPT has been meeting since 2013. To develop new recommendations for 2016-2017 and moving forward, in April JPT received presentations about care coordination as part of quality control, which involves providing referrals to an array of services for members of the Centennial Care managed care organizations. The discussion included challenges in keeping track of members for follow-up and referrals, the high turnover rate among care coordinators, communication between providers and care coordinators. Additionally, information was presented about how care coordination for Children's Medical Services (CMS), specifically children and youth with special health care needs (CYSHCN), has been practiced through the Title V program for the past 20 years. There was discussion of how the standards and processes of care coordination developed by CMS could be applied to Centennial Care.

Another topic for discussion, collaboration, and consideration for recommendations for JPT will be the New Mexico Pyramid Project, which is a collaboration between the Children, Youth & Families Department (CYFD) and the University of New Mexico (UNM) Family Development Program. The Pyramid Project seeks to put in place a mental health plan for our state's children, which is also an ongoing goal of JPT.

During the summer JPT will receive updates on community health workers (CHW), including the collaborative project between UNM, DOH, and the ECHO project on child abuse prevention using CHW as the first learning cohort.

Other efforts to decrease the incidence of child maltreatment:

· Identify the most vulnerable families and neighborhoods, utilizing "mapping" data bases which purposely overlay risk factors to determine the locations of the most need.

· Educate law enforcement, first responders, teachers, clergy, social workers, nurses and other direct service providers, including home visitors, about the principal variables of stress families' face, and particularly for single parent and/or low income households.

· Educate teachers, clergy, social workers, nurses and other direct service providers, including home visitors, about early intervention strategies to support families, and how to teach coping mechanisms and child rearing skills to parents to prevent shaken baby syndrome and other types of abuse that may generate criminal charges or removal of the children from the home.

· Employ periodic screenings for domestic violence and neglect, as well as drug and alcohol abuse, during pregnancy, and periodic screening for developmental delays and postpartum depression, as well as drug and/or alcohol abuse and domestic problems after childbirth.

· Include Adverse Childhood Experiences (ACE) questions within EPSDT screens and ensure Medicaid reimbursement for identified treatment needs.

· Standardize and uniformly apply EPSDT screening.

· Convene family support and early childhood stakeholders via the county and tribal health councils to monitor local needs and resources, as well as to identify gaps in services.

· Develop policy recommendations based on local input and community engagement.

Child Health - Annual Report

Immunization

A new and upgraded New Mexico Statewide Immunization Information System (NMSIIS) is being launched on May 31, 2016. This a major step forward for the Immunization Program. Online vaccine ordering and vaccine inventory management for providers will be integrated into the system. Trainings on the new system for providers were held statewide in the spring of 2016.

At statewide events in During "Got Shots? Protect Tots!" weeks held in 2015, participating providers opened their doors on one or more publicized dates and provided immunizations to any child who presented without an appointment, regardless of whether they are a patient or whether they have insurance. 161 0-2 year-olds, 498 3-6 year-olds, and 1503 7-18 year-olds received immunizations at “Got Shots” events in 2015.

The NM DOH organized the NM School Kids Influenza Immunization Project (SKIIP) with the New Mexico Immunization Coalition. SKIIP began in 2008. During the 2015-16 influenza season, 467 schools participated, and over 33,000 flu vaccine doses were administered. The collaboration has grown to include the DOH Vaccines for Children Program; Public Health Offices (who store and distribute the vaccine to schools); elementary/mid/high schools; physicians, nurses and nursing students in the respective communities; pharmacists; and community volunteers.

The Immunization Program conducted Vaccines for Children compliance visits to 306 VFC sites in CY 2015 by contract nurses and DOH Regional staff. Immunization Consultants and Regional staff also provided immunization training in provider practices using the Child Health Immunization Learning Initiative (CHILI) presentation. CHILI is four-hour training on immunizations.

The Immunization Program conducted over 150 toddler and over 208 adolescent Quality Improvement visits at VFC provider offices in CY 2015, which include evaluation of immunization coverage of client populations.

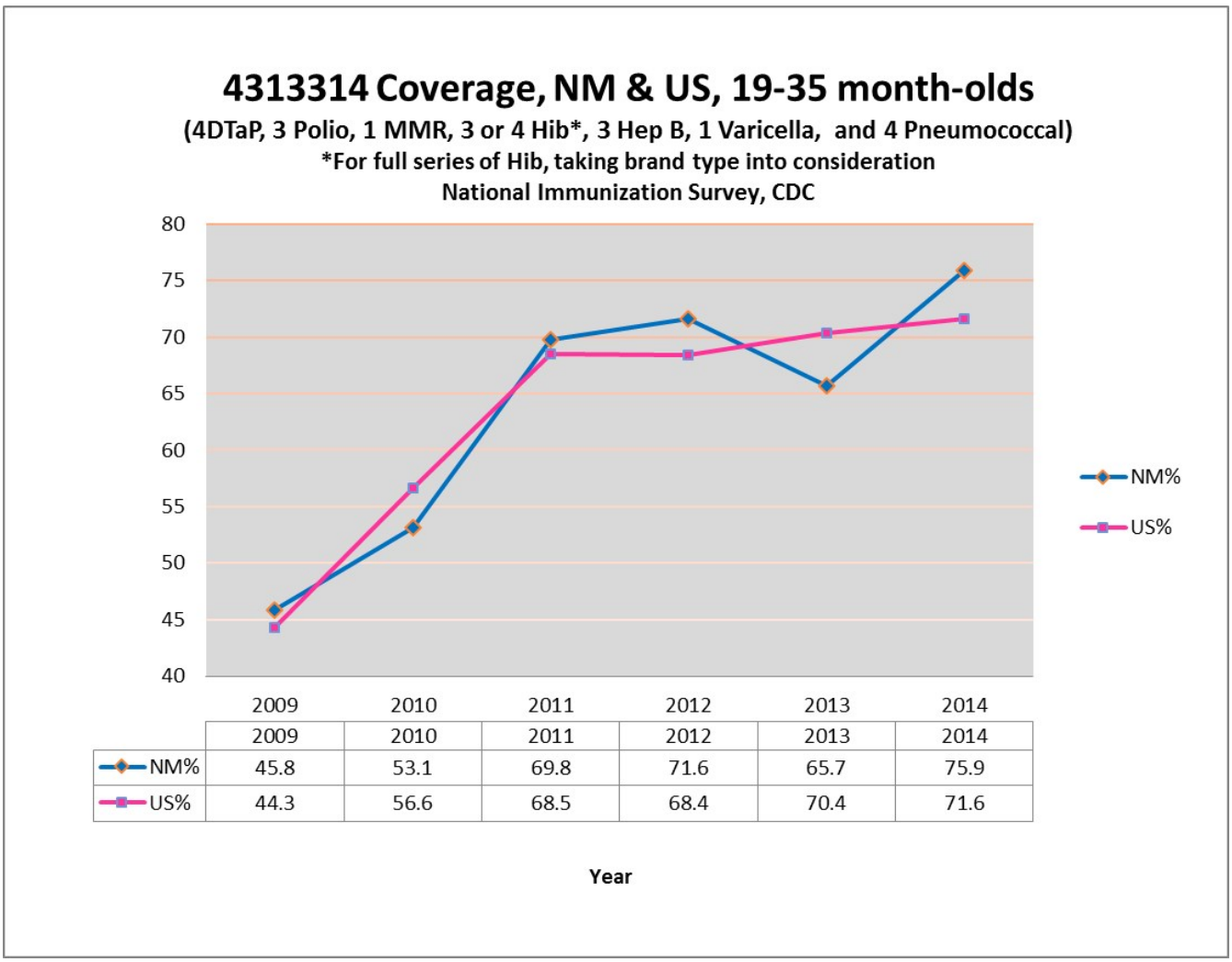
All provider coverage assessments will become integrated into the new NMSIIS system by 2018.

The Immunization Program and Infectious Disease Bureau have ongoing participation in the New Mexico Immunization Practices Advisory Council (IPAC) and the New Mexico Immunization Coalition Steering committee meetings.

“Got Shots? Protect Tots!” immunization days are being scheduled for August 2016, and the SKIIP project will continue into the 2016-17 school year.

Immunization Consultant technical assistance is ongoing in the form of VFC site visits, Quality Improvement visits, and CHILI trainings for VFC providers to improve vaccination policy, administration, and vaccine storage and handling among VFC providers. VFC visits include an evaluation of each practice’s immunization “best practices” and immunization coverage levels for a majority of practices. Immunization consultants provide immunization technical assistance and training in vaccine administration, storage and handling, and immunization best practices to New Mexico VFC providers

Every year the Immunization Program conducts a randomized school survey of immunization levels in kindergartens, and this will continue in the 2016-17 school year.



	2009	2010	2011	2012	2013	2014
NM%	45.8	53.1	69.8	71.6	65.7	75.9
US%	44.3	56.6	68.5	68.4	70.4	71.6

Oral Health

A total of 7,896 3rd graders received a dental sealant in FY 15. The data reflects both the Office of Oral Health and

Medicaid (1,506 OOH and 7,895 Medicaid enrollees).

The Office of Oral Health (OOH) will continue collecting 3rd grade data and report the data. OOH data reflects state staff and contractors providing dental sealants to 3rd graders. Medicaid data reflects those Medicaid patients that have received a dental sealant through a Medicaid Provider.

OOH has partnered with the NM Primary Care Association to promote the application of both dental sealants and fluoride varnish among the Federally Qualified Health Centers and community clinics in NM. Increasing the use of sealants/varnish by all public providers is critical since they serve urban/frontier NM children.

OOH has been working very closely with the NM Pediatric Association to educate physicians as the first contact of children to promote oral health, increase the use of fluoride varnish and dental case management. OOH has attended the annual NM Dental Association Conference to promote the use of preventive services in the daily practice of private dentists (dental sealants/fluoride varnish).

OOH has begun a state wide health education campaign to promote oral health throughout New Mexico. OOH contracted with KOAT TV Hearst Broadcasting system conducted an anti-tobacco social medial marking campaign. OOH continues to participate in community health fairs, especially Native American health fairs to promote healthy life styles, nutrition and oral health.

OOH continues to partner with the NM LOBOs to promote healthy children in New Mexico. Various health fairs will be held by the LOBOs and OOH will be present, oral health PSAs will take place via radio and bill boards at the various sports facilities during LOBO events. The LOBO health promotion also includes the DOH Office of Physical Activity and Nutrition Program to promote the consumption of water in lieu of sodas and other sugar products. OOH also promotes the importance of eating healthy foods for a healthy life style.

OOH partnered with the DOH Office of School and Adolescent Health to promote the importance of oral health prevention to school school nurses by attending OSAH school nurse meeting throughout the state. A major objective is to increase the importance of the nurse's role in promoting dental sealant among the school teachers, having the teachers pass out consent forms and collecting the consent forms from the parents.

OOH attends and presents at the annual NM Office and School and Adolescent Head to Toe Conference. OOH staff promote oral health to school leaders, school teachers, nurses, social workers, and students. The OOH Program Director and staff dental hygienist conducted an oral health assessment class for school nurses.

Other activities around Oral Health:

- An OOH Program Director presented to the Santa Fe Community College Dental Assistant Program Public Health 101 and Prevention (sealants/fluoride varnish).
- OOH each year awards school nurses with high consent rate of return with an electronic tooth brush.
- Promoted "Children's Oral Health Month" each February throughout the state via city governments, PSA, school poster announcements, and poster contests.
- Partnered with DentaQuest Foundation 2020 Oral Health Vision to promote children's oral health issues nationally and in New Mexico.
- Member of the Association of State and Territorial Dental Directors and chairs the ASTDD School and Adolescent Workgroup which develops national oral health policy targeting school oral health.

Child Injury

Due to the general lack of federal, state, county, city and private funds for injury prevention activities in combination with an increase in requirements for Safe Kids coalitions wanting to maintain official designation by the national organization, Safe Kids Worldwide, the last three Safe Kids coalitions in New Mexico have been dissolved. This includes the elimination of the state coalition previously sponsored by the New Mexico Health Department and two other coalitions previously sponsored by hospitals. However, the bimonthly conference calls and meeting notes, featuring event announcements for car seat technician trainings, car seat checks and distributions, bicycle helmet distributions and traffic safety events, as well as crib distributions projects, are continuing to be discussed and planned. This is in addition to continuing to schedule and announce home, vehicle and personal safety trainings via local nonprofits and community volunteers, DOH clinic staff, the Indian Health Service and the statewide nonprofit Safer New Mexico Now.

Promotion of the use of portable cribs in lieu of prolonged use of car seats for transport and sleeping outside of automobiles continues, and the NM Children, Youth and Families Department has now decided to collaborate with the NM Dept. of Health to expand this initiative. Again, our five-year goal is to ensure every newborn leaves the hospital with both a car seat and a portable crib. Blue Cross, Blue Shield (BCBS), the largest managed care organization in the state, continues to provide both a car seat and a portable crib to any pregnant member that successfully completes their prenatal education program with regular checkups. BCBS does not provide data, yet they did state that at any one time they are working with 2,000 pregnant clients, which already indicates a target population that greatly exceeds the total number of pregnant women receiving portable cribs statewide last year for all other programs combined.

We also continue to produce press releases, brochure publication and distribution, media interviews and other social marketing opportunities for promoting of safe driving principals, including proper installation of car seats, use of booster seats for older children, always wearing seatbelts as an example to all children, and ensuring every occupant is secured in a motor vehicle at all times. This information continued to be an integral portion of the safety workshops offered to home daycare providers, home visitors for new parents, and clinic staff for a range of state and federal programs, and we continue to average about 70 workshop participants per month. We will also hope to continue to engage youth for expanding education and safety awareness among their peers regarding the use of all-terrain vehicles in collaboration with county health councils in the future.

Report – Trainings, Presentations, Interviews and Health Fairs
Federal Year 2015
(Oct., 2014 – Sept., 2015)

- (14) WIC, CMS, FF and First Born staff - Farmington – Nov. 7th
- (48) RECEC – Home daycare training – Farmington – Nov. 8th
- (30)Head Start Conference – Albuquerque – Nov. 10th
- (26) Head Start Conference – Albuquerque – Nov. 12th
- (11) Valle Del Norte Community Center – Parent training - Albuquerque – Dec. 4th
- (15) Valle Del Norte Community Center – Parent training – Albuquerque – Jan. 27th
- (50) Mora and Las Vegas Head Start – training – Mora - Jan. 5th
- Trinity Broadcasting Network – two interviews – Safe Sleep and Texting While Driving Prevention – Albuquerque - Jan. 8th
- (24) Northwest Seniors – Elder training – Farmington – Jan. 14th
- (21) Isleta Pueblo – Elder training – Isleta Pueblo – Jan. 21st
- (8) Valle Del Norte Community Center – Parent training – Head Start -Albuquerque – Jan. 27th

- (45) - Santa Fe Senior Center – Elder training – Santa Fe
- (10) Head Start – Parent training – Arroyo Seco – Feb. 24th
- (26) Cochiti Pueblo Senior Center – Elder training – Feb. 26th
- (7) NMSU - WIC, FF, CMS, HP and FIT staff training – Carlsbad – Feb. 27th
- (53) NMSU – RECEC home daycare provider training – Carlsbad – Feb. 28th
- (10) NMAEMSE Conference – Home Safety Training - Ruidoso – March 6th
- (16) La Clinica De Familia staff training – Las Cruces – March 20th
- (13) RECEC Conference – Anthony – March 21st
- (4) Elderly falls training – American Lung Association – Albuquerque - April 16th

(26) Consumer Product Safety Commission – Presentation on "Reaching Underserved Populations" – Bethesda, Maryland – May 16th – 18th

- (15) WIC – Farmington – May 22nd
- (17) RECEC – Home daycare training – Albuquerque – May 31st
- (12) RECEC – Home daycare training – Belen – June 28th
- (10) WIC, FIT, FF & PHO staff – Roswell - July 25th
- (8) RECEC - Home daycare training - Roswell – July 26th
- (18) Jicarilla Apache Reservation – Dulce – July 23rd
- (37) St. Joseph's Health Care – Albuquerque – August 11th
- (16) WIC, FIT, FF & PHO staff – Las Cruces – August 15th
- (25) RECEC – Home daycare training – Las Cruces – August 16th
- (8) WIC, FIT, FF & PHO staff – Silver City – Sept. 19th
- (22) RECEC - Home daycare training – Silver City – Sept. 20th

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(645) Total Participants – (525) Child Safety (120) Elder Safety

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* RECEC – Regional Early Care Educational Conferences for Home Daycare Providers
* WIC – Women, Infants and Children program staff
* FIT – Family, Infant and Toddler program staff
* FF – Families First program staff
* PHO – Public Health Office staff
* CMS – Children's Medical Services staff
* HP – Health Promotion staff

Adolescent Health

State Action Plan Table

State Action Plan Table - Adolescent Health - Entry 1

Priority Need

To improve access and quality of comprehensive well exams for adolescents

NPM

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

Increase the percentage of adolescents who are on Medicaid who receive an annual comprehensive well child exam

Strategies

Implement strategies that promote the Positive Youth Development Approach and target different areas of the Socio-Ecological Model.

Increase health literacy education for adolescents age 10-24.

Implement youth-adult trainings & campaigns to increase awareness to youth & families about the importance of well exams.

Promote youth-friendly & quality health services training within schools, school-based health centers & public health offices.

Implement Quality Improvement initiatives through school based health centers focusing on improving the quality of well child exams.

Improve Access and Utilization of Preventive Services

Improve State- and Systems-Level Policies and Practices

ESMs

ESM 10.1 - The number of policies/or practices implemented at a clinical system, that helps improve access to or quality of the adolescent well visit.

ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table - Adolescent Health - Entry 2

Priority Need

To reduce birth rates among teens 15-19

SPM

Teen Birth Rate, ages 15 to 19 years

Objectives

Teen birth rate for teens 15-19 will be reduced by 30% in 5 years

Strategies

Provide clinical services that accommodate teens by means of accessible locations (e.g. school-based health centers) and clinical practices (e.g. providing teen-friendly methods including long-acting reversible contraception).

Fund, monitor, and evaluate the implementation of evidence-based teen pregnancy prevention education programming in communities across the state

Engage with FPP on expanding use on social media resources on delaying first and repeat pregnancies (BrdsNBz, Text4Baby, DayOne/DayTwo).

Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.2	79.4	80.8	82.2	83.5	84.7

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.7 %	2.7 %	130,533	168,106
2007	82.9 %	2.0 %	143,481	173,056
2003	66.3 %	2.3 %	118,111	178,026

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 10.1 - The number of policies/or practices implemented at a clinical system, that helps improve access to or quality of the adolescent well visit.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	5.0	5.0	5.0	5.0

ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	76.5	78.5	81.0	83.0	85.0

Adolescent Health - Plan for the Application Year

Teen Births

The state Title V program collaborates with the Family Health Bureau/Family Planning Program to implement activities related to reducing teen pregnancy in New Mexico. In 2014, FHB/FPP collaborated with 48 Public Health Offices (PHOs), including 4 PHO outreach sites, and 40 primary care clinics and school-based health centers (SBHCs) through Contracts and Provider Agreements by providing reproductive health services to 26,120 unduplicated clients: 22,769 females and 3,351 males. Statewide activities include clinical services with on-site provision of methods including long-acting reversible contraception (LARC), sterilization services, and community-based education for teen pregnancy prevention. The long term program impacts related to Title V are to reduce teen pregnancy and unintended pregnancy. Between 2012 and 2013 (the most current data), the teen birth rate (age 15-17) decreased to 20.5 per 1,000, or almost 9.7%. New Mexico has seen a significant decline in the teen birth rate over the past 13 years. From 2000 to 2013, the teen birth rate for 15-17 year olds in NM decreased by 48%. Both clinical services and educational programming have contributed to the decline. From the 33.8 per 1,000 baseline rate in 2009, the 2013 NM birth rate among girls aged 15-17 was 20.5 per 1,000; this represents an average of 11.7% per year decline, which exceeds the long term impact goal. LARC has proven to be highly effective in preventing teen and unintended pregnancy. FHB/FPP has made LARC available for teens through the Title X clinics. Per the 2014 Family Planning Annual Report, 163 teens under the age of 18 years and 426 teens and young adults under the age of 20 years used a LARC method (IUD or implant). Overall, over 10% of FHB/FPP female clients were LARC users in 2014. The promotion of LARC use supports the federal Centers for Disease Control and Prevention (CDC) reproductive health guidelines and Title X Program key issues.

FHB/FPP continues to support the implementation of two evidence-based teen pregnancy prevention programs: Teen Outreach Program (TOP) and *¡Cuídate!*. TOP is implemented in nine counties at 30 sites statewide by 11 different organizations. The population-based strategies used for teen pregnancy prevention are service-learning programs, adult-teen communication programs, and comprehensive sex education. FHB/FPP works with community organizations and provides technical assistance and oversight to ensure curricula are implemented with fidelity. The parents, guardians, and community members who completed the adult-teen communication curriculum, *Raíces y Alas*, will help with teen pregnancy prevention as adult-teen communication is a strong protective factor. FHB/FPP promotes the BrdsNBz text messaging service statewide. A teen or parent texts a question and a trained educator responds within 24 hours (with an average time of 6 to 8 hours). Teens text “NMTeen” to 66746 and parents text “NMParent” to 66746. BrdsNBz combines health education and personalized text messaging, to meet the public

health needs of New Mexicans. This social media system offers teens and parents free, confidential, and accurate answers to sexual health questions in either English or Spanish.

The state Title V program will continue to collaborate with FHB/FPP to implement a statewide, comprehensive, and coordinated plan focusing efforts on teen pregnancy prevention/reduction.

1. Assure continued delivery of safety net family planning services through the strategic alignment of contraceptive services.

2. Increase outreach to schools in Doña Ana, Bernalillo, Santa Fe, Luna, Cibola, Chaves, and Eddy Counties.

3. Increase services to teens through outreach and utilization of teen-friendly services and methods.

4. Increase access to intrauterine devices (IUDs) and implants through same-day insertion and through post-partum insertion and as emergency contraception.

5. Provide training for clinic staff (including through telehealth & the use of an onsite mentor).

6. Coordinate reproductive life plan messaging by other DOH agencies.

7. Increase access to IUDs and implants through same-day insertion and through post-partum insertion and as emergency contraception.

Other FHB programs that collaborate on teen pregnancy prevention activities include MCH, WIC, and Families First, by engaging around clinical services, educational services, and social media resources for teens and ensuring teen parents receive information on and have access to highly-effective, low-maintenance contraception.

Adolescent Well Visit

The Office of School and Adolescent Health (OSAH) and Title V efforts to increase well exams for adolescents and will include the following activities:

(1) Statewide school based health centers will continue to expand services and supports for Medicaid eligible youth, including conversion of sports physicals into comprehensive well exams and conducting an annual medical record review to ensure quality and completeness of EPSDT requirements,

(2) OSAH and TItle V will work in partnership with the Centennial Care Managed Care Organizations to expand marketing and outreach to Medicaid eligible youth about the importance and how to access comprehensive well exams statewide.

(3) OSAH and Title V will provide training to providers working in community health centers and other medical agencies about how to deliver youth friendly services.

(4) OSAH and Title V will work in partnership with youth-led peer-to-peer groups to deliver health promotion and education about the importance of well exams by continuing to increase health literacy education for adolescents.

The “Youth Health Literacy: A toolkit to strengthen health literacy” was developed by the NM Department of Health (NMDOH) in partnership with Envision Your Future and youth from across the state of NM. The purpose of the toolkit is to provide fun and meaningful activities for youth about healthcare. The toolkit provides an opportunity to engage

with youth in discussions that will help improve their understanding and skills necessary to support self-care and well-being. This toolkit draws from a variety of sources and focuses on the following six concepts:

- Creating a safe space to discuss health topics
- Identifying and understanding the six key areas of health
- Understanding what to do before, during and after a doctor's appointment
- Understanding youth confidentiality and minor rights
- Understanding the HEADS Model (Home, Education/Employment/Eating, Activity, Drug Use/Depression, & Sexuality/Sexual Activity/Safety) as a way to organize information shared and received during a doctor appointment
- Promoting self-care tips

Throughout the trainings there will be a strong emphasis on the importance of well adolescent exams. We will target school-based health centers, youth peer to peer helper programs, and various health educators within the schools, hospitals, Department of Health, etc. The Statewide Adolescent Health Coordinator will be responsible for oversight of the planning, implementation, evaluation and statewide coordination of this effort.

(5) OSAH and Title V will work in partnership with the NM Alliance for School Based Health Care and NM Human Services Department to improve policies and practices related to confidential services.

Adolescent Health - Annual Report

Teen Births

Current rate:

The 2014 teen birth rate for New Mexico (for teens aged 15-17) is 20.5 per 1,000. The 2015 teen birth rate will be available in August 2016.

Progress (data):

The teen birth rate has been consistently decreasing since 2007. Since 2000, NM has seen a 57% drop in the teen birth rate.

Year	Hispanic	AI/AN	Black	White	A/PI	Total
1990	62.4	60.1	68.0	24.1	13.0	46.3
1991	68.2	55.8	64.4	25.4	9.0	49.1
1992	71.0	59.7	61.1	25.5	16.7	51.0
1993	77.5	55.2	68.7	25.5	10.4	53.8
1994	75.9	51.7	69.4	26.6	19.5	53.4
1995	71.4	53.8	63.7	26.5	9.2	51.1
1996	68.7	44.4	44.6	25.7	8.7	48.5
1997	65.2	42.3	49.5	25.7	8.2	46.8
1998	66.8	42.8	45.8	22.4	13.7	46.5
1999	63.4	39.9	39.0	19.6	5.6	43.4
2000	54.3	41.0	44.4	20.1	13.1	39.8

2001	54.8	38.0	35.1	17.1	6.3	38.5
2002	55.4	38.8	23.6	15.1	10.1	38.1
2003	55.2	41.0	16.8	13.3	11.6	37.6
2004	54.4	43.6	20.0	14.5	5.6	38.1
2005	54.3	38.0	33.2	13.7	5.4	37.4
2006	52.8	38.3	25.4	13.5	10.4	36.7
2007	50.7	40.0	34.0	15.8	6.7	36.9
2008	51.2	38.8	17.5	14.6	14.5	36.6
2009	46.9	37.5	24.0	13.2	9.4	33.8
2010	40.6	30.2	22.8	12.0	6.0	29.3
2011	34.0	27.9	14.1	11.4	6.0	25.2
2012	31.4	23.4	9.7	9.5	1.5	22.7
2013	28.0	21.0	20.9	8.1	4.3	20.5
2014	24.0	19.8	14.3	5.9	2.8	17.2

red = unstable/very unstable; use caution when reporting these rates.

Query source: https://ibis.health.state.nm.us/query/builder/birth/AdolBirthCnty/AdolBirth15_17.html

Activities conducted (October 2013 – September 2014):

Between October 2014 and September 2015, NM Family Planning Program has been working in a two-pronged approach to decrease the teen birth rate: through clinical services and through educational programming. NM FPP promotes three population-based strategies: service learning and positive youth development programs, adult/teen communication programs, and comprehensive sex education programs. These strategies complement clinical family planning direct services to prevent teen pregnancy in order to bring about meaningful and measurable reductions in teen births.

Clinical services are provided in most of the state-funded public health offices across New Mexico and in primary health care clinics that are contracted through the NM Family Planning Program. Between 2009 and 2015, the use of long-acting reversible contraceptives in the teen population has increased from 2% to 10%. In 2015, 2,677 15-17 year old females received reproductive health services at a Title X-funded clinic. The most popular method of contraceptive among this population was the oral contraceptive, followed by the 3-month hormonal injection and the hormonal implant. More than 7% of this population were pregnant or seeking pregnancy. In 2014, 2,574 15-17 year old females received reproductive health services at a Title X-funded clinic. The most popular method of contraceptive among this population was the oral contraceptive, followed by the 3-month hormonal injection and the hormonal implant. Almost 9% of this population were pregnant or seeking pregnancy.

Educational programming is provided to teens across the state by local non-profits that are contracted through the NM Family Planning Program. These organizations provide evidence-based educational programs, *Teen Outreach Program* or *TOP* and *Project AIM*. *TOP* promotes positive youth development with service learning (volunteer work in the community) and curriculum-based activities in a program to decrease teen pregnancy and increase school success. *Project AIM* encourages at-risk youth to imagine a positive future and discuss how current risk behaviors can be a barrier to a successful adulthood, through interactive and small-group activities, group discussions, and role-plays. The NM Family Planning Program promotes the use of *From Playground to Prom* to increase parent-child communication, implemented with parents of the teens who participate in the educational programs. In FY16, there were 371 teens enrolled in the program. In addition to this structured educational and experiential programming, the NM Family Planning Program provides funds to support the BrdsNBz warm-line text-back service that provides medically accurate, age-appropriate sexual health and sexual behavior answers to teens and parents who text questions. The NM Family Planning Program and its contractors also participate in “Let’s Talk” month and the National Day to Prevent Teen Pregnancy.

Strategies for teen pregnancy prevention include an increase in the availability of highly- and moderately-effective primary contraceptive methods to teens (through the provision of confidential clinical services and teen-friendly clinical practices and the expansion of family planning services at school outreach locations), the incorporation of service-learning and positive youth development in teen pregnancy prevention programming, and the increase in marketing for the use of BrdsNBz.

Adolescent Alcohol Use

Last Year's accomplishments:

The Office of School and Adolescent Health (OSAH) uses a Positive Youth Development Approach (PYD) to promote youth leadership (through peer-to-peer education and youth-adult partnership) and primary prevention. Here are some of our accomplishments for 2015:

NM YouthCHAT was implemented again with students from the Public Academy for the Performing Arts (PAPA). YouthCHAT empowers youth actor/teachers to help primary and behavioral/mental health care providers to learn effective communication skills for adolescent care; specifically on sensitive issues such as sexuality, sexual and mental health; and topics such as substance use, depression and suicide. This year the PAPA actors and film students collaborated to create a video highlighting the Youth CHAT program. The video will be shared statewide to promote the project, its approach and method, in hopes of creating additional YouthCHAT groups statewide.

OSAH also facilitated a Positive Youth Development – Youth Leadership Track at the Annual Head-to-Toe School Health Conference. Over 45 youth participated in various activities & workshops promoting health literacy, teamwork, health education, values and decision making.

OSAH funded 25 youth-led, peer to peer helpers programs statewide. These groups planned and implemented various projects/workshops; created toolkits and delivered health education on school campuses and in communities. The peer to peer helper programs are based on the premise that when young people have problems, they most often turn to friends whom they trust for help, and that within every school an informal "helping network" exists. The program seeks to identify this informal network of young people who represent all the different subgroups within schools and provide training and support to those who are already serving as helpers. Additionally, OSAH's 54 school based health centers across the state also partnered with youth to do health promotion & education based on the needs of their school.

OSAH was part of the following events and activities: NM Public Education Department Annual Out of School Time Network Conference; 20th Annual Head to Toe Conference, SafeTeen Board, Indigenous Soccer Cup (ISC), Youth Intervention, Prevention & Education in School/Community (YIPES/C), Youth Jam, Youth VOICE (Violence, Obesity, & adolescent health risks Individual Community Education), Youth Risk and Resiliency Survey Workgroup and NM Title V Planning Committee.

Current Activities:

The current activities include:

· School Based Health Centers (SBHC): implementation of youth engagement, Positive Youth Development & youth-led health promotion efforts.

· Technical Assistance and Training: Provided statewide PYD and adolescent health information for contractors and other stakeholders/partners.

· Out of School Time Conference- OSAH collaborates with PED to plan and implement the conference and

assist with the including youth voice in the conference.

· Annual Head to Toe Conference

  o *Youth-Adult Partnership Breakout Sessions*- development of workshops and presentations to promote the positive youth development approach.

  o *PYD/Youth Leadership Track*- Youth teams are sponsored to participate in two days of intensive workshops and presentations to develop their leadership, improve their knowledge of adolescent health and to develop presentation skills to support their health promotion activities.

· Other effort: SafeTeen Board, Making Connections: project focused on social emotional wellness for young men; Out of School Time Network Conference, Title V Planning Committee (Lead for Adolescent & Young Adult Sub-Committee) & Indigenous Soccer Cup.

Adolescent Suicide

Family Health, in partnership with OSAH, continued efforts to reduce youth suicide by implementing evidenced-based tools such as the QPR (Question, Persuade, Refer) training, community coalition building, screening/early identification, referral and treatment. Additionally, all providers and staff associated with OSAH funded school-based health centers (SBHCs) were required to complete training in suicide prevention and intervention. Targeted training was provided to schools with SBHCs on suicide crisis planning and response and a peer-to-peer program entitled "Natural Helpers" (NH) was expanded to a total of twenty-five (25) schools. OSAH also supported and coordinated three statewide crisis line activities that were linked to the National Suicide LifeLine (1-800-272-TALK). OSAH was fortunate to receive a grant from SAMHSA in August 2012 to further expand our youth suicide prevention efforts. Although the contract ended in November of 2015, lasting effects due to the continued support of training and crisis intervention are still being noticed. Additional programming included: QPR train-the-trainer workshops for community members, adult leaders of NH groups and school personnel; additional telehealth consultations for SBHC providers; and initiatives focused on youth who identify as Lesbian, Gay, Bisexual or Transgender (LGBT).
Title V and OSAH:

· Promoted suicide prevention/intervention/postvention through schools and SBHCs. Facilitated peer-to-peer youth programs to promote awareness & resiliency.

· Provided Gatekeeper training for faculty and staff at several high schools, colleges and universities.

· Provided training, resources and programs for suicide prevention for LGBT youth statewide, including formation/support of Gay-Straight Alliances in middle and high schools.

· Provided training to community health centers and hospitals to increase staff general awareness of best practices when working with youth at risk for suicide.

· Population Trainings on warning signs and risk factors for suicide, prevention, intervention, postvention (PIP), response and reducing stigma. Include behavioral health track at Head-to-Toe Conference.

· Worked with partners to provide community-based awareness & crisis response.

· Expanded availability of training in rural and frontier areas by providing free QPR train-the-trainer workshops

· Participate in NM Child Fatality Review. Required health care quality initiative in SBHCs to improve infrastructure, quality of integration between primary & BH care and enhancement of SBHC administrative functions.

Children with Special Health Care Needs

State Action Plan Table

State Action Plan Table - Children with Special Health Care Needs - Entry 1

Priority Need

Increase access to care to a family-centered comprehensive medical home for children and adolescents

NPM

Percent of children with and without special health care needs having a medical home

Objectives

Increase the percentage of pediatric clinicians in New Mexico who have effective policies and procedures in place to provide effective integration of physical health, oral and behavioral health care and have an effective method for cross-provider communication.

Increase the percentage of pediatric clinicians in New Mexico who provide preventive health assessments in accordance with Bright Futures.

Increase the percentage of families who have access to patient and family centered care coordination that respects the culture and primary language of the family to assist in integrating physical, oral and behavioral health issues into the care plan.

Strategies

Collaborate with the New Mexico Child Health Improvement program ENVISION to provide training to pediatric providers on care integration and cross provider communications.

Participate in the SIM grant planning and implementation work groups to develop standard policies and procedures for medical home providers.

Collaborate with the National Center for Medical Home Implementation to provide technical assistance to pediatric clinicians.

Collaborate with the New Mexico Pediatric Society to provide training to PCP's and their staff on Bright Futures including information on how to bill for screenings and assessment.

Collaborate with the New Mexico Pediatric Council to address issue of payment for use of Bright Futures with the managed care organizations.

Collaborate with the National Center for Medical Home Implementation to provide technical assistance to pediatric clinicians.

Collaborate with the New Mexico Child Health Improvement program ENVISION to provide training to pediatric providers on care coordination.

Increase collaboration between the Title V CYSHCN program care coordinators, the Managed Care organizations who also provide care coordination and Family leaders representative of the diverse cultures in the State to strengthen the best practice model for children with special needs and their families across the state.

ESMs

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care and family engagement

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table - Children with Special Health Care Needs - Entry 2

Priority Need

To increase the amount of services available to assist adolescents to make successful transitions to adult health care services

NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Objectives

Increase the percentage of pediatric and pediatric specialty care practices who report that they have written health care transition policy and process to help youth with special health care needs prepare and plan for transition to the adult physical and behavioral health care systems

Increase the percentage of adult primary and specialty care practices that report they have a written health care policy or approach to support youth with special health care needs to integrate into the adult health care practice

Strategies

Collaborate with the Transition Task Force to implement policy and practice recommendations for pediatric practices

Collaborate with the NM Family to Family Health Information Center and the Center for Development and Disability to provider resources, supports and training to pediatric health care providers, and to families and youth on health care transition for physical and behavioral health.

Collaborate with Got Transition to provide technical assistance to pediatric providers in developing transition policy

Collaborate with the Transition Task Force to implement policy and practice recommendations for adult practices

Collaborate with the NM Family to Family Health Information Center and the Center for Development and Disability to provider resources, supports and training to adult health care providers, and to families and youth on physical and behavioral health care transition

Collaborate with Got Transition to provide technical assistance to pediatric providers in developing transition policy

ESMs

ESM 12.1 - The number of Health Care providers participating in health care transition education and training on the 6 core elements of transition

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

Measures

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	38.9	40	41.1	43.1	45	47

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.6 %	4.0 %	34,748	90,144
2007	43.0 %	3.8 %	33,398	77,684

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	50.1 %	2.1 %	204,506	408,109
2007	50.1 %	2.0 %	198,036	395,065

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care and family engagement

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	10.0	15.0	20.0	25.0	30.0

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	36.8	38.6	40	41.4	42.8	44.2

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	35.7 %	3.8 %	9,776	27,412
2005_2006	33.7 %	2.7 %	8,126	24,117

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 12.1 - The number of Health Care providers participating in health care transition education and training on the 6 core elements of transition

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	100.0	125.0	150.0

Children with Special Health Care Needs - Plan for the Application Year

Medical Home:

Activities for which the Title V program provides primary leadership:

The focus of the state action plan will be to improve the system of care for CYSHCN with a focus on Medical Home. CMS will continue to provide leadership in the area of care coordination for CYSHCN. CMS employs medical social workers trained in the provision of care coordination for the special population of CYSHCN. For many years, the CMS medical social workers have provided care coordination for CYSHCN from birth to age 21 in New Mexico, helping to bridge the gaps in the healthcare system and link families to needed services. This coordination of care across settings leads to an integration of services, which decreases health care costs, reduces fragmentation of care, and improves the experience for the patient and family.

With the implementation of Centennial Care in 2014 and new requirements by Medicaid to the MCO's around assessment of level of care needed for every MCO member enrolled and provision of care coordination, a new partnership developed between the MCO's and CMS. This partnership was enhanced by the NM team participation in an AMCHP Action Learning Collaborative in Washington DC and the team continues meeting regularly with representatives of all the MCOs, Medicaid and CMS to continually improve this partnership. In 2014 the Managed Care Organizations (MCOs) in NM hired care coordinators to assist all clients as part of an overhaul of Medicaid services. CMS has worked closely with the MCOs to ensure that they are aware of the special services CMS provides and the value the CMS social workers bring to the system. The CMS social workers collaborate with the MCO care coordinators to ensure the families receive everything they need and there is no duplication of effort.

The Patient Protection and Affordable Care Act (ACA) extended Medicaid coverage to over 100,000 uninsured children and adults during the first enrollment period. A significant requirement is to implement initiatives to improve the quality of care to reduce health care costs and improve overall health outcomes. This provides a wonderful

opportunity to leverage these requirements to develop a state plan for CSCHN in New Mexico and continue work on the joint goal of assuring each child has a Medical Home. Although the uninsured rate in NM has dropped significantly with the ACA, over ten percent of New Mexicans remain uninsured. Many, but not all of these, are undocumented individuals, frequently living in mixed status families. When a child who is medically eligible for CMS has no health insurance, CMS acts as a very limited "insurer," paying for needed medical services related to the eligible condition, and assisting clients in applying for NM's High Risk Insurance Pool. For high cost clients with no other source of insurance, CMS pays the premiums for the High Risk Pool, giving the client full insurance benefits.

CMS social workers continually strive to improve three of the core outcomes for all CYSHCN clients. These outcomes are: 1) families partner in decision making and are satisfied with the services they receive; 2) families of CYSHCN have adequate private and/or public insurance and financing to pay for the services they need; and 3) services for CYSCHN are community based and culturally and linguistically competent. CMS continually assures family satisfaction and assesses the quality of program services rendered through chart audits by social work supervisors and the use of parent/client surveys, respectively. The results from these surveys actively shape the program's priorities and services offered. A new data system that is scheduled to roll out in Spring 2016 will enhance the program's ability to audit charts and pull reports for quality assurance activities. Additions to the client care plan related to the Medical Home and the youth transition readiness assessment will also provide important information that will assist the Title V program in its evaluation of its performance.

Best practice for care coordination of CSHCN involves collaborative patient and family-centered care; for example, the American Academy of Pediatrics (AAP) identifies the following desirable characteristics of coordinated care within a Medical Home: (1) a plan of care is developed by the physician, child, and family in collaboration with other providers and agencies; (2) all pertinent information about medical care and use of services is accessible to the care team while protecting confidentiality; (3)families are linked to support groups and other resources; and (4) the plan of care is coordinated with educational and community organizations to ensure goals of the care plan are addressed.

The system of care in NM is uniquely strengthened by having the CMS medical social workers based in public health offices throughout the state, providing family centered, culturally competent care coordination and case management. CMS social workers interact with the child and family and are sensitive to economic and cultural factors affecting management in the communities where they provide services. CMS social workers are able to reinforce health care and provider messages and identify and facilitate access to required resources. For example a youth with cleft palate and is deaf from the Navajo reservation attends the residential school at the School for the Deaf in Santa Fe a 4 hour drive from his home. The CMS social workers link the youth with the cleft palate team when in Santa Fe and when he is home for the summer with the team in Farmington. Care must be coordinated with the family who lives remotely and the team from the School for the Deaf.

CMS has also worked to strengthen partnerships with the lead agency for child welfare, the Children, Youth and Family Department (CYFD). CMS social workers will be selected in target communities to participate in a quality improvement project led by the New Mexico Initiative for Child Health Care Quality, ENVISION to improve integration and coordination of care for CYSHCN. CMS will continue to provide direct care coordination and the program will provide training opportunities to strengthen skills. The CYSHCN/Child Protective (CYFD) services pilot project will be expanded to all counties in New Mexico. The goal is to provide CYFD staff with an efficient means to improve overall care of children with chronic medical conditions on their caseloads through collaboration with Children's Medical Services (CMS) staff. Based on Medicaid data we have found that these children and youth have much higher rates of diagnosis for developmental disorders, ADHD, and mental health issues, than the rest of the child Medicaid population.

CMS social workers can provide consultation and co-management for this population as they are specially trained in care coordination for children with chronic medical conditions. They know the pediatric subspecialists well and also

have close ties to the Primary Care offices and dental practices in the local communities. CMS social workers continue to work with the clients until they turn 21, which provides continuity for those CYFD clients who are aging out of their system at 19, and also provide intensive work around youth transition in all areas (healthcare, educational and vocational). They can also work with foster families to teach them about the medical needs of the child, how to navigate the specialty healthcare system, and assure a medical and dental home.

Activities in which the state Title V program has a partnership role but does not have primary responsibility for implementation:

The New Mexico Pediatric Society's Pediatric Council has been working with the NM Quality Improvement Partnership (ENVISION New Mexico), the FHB/CMS Medical Director, and the Medical Directors of the four state Medicaid managed care plans to develop a consistent set of Patient Centered Medical Home (PCMH) standards. Having this clear and consistent set of standards will encourage physicians to embrace the medical home model and enable practices to more easily make the transition to becoming certified medical homes. Preventive health assessments and utilization of Bright Futures will be integrated into this work. This project became a center point of the Health System Innovation model developed jointly by DOH and HSD through a million dollar planning grant from the Center for Medicare and Medicaid (CMS). The Medical Home model was key to the grant proposal along with the integration of physical, behavioral and oral health and the integration of primary care and public health. NM took a Triple Aim approach to the design of its' state model and plans to develop a consensus based design for a statewide healthcare and wellness system that uses a Patient Centered Medical Home model that meets the needs of its diverse communities and population groups. CMS participated in this stake holder group and will integrate the work of Title V into the development of the model. The planning grant wrapped up in March 2016 and was submitted to CMS. Although no further federal funding is expected for the implementation, DOH hopes to be able to move forward on many parts of the plan through collaboration and leveraging of other funds.

In addition to needing more Medical Homes, New Mexico is also in need of increased family leadership and advocacy, especially with regards to the system of care for CSHCN. One reason there is an increased need for prepared family leaders in New Mexico is the state's recent transition to Centennial Care, in which multiple managed care organizations have been selected to implement the state's Medicaid program. This massive system overhaul occurred in a very short time period and has reportedly disrupted patient – provider relationships, made for fragmented and isolated service delivery and increased the need for information and education to patients and families. Each managed care organization is required by state guidelines to provide opportunities for family input at multiple levels.

From feedback received by Parents Reaching Out (PRO), the state family-to-family organization, family members have identified multiple barriers in obtaining the necessary information to navigate the new complex managed care system. The Title V program will continue to strengthen the existing family networks to be fully prepared, mentored and connected to meaningful opportunities of program and policy partnership and ensure that the four Managed Care Organizations (MCOs) are guided by patient and family voices.

The ECHO model™ which was launched in 2003 out of the University of New Mexico Health Sciences Center makes specialized medical knowledge accessible wherever it is needed to save and improve people's lives. The ECHO model™ breaks down the walls between specialty and primary care. It links expert specialist teams at an academic 'hub' with primary care clinicians in local, rural communities as the 'spokes' of the model. Together, they participate in weekly teleECHO™ clinics, which are like virtual grand rounds, combined with mentoring and patient case presentations. The clinics also create an ongoing learning communities where primary care clinicians receive support and develop the skills they need to treat a particular condition, such as hepatitis C or chronic pain. As a result, they can provide comprehensive, best-practice care to patients with complex health conditions, right where they live. This model is being expanded all over the country and the world. Recently the NM F2F at Parents Reaching Out expanded this model to address health care financing issues for CYSHCN. The "hub" in this case are experts

from Medicaid, the MCO's, the disability community, Title V and others and the "spokes" are care coordinators and families in rural communities who meet in local Public Health offices.

The Project ECHO CYSHCN Health Care Financing clinics will occur twice a month. Case presentation will address gaps in insurance coverage or other barriers such as prior authorizations that prevent CYSHCN receiving the health care they need. Didactic presentations occur with each ECHO clinic which provides a perfect opportunity to promote and educate families and other clinic team members about the Medical home and core components. This platform will also be used to educate participants on the 6 core elements of successful youth transition developed by the Got Transition National Center.

To improve the quality of CMS social worker care coordination for Children with Special HealthCare Needs (CYSHCN) and improve integration with the Medical Home CMS has developed a contractual partnership with ENVISION (ENM) the Child Health Improvement program in the Department of Pediatrics at the University of New Mexico. Add more here describing what ENVISION is doing for us in various capacities

CMS social workers live and work in the communities they serve. In this setting they are able to address the significant barriers to the routine follow-up care required by families that encompass transportation, educational, and cultural/linguistic elements. The CMS social workers are a critical resource for CYSHCNs in New Mexico and need to be well integrated into a changing healthcare system.

Complex and uncoordinated care is a contributing factor to poor health outcomes in the pediatric population of Children and Youth with Special Health Care Needs (CYSHCN). There is an increased demand for services for CYSHCN and families at all levels necessitating health care from multiple organizations and programs. The Title V agency for CYSHCN in New Mexico, Children's Medical Services (CMS), as the point of entry for these services, is in a unique position to change and improve care coordination for CYSHCN and their families through their staff of medical social workers.

The project will engage CMS social workers in an initiative with ENVISION designed to discover areas for targeted improvements in coordination of care and family engagement for CYSHCN. The focus will be on the school-aged population, children ages 5-10. Projected outcomes of this process will be:(1) a plan for implementing positive changes in knowledge, attitudes and provider practice in care coordination for CYSHCN by CMS social workers, (2) a plan for implementing significant improvements in patient/family engagement in care consistent with AAP Bright Futures Guidelines for evidenced-based approaches to care coordination; (3) a plan to improve PCP engagement with CMS social workers as part of the care team, and , (4) a plan to improve tracking of and follow up for families of CYSHCN receiving care coordination services. Five target communities identified by CMS (Farmington, Las Cruces, Roswell, Hobbs, and Santa Fe will us a modified focus group approach called a "mingle." Notes from the mingle session are then used to identify themes that impact planning for improved care coordination. Groups in the target communities are composed of primary care providers, CMS personnel, families and representatives of community organizations that serve CYSHCN. Other partners include the NM Pediatric Society

Transition:

Activities in which the Title V program provides primary leadership in administering the activity:

Children's Medical Services has built some foundational activities to improve transition for YSHCN thanks to the D70 funding for the past 3 years.

The grant has helped in supporting the work of the CMS social workers as they coordinate care for adolescent clients. They were used to working with pediatric providers but were limited in their connection with the adult providers in any meaningful way. Activities include partnering more closely with the adult provider (either medical home or specialist) through a warm hand off to help bridge the gap between pediatric and adult providers, improve

the transition and transfer process and increase satisfaction of the provider, youth and family with the transfer process.This has been proven to be successful in a small Northern community where the CMS social work has relationships with adult providers and is able to do a joint visit with the transitioning youth and the adult provider at the time of transition.This has been less successful than anticipated due to difficulty getting buy-in from both the social workers and the adult providers. We will continue to focus on training and mentoring in order to increase the level of comfort the social workers feel with this role, as well as additional training needs for providers to help them understand the benefits of partnering with the CMS social worker.

Annual training at the Southwest Conference on Disability in October was provided for the past three years and will continue. This will be the 4th year of training staff on transition and a wide range of disability topics. A total of 75 CMS staff, including 45 social workers, receive two days of training in transition-related topics during this conference.

CMS social workers will continue to receive training and support around transition planning with youth. The new data system CACTUS has integrated the transition assessment and includes a care plan that will be co-developed with the social worker and the youth to highlight areas of work that need to be focused on to assist with a successful transition.

Arrangements are being made to participate in the Baylor University Transition conference through a live stream as to support the training of the CMS social workers.

The CMS Management team will begin to review the materials from Got Transition and develop technical assistance requests. Appropriate materials from the site that are applicable to the work of the CMS social workers will be tested.

Activities in which the state Title V program has a partnership role but does not have primary responsibility for implementation:

UNM has developed a Youth in Transition Learning Portal to serve as an online source of trainings, webinars, and courses covering a variety of transition topics. The project is a collaboration between many partners such as CMS, UNM, PRO and the Governor's Commission on Disability. The goal is to have these trainings available to providers of all types throughout the state, including medical providers, social workers, counselors, vocational workers, educators, youth, parents, and others. A webinar on "Understanding Guardianship Issues" was developed and added to the portal. Additional courses are being developed in areas including legal issues, vocational training, navigating the system, family centered care, and several condition-specific topics as well such as transitioning the youth with cerebral palsy, for example. It will also house best practice information on transition including care plans, copies of office policies and processes for medical practices and links to Got Transition. It will be launched during this action plan year.

A transition track will be supported through funding and professional presentation to continue training families who have CYSHCN at the annual family leadership conference sponsored by Parents Reaching Out (PRO) the NM F2F. Families from throughout New Mexico, and some CMS staff members, attend this conference.

The Governor's Commission on Disability will continue its advocacy around transition education in the schools and will fund training of trainers who can go into elementary schools to address disability as part of the human condition and increase student awareness of disability issues.

The Center for Development and Disability is CMS' primary academic partner in the project. One component of the D70 project is to examine transition-focused policies, programs and services in order to make recommendations on how the transition system can be improved to reduce fragmentation, increase coordination between pediatric and adult health care systems and improve the quality of care for children and youth who are moving through the transition process. The Transition Task Force is the primary vehicle for achieving this project objective and was legislatively

executed through a Joint Memorial in the 2015 Legislature. Stakeholders include: the MCO's, UNM, School of Nursing, National Association of Social Workers, PRO, AAP, several nonprofit organizations representing the Disability community, Medicaid, Indian Health Services and others. The Task Force is currently in process and is focused on assessing the fragmentation that exists; identifying strategies to address the barriers to effective health care transition and transfer services, including evidence-based strategies that have been successfully used in other states and through Got Transition; and making recommendations for changes to existing policies, programs and regulatory provisions or recommendations on regarding transition-focused policies, programs or regulatory provisions. The goal of the recommendations will be to address barriers to effective health care transition for children and youths with special health care needs; and increase the efficiency and effectiveness of services for children and youth with special health care needs as they make the transition from pediatric to adult health care services. The report will be submitted to the Governor's Office, the Cabinet Secretaries, the University of New Mexico and the NM Legislature in the Fall of 2015.

During the 2017 Legislative session the Task Force will follow-up with Legislatures regarding implementation/funding for recommendations developed by the Task Force that were presented to the Senate Disabilities Subcommittee in the Fall of 2105.CMS will utilize the Project ECHO Health Care Financing clinics to highlight the needs of transitioning youth and elicit feedback on policies and practices that have been effective. The Youth in Transition Learning portal will be promoted widely among the medical community. Transition training for parents and youth at the Family Leadership annual conferences will continue to be included as a deliverable in the contract with PRO and EPICS.

Children with Special Health Care Needs - Annual Report

Medical Home

Children's Medical Service (CMS) worked to expand the medical home concept in New Mexico, promoting the discussion of the concept at professional meetings and conferences and continuing work on the Medical Home Portal to provide accurate and comprehensive information on health information and community resources for families in English and Spanish. CMS has a family-centered approach in care coordination, including involving youth in transition planning for State Children and Youth with Special Health Care Needs (CYSHCN) Program. CMS made referrals to family support organizations for family-to-family connections. This included referrals to Parents Reaching Out (PRO), Education of Parents of Indian Children with Special Needs (EPICS), and family liaisons from the NM School for the Deaf (NMSD). The Cleft Palate clinics employ a family support agent who is available to families during the clinic. EPICS and PRO also bring their family leaders development curriculum into small local communities and train groups of families' thus spreading information, resources and tools for empowerment to the local level. CMS participates in annual trainings with the LEND program around Title V services and concepts such as the Medical Home.

CMS sustained family participation in the Maternal and Child Health (MCH) Collaborative, NM Interagency Coordinating Council (ICC), Newborn Hearing Screening (NBHS) Advisory Council, Early Hearing Detection and Intervention (EHDI) meeting and Association of Maternal and Child Health Programs (AMCHP) Conference. CMS contracted with family organizations to ensure that families partner in decision-making at all levels; the scope of work includes participation in local, state and national meetings/conferences, training for staff/families, and an advisory

role regarding policy.

CMS was able to provide continued funding to PRO as part of the D70 grant to support the family leadership training meeting. Funding is also provided to EPICS for their family leadership training conference which focuses on Native American families with special needs children and attracts over 400 participants annually. CMS recruited a parent representative to join the Newborn Genetic Screening Advisory Council and serve as a family liaison to the Mountain State Regional Genetic Collaborative. Family organizations are invited to provide input into CYSHCN Program activities during scheduled meetings. A contract was secured to begin a Hands & Voices chapter in NM for family-to-family support during early identification of hearing loss in infants.

CMS continues to meet with Family organizations to discuss ways to improve efforts to ensure that families partner in decision-making at all levels and are satisfied with the services they receive. This includes participating in the Title V needs assessment. CMS social workers empower parents and youth to partner with their primary care provider in order to ensure their needs are met within the Medical Home. CMS and family representatives present jointly on the system of services and care for CYSHCN in the State. Feedback is received on gaps and barriers. A family consultant attends the cleft palate clinics and provides direct family to family support during clinic days. The Newborn Genetic Screening program met with a new NM family representative for the Mountain State Regional Collaborative to provide training and to receive feedback on the newborn screening program.

Children's Medical Services (CMS) social workers continued connecting Children and Youth with Special Health Care Needs (CYSHCN) clients to a Medical Home. CMS social workers continued to fax asthma action plans to the primary care provider and the school nurse after each asthma outreach clinic, providing a link to the Medical Home and wrap-around services. The Newborn Hearing (NBH) and Newborn Genetic Screening (NGS) Programs continued to include the medical home during follow-up when an infant is identified through newborn screening. The Newborn Hearing program developed a road map for medical home providers to assist them with identification of medical needs for newly diagnosed deaf or hard of hearing infants and sends this to providers when an infant is identified with a hearing loss.

The FHB Bureau Chief/Medical Director meets with the Pediatric Council of the NM Pediatric Society on promoting the Medical Home concept and on developing standardized criteria for Patient Centered Medical Home certification. The Title V Program contracts with EPICS and other family organizations to provide needed training and support to families regarding medical home, transition and family involvement in decision-making. CMS leadership meets quarterly with the MCOs to improve the collaboration between MCO care coordinators and CMS staff as care coordinators. A common goal has been developed to increase involvement with the client's medical home to improve coordination of care. The FHB Medical Director continues to work with Project LAUNCH and the Center for Development and Disability at UNM to populate the medical home portal with NM-specific resources and translate documents on the portal into Spanish, and maintain medical home online training for home visitors and early intervention providers. Promotion of the medical home portal is an ongoing activity. CMS included training on the Medical Home for all CMS staff as part of the curriculum for the statewide conference in the fall of 2014.

CMS contracted with the NM Child Health Improvement program ENVISION to develop quality improvement activities around newborn hearing screening and the Medical Home.

The goal of the initiative was to provide the CMS team access and support through Envision's quality improvement (QI) coaching model, with the aim of reducing loss to follow up after a failed newborn hearing screen. The model is being applied globally to both a health system and in individual practice settings. The Developmental Screening Initiative (DSI) of which Newborn Hearing Screening (NBHS) is a measure, provides expert quality improvement training, support, data tracking and reporting.

The QI team is updating or improving tools, and data collection systems. Opportunities to collaborate across systems were used in order to identify potential community partners who will help achieve overall aims. There were

five different pediatric practices working on the NBHS portion of our Developmental Screening QII. The ENM team has partnered with early intervention providers in the area in order to expand the services available to children and families as well as provide opportunities for rescreening of babies where a concern has been identified or no screen occurred at birth.

Adequate Insurance

Children's Medical Services (CMS) social workers provided care coordination to approximately 4000 Children and Youth with Special Health Care Needs (CYSHCN), many of whom were not Medicaid/CHIP eligible. CMS social workers provided assessment of insurance options for clients and assisted with Presumptive Eligibility-Medicaid on site application (PE-MOSAA's) to determine if the children or youth were eligible for Medicaid or CHIP. The social workers assisted clients to enroll in the state high risk pool called the NM Medical Insurance Pool (NMMIP) and off-exchange plans. CMS pays the NMMIP premiums for clients with high cost diagnoses and serves as payer of last resort for uninsured clients who meet program eligibility criteria. CMS is very concerned about the possibility of the high risk pool being dissolved. At the request of the Pool Board, CMS (along with the DOH HIV Program) moved many clients off of the Pool during the 2014 open enrollment period and onto off-exchange plans. CMS pays the premiums for these clients through the help of an insurance broker. Medicaid expansion for adults up to 138% of FPL has positively affected youth in transition who now have access to insurance coverage. CMS refers clients to Navigators in the PH offices to assist with enrollment. CMS social workers are trained to do on-site presumptive eligibility applications to ease the enrollment process for CYSHCN who need immediate coverage. The on-line application system has improved the overall enrollment process.

In 2014 the insurance plan that CMS had moved over 100 clients to from the High Risk Pool decided to pull out of the New Mexico market. The program worked with the Pool to transfer these critically ill children back onto the Pool for a January 1 start date. The CMS Medical Director (who is also the Title V Director) attends the monthly NMMIP board meetings and keeps the program informed of the fluctuations in the insurance industry in NM. (See Health Care Reform section for more details).

CMS began collaborating with the NM F2F at Parents Reaching Out on the development of a Project ECHO Health Care Financing clinic. The premise is that at the Hub will be experts in the field of financing including Medicaid, the MCO's, the waiver programs, NM Center for Law and Poverty and CMS. The spokes at the Public Health offices will be families with CYSHCN, CMS social workers, care coordinators from other programs and others. Cases will be presented to the experts around financing issues for CYSHCN and recommendations will be developed. Two mock ECHOS have been held and the go-live is scheduled for June.

CMS continues its work with the Commission for the Deaf and/Commission for the Blind and Visually Impaired to improve services to children in these communities. The CMS program continues work closely with the Family-to-Family Health Information Center at PRO, which is addressing insurance coverage for CYSHCN in the state especially changes in the Medicaid waiver programs. CMS social workers are building functional relationships with the MCO care coordinators to assure CYSHCN can access benefits from their insurance plans.

Community Based Service Systems

Continued care coordination which is provided by Children's Medical Services (CMS) staff and available to all Children and Youth with Special Health Care Needs (CYSHCN) and their families to facilitate coordinated community based care. There were 130 specialty clinics statewide including cleft palate, nephrology, endocrine, pulmonary, neurology, and genetics. Negotiations with the cardiology team were successful and resulted in the addition of 20 additional outreach clinic in rural areas to provide access to pediatric cardiology visits. More cardiology clinics will be added next year.

Cardiology clinics included successful programs in Santa Fe and Las Cruces. The Gallup clinics are on hold due to difficulties in recruiting patients and outreach to PCPs. Specialty clinics were maintained in all the Regions

throughout the year.

CMS staff continued to work to strengthen partnerships with community providers to improve referral network for CYSHCN and their families. CMS was successful in completing almost 800 provider agreements to satisfy agency requirements and assure continuity of care and access for CYSHCN.

CMS continued its series of Meet and Greet with local CMS staff and MCO care coordinators. The goal of the meetings is to strengthen partnerships through in person gatherings, share resources and develop referral processes to improve the coordination of care for CYSHCN in the counties.

Two pilot projects were implemented with the Child Protective Services county agencies to improve the referral of CYSHCN to CMS when a child is being taken into custody or entering foster care. This was initiated out of concern that medical needs are often overlooked or minimally addressed during this stressful time in a child's life. The CMS social worker could assist in assuring continuity of care, that the child has a medical home and provide support to foster parents around the medical issues.

CMS continues to support the work of the Children's Cabinet as it addresses health care issues for families. The program continues to monitor the effects of the health reform on access to care for CYSHCN especially issues around contracting with specialists by the MCO's. CMS continues work with UNM and Presbyterian to look at needs for specialty clinic expansion based on funding available. The CMS team keeps the PHD Leadership and Cabinet Secretary informed of on-going clinic needs. Funds continue to Commission for the Blind to address gaps in access to technology.

Transition

CYSHCN Social Workers provide service coordination and transition planning to youth aged 14-21 through the use of the "CMS Youth Transition Plan." Copies of the inspirational DVD "What Comes Next" continue to be distributed to CMS Staff and other interested individuals/agencies statewide and nationally, along with its accompanying discussion guide.

Staff will search for available avenues of obtaining health care insurance for clients aging out of the Program. CMS funds premiums and deductibles for qualifying clients enrolled in the New Mexico Medical Insurance Pool to give clients a head start on obtaining medical insurance once they transition out of the Program. CMS staff will continue to work with youth so they understand what they need to do in order to continue their insurance coverage once they age out of the CMS program.

CMS staff continued participation in the Curriculum Committee for the State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs. Training needs specific to youth transition issues continue to be identified and CMS Staff receive regular updates and resource information on youth in transition through the use of a Transition Newsletter. CMS again partnered with the SW Conference on Disability and in 2014 sponsored a tract on youth transition which was well attended. Through funding from the HRSA grant, the transition consultative clinic at UNM has expanded statewide; a youth leadership/peer mentor program has started; Parents Reaching Out (PRO) has developed some resources and now have a trained staff member to help families with transition; the annual Family Leadership conference was supported to include a youth transition tract; and the Medical Home portal has been updated with NM specific information and additional transition resources on transition in English and Spanish. A statewide task force had its first meeting in winter 2014 to evaluate issues related to youth transition and recommend policy changes. A joint memorial was introduced and passed in the 2015 legislative session to support this task force.

CMS staff again participated in the 2015 Southwest Conference on Disability. One of the featured speakers was Isabel Stenzel Byrnes who is the author of 'The Power of Two" the story of she and her sister who have cystic fibrosis. She spent time talking about staff about what transition was like for her as a young adult and also shared her

perspectives on what kind of help is useful for the social workers to provide. The Health Care Transition Task Force (House Memorial 44) for New Mexico Children and Youth with Special Health Care Needs met from January through August 2015. The task force was formed to address the needs of the children and youth in New Mexico with special health care needs and/or disabilities, acknowledging from the start that for this population, the process of moving from pediatric to adult medical care is often difficult. The report was the result of eight months of study and deliberation. The Task force developed 9 recommendations around issues such as financing, oral health, guardianship, care for immigrant youth, family involvement and education, interagency communication, training and the feasibility of creating a complex care clinic. The results of the work of the Task Force were presented to the Senate Disabilities Committee in the Fall and was well received.

Cross-Cutting/Life Course

State Action Plan Table

State Action Plan Table - Cross-Cutting/Life Course - Entry 1

Priority Need

Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.

NPM

Percent of children ages 0 through 17 who are adequately insured

Objectives

Improve access to and navigation of health insurance coverage and resulting services; learn how ACA has impacted the access and how navigation can be implemented

Increase prenatal utilization in the first trimester (and by adequacy index)

Improve linkages and referrals between existing health services to optimize primary and specialty or behavioral health and wrap around care; improve cross-border collaboration

Strategies

Present to and hear from the communities on health priorities and solutions or strategies for the next 5 years; in particular survey the families and clients to know if we are on the right track with our needs assessment and strategic planning

Improve state collaboration between DOH, HSD, and tribal health entities, including Albuquerque Area Indian Health Board (AAIHB), Tribal Epidemiology Centers, and Medicaid Managed Care tribal liaisons to evaluate access to post- ACA insurance coverage for Native American families.

Continue to expand and reinstate insurance navigation staff and outreach statewide

Coordinate inter-agency solutions to facilitate transition from prenatal Medicaid to adequate postpartum and well-woman insurance coverage

Continue to expand and coordinate navigation support for families trying to access insurance from the perinatal period through adolescence

Organize with regional community health workers/promotoras, DOH case coordinators, and navigators to coordinate support for families trying to access insurance from the perinatal period through adolescence

ESMs

ESM 15.1 - Develop at least one cross-agency agreement or policy developed to address insurance gaps for prenatal and child coverage.

ESM 15.2 - Percent of children 0-17 previously uninsured at baseline who are insured at period end, among Medicaid-eligible, insurance pool/high risk and private insurance populations.

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 21 - Percent of children without health insurance

State Action Plan Table - Cross-Cutting/Life Course - Entry 2

Priority Need

To increase and improve access to preventive dental care in pregnant women and children

NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Objectives

Increase the percentage of women who have a dental visit during pregnancy

Increase the percentage of children aged 1 to 17 who had preventive visit in the past year

Strategies

Apply a focus on systems building and theory-based clinical change to build an MCH primary care oral health care delivery model

Translate the California Evidence-Based Practice oral health guidelines to implement oral exams, clinical risk-based screening and management, patient education and referrals to dental providers in primary settings for pregnant women

Promote the importance of oral health via a state wide health education campaign

Work with the NM Pediatric Association to educate physicians as the first contact of children to promote oral health, increase the use of fluoride varnish and dental case management

Promote the development of inter-agency partnership that will champion and promote oral health programs and initiatives

Implement inter-agency partnerships to coordinate dental and other services.

ESMs

ESM 13.1 - Number of interagency partnerships implemented to coordinate dental and other services

NOMs

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM 19 - Percent of children in excellent or very good health

Measures

NPM-13 A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	46.9	48.3	49.6	51.0	52.0	52.0

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	45.6 %	1.4 %	10,957	24,011
2012	47.6 %	1.8 %	11,791	24,766

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NPM-13 B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives

	2016	2017	2018	2019	2020	2021
Annual Objective	82.7	84.3	85.9	87.5	89.2	90.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	81.1 %	1.5 %	389,669	480,550
2007	79.3 %	1.6 %	364,581	460,038

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 13.1 - Number of interagency partnerships implemented to coordinate dental and other services

Annual Objectives

	2017	2018	2019	2020	2021
Annual Objective	6.0	6.0	6.0	6.0	6.0

NPM 15 - Percent of children ages 0 through 17 who are adequately insured

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	82	84	85.7	87.3	89	90

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	80.4 %	1.5 %	386,077	480,422
2007	78.8 %	1.6 %	342,599	434,778

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

ESM 15.1 - Develop at least one cross-agency agreement or policy developed to address insurance gaps for prenatal and child coverage.

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

ESM 15.2 - Percent of children 0-17 previously uninsured at baseline who are insured at period end, among Medicaid-eligible, insurance pool/high risk and private insurance populations.

Annual Objectives					
2017	2018	2019	2020	2021
Annual Objective	50.0	55.0	60.0	65.0	70.0

Cross-Cutting/Life Course - Plan for the Application Year

MCH Epidemiology and Maternal Health Programs co-lead the activities associated with cross-cutting strategies. The first year of the action plan included the following activities identified through the needs assessment process:

Access to Care

Border health/cross-cutting priorities

1. Improve access to and navigation of health insurance coverage and resulting services; learn how ACA has

impacted the access and how navigation can be implemented
2. Increase prenatal utilization in the first trimester (and by adequacy index)
3. Improve linkages and referrals between existing health services to optimize primary and specialty or behavioral health and wrap around care; improve cross-border collaboration

Title V Programs Maternal Health and Maternal Health Epidemiology are responsible for partnering with US-Mexico area health organizations to continue the work of understanding barriers to health insurance, timely prenatal care and linkages between primary and behavioral/mental health care. There are unique challenges with regard to border residence. Although Mexico has nearly universal healthcare, families must have at least one officially employed member to access care. For those families who migrate between the US and Mexico this may not be the case, year round.

In addition, some families are still fearful or unfamiliar with accessing care in the United States even if they have legal citizenship. Therefore, NM Title V programs are in a position to help communicate insurance options through Public Health Office media, and by working with partners such as the First Step Clinic, Memorial Medical Center, La Clinica de Familia Healthy Start, Ben Archer Healthy Start and the Dona Ana County Health and Human Services Health Promotions.

NM has partnered with these organizations for over two decades through the NMDOH Office of Border Health and through the Title V programs. In the next year we will follow the recommendations gathered in the needs assessment stakeholder gatherings in July, 2014 and April, 2015. We have partnered in research and health promotions including a collaborative research project with the UNM Health Sciences Center for the Programa de Investigacion en Migracion y Salud from 2011-2013. These findings and stakeholder input over the last year led to the following recommendations:

Recommendations, solutions and action items

1. Present to and hear from the border communities on health priorities and solutions or strategies for the next 5 years; in particular survey families and clients to know if we are on the right track with our needs assessment and strategic planning
2. Expand perinatal doula programs and CHW capacity via DOH and local border health entities collective effort
3. Identify and assess the home visiting and case management models that work best within the existing health and human service environment for the region; evaluate existing evidence and literature to see how we can help finance or articulate the need for appropriate home visiting models

We are in the process of expanding the detailed strategies and objectives for the three broad recommendations to reach regionally and culturally or population-specific solutions for year two. The recommendations were originally derived based on needs assessment directed at the US-Mexico border region health systems and stakeholders, but there are many crossovers applicable to other regions and sub-populations. For example, directly evaluating the experiences of families and clients to confirm or re-direct our efforts is something we are doing statewide with perinatal case management, doula programs and in metro areas, as well as in the border counties. Based on the preliminary efforts, we have found that in addition to navigation of insurance options or most cost-effective healthcare access, women (in particular) may not be aware of options such as home births, which are covered by Medicaid in New Mexico. In addition, barriers to provider reimbursement complicate the solutions to opening these access points. Title V Programs are partnering with the March of Dimes, Young Women United, community-based health councils and the University of New Mexico to assess and strategize for improvements in access to well-woman/interconception care, reproductive life planning, and personal healthcare financing. Many of these partners on December 9, 2015 in a MCH strategic planning session for the Southern part of the state, an event which was

hosted by La Clinica de Familia Healthy Start in Las Cruces. That group meets quarterly and crosses all population domains in its representation of programs and outcomes of interest. We also updated plans to hold a statewide summit on prenatal substance use and neonatal abstinence syndrome, an epidemic which leaves every demographic of family, unscathed. Along with the Children Youth and Families Department, our agency has plans to address the drivers and poverty-related determinants of risks associated with drug addiction, especially among women of childbearing age.

For the plans associated with the Tribal Health needs assessment, the following activities were identified for the next year:

Tribal health/ cross-cutting priorities

1. Improve knowledge about insurance options among Native American families

2. Continue to expand and reinstate insurance navigation staff and outreach, statewide

3. Improve State agency (DOH, HSD) collaboration with tribal health entities including, but not limited to the Tribal Epidemiology Centers, Indian Health Services, Navajo Nation Department of Health and the Albuquerque Area Indian Health Board

We will continue to conduct focus groups and hold community input sessions in tribal communities and with organizations who serve Native American families. One of our objectives is to obtain direct input from tribal members on their current understanding of insurance options and find out if they share the same perceptions about barriers to insurance coverage as the organizations that may be serving them. In particular we plan to explore the process by which Native American families choose a Managed Care Organization or opt out. As a component of this research we will work with our internal Title V programs and the Health Promotions teams in the Five Public Health Regions to obtain family and consumer input.

The information will be collected according to population domain and interfaces well with the NM Dept. of Health SIM grant. The goals of the grant described elsewhere in the TVBG application include the following:

Enhancing patient experience of care, reducing health care costs, and improving population health – the Triple Aim approach to health system transformation – will result in improved health outcomes for all people in New Mexico. The state's vision of "A Healthier New Mexico" is informed by the following goals: (1) Aligning health care delivery with community activities that promote healthy behaviors and environments; (2) slowing the rate of health care inflation by bending the cost curve over time; (3) increasing the number of New Mexicans who have health insurance; (4) re-envisioning and building the state's healthcare workforce and infrastructure; and (5) using health information technology to fill critical information gaps, and support transparency and delivery system reform. New Mexico has already laid the groundwork for transformation through innovative efforts at the New Mexico Department of Health (NMDOH) and the New Mexico Human Services Department (NMHSD).

Stakeholder Engagement and Mobilization – This phase will focus on the Steering Committee and stakeholder organization. The Steering Committee is expected to meet for the first time during this phase, develop a process for Model Design activities, establish a communication framework, and begin to identify key stakeholders to address targeted issues. These stakeholder focus groups will address the vision of "A Healthier New Mexico" by targeting health outcomes at all life stages, and the intersection of public health and health care. The focus groups will be directed at: • Child Wellness, Adult Wellness, and Older Adult Wellness • APCD Design Internal Planning and Goal Setting Stakeholder Engagement and Mobilization Model Design Financial Analysis Finalize Design Requirements Implementation Planning 3 • PCMH Strategies • Health Information Technology • Community Health Workers and Community Paramedicine • Payers and Providers • Long Term Care Existing indicators and performance measures from NMDOH and NMHSD will be used as a baseline, and stakeholder feedback on refining or finding alternatives to these indicators and measures will be a key activity. The overarching goal during this phase is to conduct statewide

stakeholder meetings and community education around the process, initial goals, and vision. The goals of the SIM stakeholder meetings are cross-cutting and life-course driven. This gives Title V programs the opportunity to continue the MCH needs assessment work and measure against new findings and recommendations over the next five years.

In addition, NM will build on various early childhood (birth to 3 years) investment zones developed in several contexts to understand how we can optimize our existing efforts, expand them and improve shared resources to impact the same or similar outcomes of interest. For example, the WK Kellogg Foundation, the McCune Foundation and the Con Alma Foundation are all interested in optimizing birth outcomes, preventing adverse events and setting population targets to assure the best possible outcome on a variety of events. For the birth target population we will use the following measures as shared metrics, in addition to those identified further down the road.

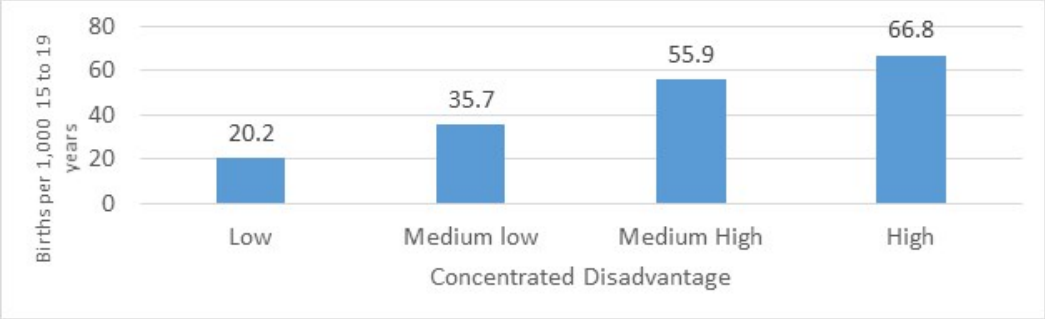
- Percent of births to first time mothers
- Percent of births to single mothers
- Percent of preterm births
  (Less than 37 weeks)
- Percent of women who received
  'low' or late prenatal care
- Percent of women who breastfeed at least six weeks, two months, six months, and one year

Many or our findings regarding Native families or vulnerable families throughout the state are similar with regard to access. The age groups which struggle to maintain adequate levels of insurance are cross-cutting. Therefore, the activities in the following year will remain in a life-course and life-span framework. As part of our years two and three Title V plans, we have established a sampling plan with 26 New Mexico Tribes to conduct a parallel, tribe-specific PRAMS surveillance with Navajo Nation and with the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC), to begin in 2016. Agreements and data sharing plans were signed with both Tribal Epidemiology Centers and the Department of Health to assure a long-term, collaborative surveillance plan which builds in capacity sharing, resource/cost sharing, and community participatory research.

Health Equity and Lifecourse metrics

The New Mexico Department of Health MCH Epidemiology team participated in a Technical Assistance opportunity (AMCHP, 2015-2016) on Life Course Indicators which reinforced the need to understand the upstream contributors to health disadvantages. NM is a post-colonial state with a population grappling with health inequities due to historical trauma[i] and loss of connection to traditional knowledge. Today, Native American and Hispanic communities experience pejorative health conditions and well-being. Historical trauma calls for continuous interventions and dedicated resources towards healing in order to remedy past atrocities and advance health equity among all women, their infants and families. Adverse Childhood Experiences and stress events which people of color disproportionately bear must be understood before we can effectively terminate discrimination in healthcare, limited access or utilization of care among minority populations, or improve the experiences of families living in areas of concentrated disadvantage. We, therefore, propose to address the social determinants of perinatal outcomes in order to promote equitable opportunities for achieving health and well-being among families. Racism and historical trauma can be addressed directly and within community conversations to understand birth outcome disparities, given the appropriate data and community engagement resources. Our recent descriptive analysis geocoding births by quartiles of concentrated disadvantage reflect important relationships between socio-economic conditions and birth outcomes. As an example, teen birth rates are three times higher in geographies of high social disadvantage compared to those in the lowest quartiles of concentrated disadvantage. This indicates there is a community-related aspect to early child-bearing rather than, or in addition to individual behaviors (Fig. 1) (additional data in data appendix).

Fig. 1 Births to teens 15-19 years, by Quartiles of Concentrated Disadvantage, 2011-2013



The New Mexico Department of Health (NMDOH) has made health equity a priority in the state's strategic plan for fiscal years 2014-2016. The goals are to reduce health disparities due to characteristics such as race/ethnicity, limited English proficiency, disabilities, sexual orientation, gender identity, economic status, and geographic location. New Mexico Title V team members understand the multi-factorial nature of addressing heath inequities with regard to social environment, determinants of health and socioeconomic disadvantage. We have actively engaged with partners in the analysis and policy development to address these determinants at the neighborhood level and within a health and policy systems framework. The Title V team brings together individuals from the NMDOH Family Health Bureau (MCH Epidemiology, case management, Children's Medical Services, Family Planning/Title X, and WIC, Office of Oral Health, Adolescent Health), community-based organizations, and community members who have experience in maternal and child health and have a passion for reducing adverse health outcomes in the community. The diverse team skills include policy development, community engagement, program evaluation, and data analysis and epidemiology. This team also leads the infant mortality Collaborative Improvement and Innovation Network (CoIIN) for NM involving participation from the New Mexico Public Health Association (NMPHA), the New Mexico Alliance of Health Councils, the NM March of Dimes, the NM Health Equity Partnership, Young Women United, and the Office of African American Affairs/Centering Pregnancy pilot. We have convened a sub-group to focus entirely on health equity in birth outcomes over the next year.

[i] Historcial trauma is defined as the cumulative emotional and psychological wounding, extending over an individual lifespan and across generations, caused by traumatic experiences. Intergenerational traumas have been caused from the removal of children from families and forced into boarding schools, genocide, raping of women, oppression and violence, dislocation of families and communities from their land and birth homes, culture and language loss due to forced assimilation.

Oral Health

In 2015, the University of New Mexico (UNM) received a grant to improve perinatal and infant oral health in New Mexico. This gave birth to the New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The priorities of the UNM oral health project correlated heavily with the Title V Oral Health related priority to increase and improve access to preventive dental care in pregnant woman and children. Consequently, a partnership has been formed between UNM and Title V to collaborate. Title V will collaborate with UNM on common strategies.

UNM and the Maternal Health program (MHP) will partner with at least one program impacting targeted pregnant women such as WIC, Healthy Start, or home visiting program, with broad geographic reach that will incorporate

targeted oral health messages into routine business activities.

UNM and MHP will develop, adopt, or improve operationalization of at least one pregnant woman-centered policy and/or practice at the state, clinical system, health plan, or dental hygiene school curriculum level that helps to improve access to or quality of oral health care for those populations.

The Office of Oral Health (OOH) will continue collecting 3 grade data and report the data. OOH data reflects state staff and contractors providing dental sealants to 3 graders. Medicaid data reflects those Medicaid patients that have received a dental sealant through a Medicaid Provider.

OOH will continue it partnership with the NM Primary Care Association to promote the application of both dental sealants and fluoride varnish among the Federally Qualified Health Centers and community clinics in NM. Increasing the use of sealants/varnish by all public providers is critical since they serve urban/frontier NM children.

OOH will continue to work very closely with the NM Pediatric Association to educate physicians as the first contact of children to promote oral health, increase the use of fluoride varnish and dental case management. OOH has attended the annual NM Dental Association Conference to promote the use of preventive services in the daily practice of private dentists (dental sealants/fluoride varnish).

Cross-Cutting/Life Course - Annual Report

Within the 2010-2015 Title V Block Grant there were no activities that directly involved this population domain.

Other Programmatic Activities

New Mexico is in the process of evaluating perinatal and early childhood (0-3) outcomes for families participating in home visiting. There are several different models of home visiting offered in New Mexico, and they vary in terms of eligibility criteria or population demographics. Title V has a unique role to facilitate some coordination and complementary referral processes with the various home visiting models and pilot programs. Therefore, as a first step, we will use PRAMS surveillance and CYFD home visiting data to evaluate, on a large scale, differences in health outcomes among women and families participating in home visiting compared to those not accessing those services, adjusting for participation status in public health programs such as WIC and perinatal case management. In a more robust long-term method we will also utilize results from New Mexico's first toddler survey (follow up to PRAMS) to evaluate outcomes longitudinally.

In July 2016, the Maternal Health Program held its inaugural meeting of the Maternal Mortality Review Committee with approximately 25 persons attending and representing birth providers, birthing hospitals, Indian Health Service, the Office of the Medical Investigator, health care entities from the US-Mexico Border, the NM Hospital Association, the NM Perinatal Collaborative and the NM Department of Health. The convening was to present on current status MMR review in the state and gain support for future participation in the MMR process moving forward. Another meeting is planned for October 2016 where a draft of methodology and step-wise process for the MMR process will be presented to the group. Since then, other related developments have started or are continuing to progress:

- The Centers for Disease Control's Reproductive Health Division will be making a technical assistance visit to the state later in October 2016 to train a core team of personnel on chart abstraction, data entry, case summary and preventability analysis using the CDC-developed Maternal Mortality Data System (MMRDS, now retitled to MMRIA or Maternal Mortality Review Information Application).
- A work team has drafted revision wording to the existing admin code on MMR (1998 NM law) which improves the sections on non-disclosure, confidentiality and access to records. The plan is to seek adoption of these changes in

the 2017 state legislature session.
• The NM Department of Health, the University of NM and a national expert on Maternal Mortality have also been invited to speak to the NM State Legislature Health and Human Services Sub-committee in late October to present on the topic and the work going on nationally and in the state.
• The Maternal Health Program is also involved in the creation of a technical report sponsored by the US-Mexico Border Health Commission that will present a situational analysis on maternal mortality along the border using aggregate data on representative cases, as well as discuss and compare MMR methodology as utilized by domestic border states and the corresponding Mexican states along the border. The report will give recommendations to the Commission on how to conduct MMR review along the border which will help to identify key areas of future planning and coordination between the two countries for addressing the health needs of the maternal population along the border.

II.F.2 MCH Workforce Development and Capacity

Title V Director's Office

The Family Health Bureau houses 10 separate programs. The Bureau Chief/Medical Director/Title V Director, Dr. Janis Gonzales, oversees all programs &works with each of the 8 program managers for direct oversight of each program. Dr. Gonzales is Board Certified in Pediatrics and in Hospice &Palliative Medicine, and has a Master's Degree in Public Health. She previously spent 9 years in private practice &then worked in hospice and in Early Childhood Developmental Screening before joining CMS. She also had a daughter with special needs. Dr. Gonzales serves as the AAP Chapter Champion for the EHDI program and works closely with the newborn hearing screening coordinator and served as Medical Director for CYSHCN in New Mexico. She served as the CMS Medical Director for 5 years and as the Family Health Bureau Medical Director for the past 2 years. She was promoted to Title V Director in Feb. 2015.

Maternal & Child Health, Title V Funded Staff

Katie Avery, RN, CNFP is the Maternal Health Manager, responsible for the High Risk Prenatal program, Midwife Licensure &Regulation & the Maternal Health program. The Child Health Manager, Gloria Bonner, is responsible for the Early Childhood Comprehensive Systems (ECCS) Grant & program activities that focus on child health with a focus now on developmental screening. Health Educator, Diane Dennedy-Frank, MSW, assists with segments of the ECCS grant & the child health component of the program including training on Ages and Stages Questionnaire tools. She also assists the Maternal Health Program Manager with special projects. The clerk specialist position that supports the Maternal & Child Health (Title V funded) staff in an administrative and financial capacity was vacated in December 2015, and restricted from re-filling during a department-wide budget restriction period. Amber Montoya, in a new position as financial specialist for the Family Health Bureau, has continued to assist in-kind but it is anticipated that the position will re-open for posting and hiring in summer 2016.

The Families FIRST Program is revenue driven program obtaining reimbursements negotiated through Managed Care Organization (MCO) contracts & Medicaid (JPA). Maureen Burns, Program Manager, supervises 5 state staff & provides oversight of 4 Regional Coordinators, 24 Care Coordinators, & 5 Clerks. Bonnie Hargrove, Registered Nurse Consultant, provides programmatic direction to 4 Regional Coordinators. She also monitors the Families FIRST Provider network & provides oversight of quality improvement for the perinatal case management population. Care Coordinators provide care coordination for pregnant women & children, assist clients with Presumptive Eligibility/Medicaid On Site Application Assistance (PE/MOSAA) & the MCO process. They also assist with establishing medical homes, community resources & referral networks. Families FIRST Care Coordinators are located in 23 sites throughout the state. Regina Sena, Management Analyst, maintains financial processes & budget operations. Jessica Tapia, Medical Secretary, maintains client & claim-processing databases.

CYSHCN Children's Medical Services

Ms. Susan Chacon, LISW is the Title V CYSHCN Director. Ms. Chacon has 10 years of program management within the Maternal &Child Health Program. The Title V CYSHCN Director position is the Statewide Program Manager for Children's Medical Services, under which fall the CYSHCN Program, The Multidisciplinary Specialty Outreach Clinic Program; the Newborn Genetic Screening Program; the Newborn Hearing Screening Program. Dr. Janis Gonzales remains as the CMS Medical Director since 2008.

The state office staff consists of the Title V Statewide CYSHCN Program Manager, two nurse consultants who work with Newborn Genetic Screening Ms. Brenda Romero and Carla Oritz, a Newborn Hearing Screening Coordinator whose position is funded by a HRSA/MCHB grant (currently vacant), a clinic coordinator Executive Secretary Michelle Quintana, a financial specialist Mary Lewis, a training &development specialist Elaine Abhold, Finance Manager Paul Frey and general clerk Lydia Sanchez A second financial specialist position is vacant. The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, regional program managers &key state office staff. The management team meets monthly to review policy issues related to the implementation of the CMS programs.

Ashley Galloway was hired as the Newborn Hearing Screening Coordinator in November 2105. She has a Master's in Public Health and several years of experience coordinating Public Health programs. Kaye Martin was hired in the Spring of 2016 to support the state office administrative duties. Elaine Abhold retired November 2105 and this critical position has remained vacant until May 2016 with the promotion of Michelle Quintana into this position. The CMS staff in the Public Health offices consist of regional program managers, social work supervisors, social workers, clerks and nutritionists. Fully staffed CMS is about 80 personnel. The program continues to struggle with hiring and filling hard to recruit positions and staff continue to travel to other counties in the State to cover vacant caseloads.

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

Maternal & Child Health Epidemiology

Currently, there are four epidemiologists, a data manager, two data collection staff and a program clerk. Eirian Coronado, MA, MPH candidate, coordinates the PRAMS survey and is the Program Manager. Christopher Whiteside MPH, coordinates the Title V grant & Needs Assessment. He also coordinates and leads New Mexico in the Collaborative Improvement and Innovation Network to prevent infant mortality. Christopher was hired in Sep. 2014. Garry Kelley, MPH provides advanced analytic support for the CMS and WIC programs. Garry was hired in May,2014. Glenda Hubbard, MPH, RN, is the PRAMS analyst and SSDI data linkage project director. Glenda was hired in June, 2015. Dorin Sisneros is a data manager and provides fiscal oversight to the program. Nicole Hernandez and Angelica Romero provide survey data collection, data entry and general program support to MCH Epidemiology, CMS, the ERD Asthma Program. Nicole was hired in June, 2015. The CMS program works in collaboration with the MCH Epidemiology program in data collection & analysis of the newborn screening program.

The Family Planning Program (FPP):

The Program Manager Susan Lovett in the State Office manages the statewide Family Planning Program including oversight of budget, personnel, and Federal Grant requirements. Dr. Wanicha Burapa is the Medical Director.

Other Workforce capacity:

There is a new MCH certificate program through New Mexico State University that is designed to help increase capacity in the MCH workforce. The Graduate Certificate program is designed for MCH professionals working in rural, border and under-served populations and can lead to a Masters of Public Health.

II.F.3. Family Consumer Partnership

New Mexico will continue established family consumer partnerships while creating new partnerships for the application year. Our partner agencies and advocacy groups represent families and family consumer partnerships formed before and during the ongoing Needs Assessment process.

Children's Medical Services has a family-centered approach to care coordination, including involving youth in transition planning for the state Children and Youth with Special Health Care Needs (CYSHCN) Program. CMS makes direct referrals to family support organizations for family-to-family connections. This includes referrals to Parents Reaching Out (PRO), Education of Parents of Indian Children with Special Needs (EPICS), the family liaisons from the NM School for the Deaf (NMSD), and family guides through Hands & Voices for children deaf or hard of hearing. The Cleft Palate clinics employ a family support agent who is available to families during the clinic. CMS sustains family participation in the Maternal and Child Health (MCH) Collaborative, NM Interagency Coordinating Council (ICC), Newborn Hearing Screening (NBHS) Advisory Council, Early Hearing Detection and Intervention (EHDI) advisory group and the Association of Maternal and Child Health Programs (AMCHP) annual Conference. CMS recruited a parent representative to join the Newborn Genetic Screening Advisory Council, which includes participation in the Mountain States Regional Advisory Collaborative. Family Organizations are invited to provide input into the CYSHCN Program activities and the Title V Block Grant during scheduled MCH Collaborative meetings.

CMS contracts with and provides funding to family organizations to ensure that families who have children with special needs have input into programming and serve in an advisory role regarding policy. The funding also supports family participation in local, State and National meetings/conferences and provide training for staff/families. Funds from the CMS program support an annual family leadership conference sponsored by EPICS and PRO where over 400 families who have children with special needs gain new skills, support and resources.

Contracts were maintained with family organizations PRO and EPICS to support their annual family leadership conferences. A family consultant was hired to review and critique the newborn hearing screening education material. Susan Chacon, the CMS Program Manager participates as a member of the stakeholder committee for the National Parent and Professional Partnership organization through Family Voices. Contracts were also maintained with Hands & Voices to support the work they do with families who have a child that is deaf or hard of hearing. The contract also funds (2) parents to attend the annual EHDI meeting. CMS sponsored a parent to attend the AMCHP annual conference but with the conference being rescheduled the parent representative could not attend.

The Early Childhood Comprehensive Systems (ECCS) State Team includes members from parent advocacy organizations as well as parents of our target population. During this grant year, formative research was conducted in order to gain insight into the values, barriers, and motivators of parents of young children and assess their informational needs regarding child development and child well-being. The research activities included written surveys with parents and professionals (childcare workers, early childhood educators, health providers) and focus group interviews with parents of children 0-3 in various communities around the state.

The Office of School and Adolescent Health (OSAH) with the Title V Epidemiologist and UNM staff conducted focus groups with teens to ascertain their ideas and priorities around adolescent health. This was coupled with findings from a large consortium of youth called OYE (Organizing Youth Engagement), which is convened by NM Forum for Youth. The May 15th OYE summit included the Public Allies, NM; Youth Alliance; and Forum Network.

Title V programs have strong ongoing collaborations with partnering agencies, such as Medicaid/Human Services Department and parent advocacy groups. We participated in Action Learning Collaboratives to improve birth outcomes with Dona Ana County Healthy Start/La Clinica de Familia sites, Medicaid's Medical Assistance Division, and CYFD home visiting programs throughout the state. We have partnered with the Las Cruces and Deming Healthy Start Sites for focus groups to gain input from families over the last ten years. Specifically, input has been

gathered from clients' families in Healthy Start to understand barriers to prenatal care, address mental health and postpartum depression, to learn about awareness of the need for preconception folic acid, and to help improve services to the MCH population in the US-Mexico border communities and colonias. Healthy Start programs participate in the PRAMS Steering Committee, an Action Learning Collaborative on optimizing healthcare reform and in the statewide perinatal collaborative, initiated in 2013.

The Families FIRST program obtains a Client Satisfaction Survey from our clients. The surveys contain the following two questions which are used by the program to evaluate and improve the services that we provide to our clients.

• Tell us what you liked about the Families FIRST program

• Tell us what you did not like about the Families FIRST program

The NM WIC program obtains an annual Client Satisfaction Survey from WIC participants. The survey sometimes varies from year to year, but contains questions which are used by the program to evaluate and improve the services we provide to participants. The program obtains an opinion survey from Breastfeeding Peer Counselors, who are current or past WIC participants, approximately every other year to include their voices in needs assessment and evaluation of the services provided by WIC. Strong collaborations are ongoing with the NM Breastfeeding Task Force, an advocacy coalition representing families and family consumer partnerships. This information is analyzed and shared with the WIC regional managers. We then agree to an action plan on how to improve the client's experience.

The NMDOH has held tribal health fairs for the last three years to formalize health promotion, knowledge sharing and collaboration among the majority of American Indian tribes in New Mexico.

Throughout the Needs Assessment process, family and consumer partnerships were established through focus groups and surveys. Family/consumer stakeholders are assured a voice in the Needs Assessment process in addition to being given opportunities to give input on the state’s selected priorities.

II.F.4. Health Reform

Although the ACA brought several welcome changes to NM, including Medicaid expansion for low-income adults and a 24% decrease in the uninsured rate from 2013 to 2014, there are signs that things are still unsettled and that we may start to see regression or reversal of these trends in the near future. Over 850,000 NM residents were covered by Medicaid as of Feb. 2016, which is over a third of the state population. However, due to the decrease in federal match over time, Medicaid had a budget shortfall of over $80 million in state general fund for FY17. The legislature approved less than half of this amount, due to declines in oil and gas revenues impacting the state budget; therefore, the Human Services Department is proposing cuts in provider rates beginning Aug. 1, 2016. For DOH, like other providers, the impact would be that Medicaid revenue generated by clinical services provided in the public health offices would be cut by 4%. More concerning, however, is the prospect that we may lose Medicaid providers in the state (when we already have huge provider shortages) or that some providers may impose tighter limits on the number of Medicaid patients they will take in their practices, which would impact access to care for the most vulnerable populations.

NM has a Health Insurance Exchange (HIX) that was developed as a state-federal partnership, utilizing the federal portal (HealthCare.gov) for individual enrollment and the NM portal (BeWELLNM.com) for the state-run Small business Health Options Program (SHOP) exchange. Over 54,000 people enrolled in private plans through the NM HIX during the 2016 open enrollment period, including renewals and new enrollees. This is an increase of nearly five percent over the 52,358 people who enrolled during the 2015 open enrollment period. The HIX has struggled somewhat as claims have been higher than anticipated and they have had difficulty getting young healthy people to sign up, in spite of the dedicated outreach being done to this population.

In the summer of 2015, Blue Cross Blue Shield of NM filed a proposal to increase premiums for 2016 by an average of 51.6%, citing losses that were not fully covered by the risk adjustment mechanisms put in place by the ACA. BCBS of NM did receive far more in reinsurance and risk adjustment payments than the other NM carriers, based on 2014 claims (nearly $25 million, compared to the three other carriers who received a combined total of $11 million). But in early August, the Office of the Superintendent of Insurance (OSI) denied the proposed rate hike, stating that the data submitted with the rate proposal didn't justify a rate increase of more than 24%. BCBS pulled out of the individual market (with the exception of one bronze level HMO plan), leaving the HIX without any PPO plans for individuals. This is a trend nationwide, in an effort to keep premiums affordable. But the off-exchange HMO plan had very few enrollees in 2015, so the vast majority those covered by BCBS's individual market had to switch to new coverage for 2016. Half of the people who were enrolled through the HIX in 2015 were on Blue Cross Blue Shield plans, so assistors and navigators were scrambling during the open enrollment period to move those people to other plans. In July 2016, Presbyterian Health Plan announced that it would not be offering individual or family plans on the HIX in the coming year. This will limit the choices in the Exchange and likely make it even more unstable as the burden of claims falls on fewer carriers.

NM Health Connections, one of the four carriers expected to offer plans for 2018 in the NM HIX, is a CO-OP (consumer oriented and operated plan) established with funding provided by the ACA. By March 2015, total enrollment in NM Health Connections had reached nearly 40,000, and by February 2016 enrollment had grown to over 50,000 members. However, its long-term viability continues to be in question, since NM Health Connections by law has to offer plans on the HIX, while other insurance carriers have a choice to pull out if they feel it is not financially viable.

The NM Medical Insurance Pool (NMMIP), the state's high risk pool, continues as a safety net insurance provider for some of the sickest New Mexicans although it has shrunk from over 8000 members to approximately 3200 after the ACA opened up other options for those who were previously uninsurable. The NM DOH HIV Services Program assists eligible clients with access to health insurance through the Program's Insurance Assistance Program (IAP). This program assisted 227 clients to enroll in NMMIP during the state fiscal 2015. Children's Medical Services utilizes the Pool as well to provide insurance coverage for children with high-cost conditions - such as cancer, cleft lip and palate, or cystic fibrosis - whose families are low-income and who are not eligible for Medicaid (mainly due to their undocumented immigration status). In Dec. 2015, approximately 100 of these children who had been moved to BCBS individual plans had to be moved back onto the Pool when BCBS canceled the plan. Luckily the Pool was there to accept them, because at the time no other carrier was willing to offer them coverage. The CMS program currently has 139 clients on NMMIP. The continued existence of the Pool is uncertain, which is causing concern among those who depend on it for coverage. Not only is the Pool currently the sole source of access to insurance for these clients but it also is a financial benefit to the DOH and the healthcare system as a whole. It is much less expensive for DOH to pay the insurance premiums than to try to pay the medical claims for the clients. CMS pays an average of $5000 per client for the premiums and co-pays but would pay at least three times that per client if the Pool was not available. In addition to the premiums, which do not cover the claims costs, the Pool is financed by assessments on the insurance carriers. These assessments are offset somewhat by tax credits. During the 2016 Legislative session the Legislative Finance Committee recommended closing the Pool so that the tax credits would no longer need to be given to the carriers and that money could be used to fund the Medicaid deficit. No legislation to close the Pool was proposed during the 2016 Session but we are concerned this will be a recurring issue in future Sessions.

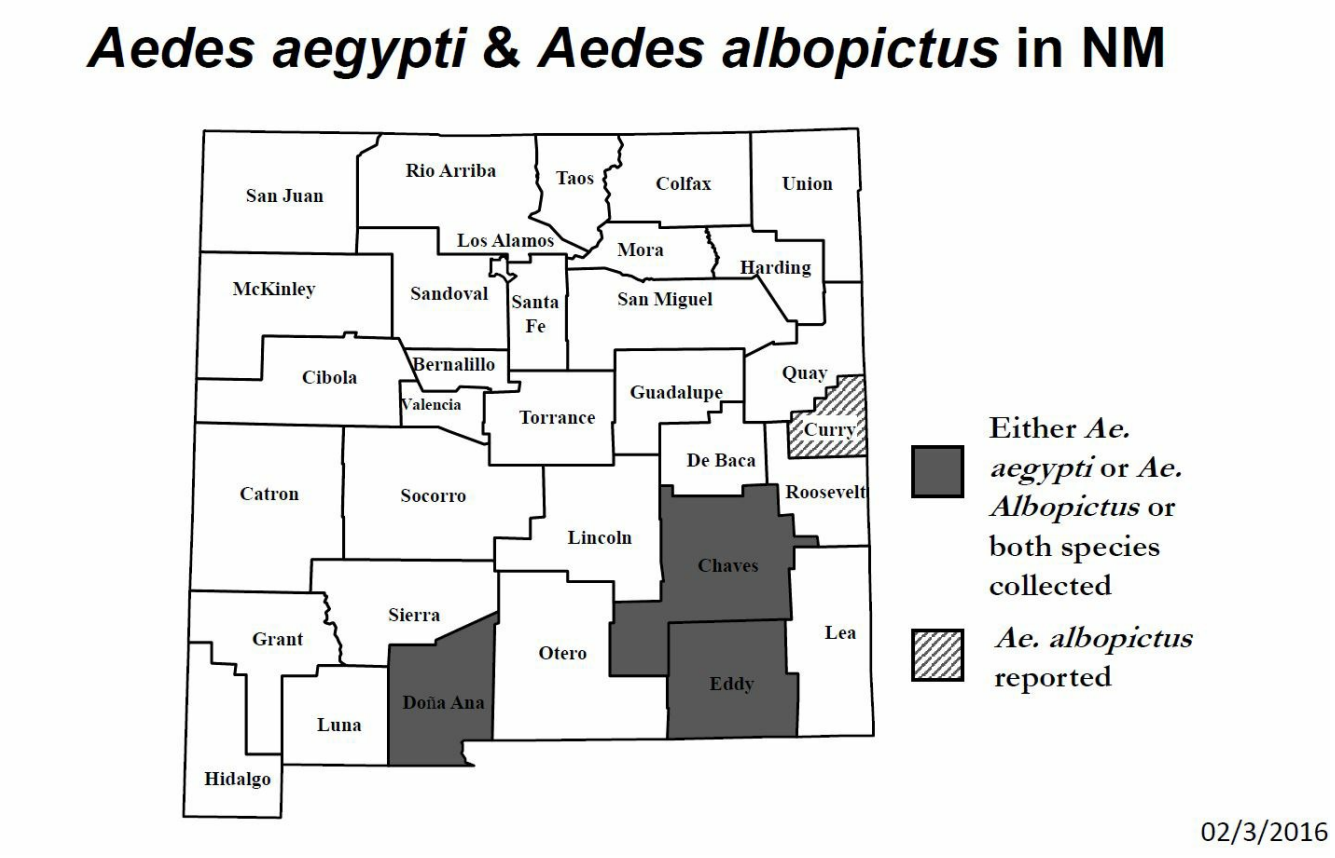
Although the percentage of uninsured people in NM has decreased from 20.2% in 2013 to 13.1% as of June 30, 2015, there were still 233,000 uninsured NM residents in 2015. Of these remaining uninsured, 47% are Medicaid eligible, 13% are tax credit eligible, and 40% are ineligible, according to a recent Con Alma Foundation report. American Indian/Alaska Native Children are the most vulnerable with 22% uninsured, followed by Hispanic/Latino

children at 9%. The uninsured rate is likely to rise in 2017 as NM residents are increasingly unable to afford the cost of premiums, especially when deductibles, copayments and out of pocket expenses are figured in. Undocumented immigrants will remain largely uninsured as they are not eligible for Medicaid or for subsidies on the HIX, and even if they could afford off-market plans, most of the carriers up to now have been denying coverage to undocumented residents.

II.F.5. Emerging Issues

Zika Virus

The current Zika outbreak that is happening in many countries and territories is of concern here in New Mexico as well due to the potential impact and risk of adverse maternal outcomes. The two mosquito species in the United States that can transmit Zika virus have been found in some parts of southern New Mexico. If a person gets infected with the virus while in an area with Zika virus transmission and then goes to a part of New Mexico where *Aedes aegypti* or *Ae. albopictus* mosquitoes are present, those mosquitoes could become infected with the virus by biting the infected person and could then spread the infection to other people they bite. The Family Health Bureau is working with others in PHD and DOH (including in the Epidemiology and Response Division and the Bureau of Emergency Management) to develop a state plan for Zika. FHB staff from various programs will be very involved in the outreach to the maternal and child population, especially the outreach to pregnant women. FHB staff also collaborated with the Epidemiology and Response Division's Birth Defects Program on a CDC grant application directed at developing a pregnancy registry for Zika cases. CMS social workers will be intimately involved in the identified infant cases as care coordinators and will make referrals to other agencies (such as Part C) and linkages to Medical Home.



New Mexico has had 3 reported cases of Zika virus disease. Of those, all 3 were in travelers who were infected abroad and diagnosed after they returned home.

Case Counts by County:

- Bernalillo - 2
- Chaves - 1

Neonatal Abstinence Syndrome

New Mexico continues to see a steady rise in prenatal opioid use and neonatal abstinence (withdrawal). The rising prevalence of maternal opioid use is demonstrated by hospital discharge records revealing a nationwide increase in NAS from 1.19 to 5.63 per 1000 births per year from 2000 to 2009. In 2012, an estimated 5.9% of women nationwide aged 15 to 44 years used illicit drugs during pregnancy. Marijuana use is most common, followed by prescription opioids and, less commonly, stimulants, heroin, and psychotropic drugs. The epidemic abuse of prescription opioids and continued heroin use have increased the rates of Neonatal Abstinence Syndrome (NAS) from 1.2 per 1000 births in 2000 to 3.4 per 1000 births in 2009, with an estimated 1 newborn per hour born with NAS in the United States in 2009. In New Mexico NAS diagnosis at hospital discharge increased from 1.3 cases per 1,000 live births in 2000 to 8.8 per 1,000 in 2014. In at least two counties the rate is as high as 58 cases per 1,000 live births increasing from 35 per 1,000 in 2013. As a result, New Mexico is trying to understand some of the preconception and prenatal drug use through the PRAMS survey and added questions in the 2013 data collection. The data have not been released by the CDC, but will be available over the next five years for monitoring..

Health care spending for pregnancy complications related to illicit drug use during pregnancy and related neonatal outcomes has increased from an average of US$39,400 per NAS hospital admission in 2000 to $53,400 in 2009, with 77.6% of these charges attributed to state Medicaid in 2009.The length of stay for NAS averages 16 days and has not significantly changed during this time. According to a recent survey, only about half of neonatal intensive care units (NICUs) in the United States have a written protocol for the diagnosis and management of NAS, which represents an important area for educational improvement.

New Mexico's rate of opiate overdose death leads the nation. The University of New Mexico (UNM) reported a doubling in volume over the last 3 years of women cared for in the Milagro program located in Albuquerque, NM (prenatal care for women with addictions). Over 180 women with opiate addiction delivered babies at UNM last year. In addition, the South and Southwest regions have the largest estimated opioid-dependent treatment gap in the nation. 70.3% of the population of New Mexico lives in rural or frontier counties, where treatment of opiate use disorder may be far less accessible and rural hospitals may have less experience managing neonatal abstinence syndrome.

A newly formed Perinatal Collaborative in NM (2013) chose NAS as one of four areas of focus (the others being early elective deliveries, maternal mortality/hemorrhage, and increasing the availability and use of LARCs). In 2015 NMDOH applied for a small AMCHP grant which we are planning to use to assess current hospital practices around NAS with regards to training of staff and protocols for treatment. In addition, the March of Dimes in NM has chosen NAS as its area of focus for 2015. The March of Dimes supports policy initiatives aimed at providing care for mother and baby which include the following elements:

•Access to comprehensive services: Pregnant women who abuse drugs, such as opioids, should have access to comprehensive services, including prenatal care, drug treatment, and social support services. These women often have other psychosocial risk factors that need to be addressed in order to ensure they successfully stop abusing drugs.

•Priority access and flexible treatment: Drug treatment programs should be tailored to pregnant or parenting women,

taking into account the woman's family obligations, and should provide priority access to pregnant women.

•Immunity during prenatal visits: Research has shown that obtaining prenatal care, staying connected to the health care system, and being able to speak openly with health care providers about drug use creates a healthy environment for mothers at risk of drug abuse to seek treatment that can improve birth outcomes.

•Provider Education: Provider education and public awareness efforts can increase the patient-provider discussion on the risks and benefits of various medications, including opioids, and potential risks to the unborn child. Additionally, providers should be educated on the most updated substance abuse screening tools and the standard of care for all obstetrics patients.

NAS education and protocols are crucial to addressing this problem in our state, and addiction relates to several priority areas identified in the needs assessment: child maltreatment and neglect, access to behavioral and mental health, teen pregnancy and births, and bullying, depression and suicide. NAS is a cross-cutting, emergent issue which ties into our life-course strategies to address Title V priorities within a systems framework. It requires a long-term, multi-disciplinary approach to assuring access to healthcare and treatment for families in New Mexico.

II.F.6. Public Input

New Mexico has made many efforts to open dialogue and include community members in many aspects of the five-year needs assessment and Title V plans for 2016-2020. Domain groups and the Assessment leadership engaged with the Public Health Regions and Community Health Councils to solicit input on DOH health priorities for Maternal Child Health. Chris Whiteside, Title V Epidemiologist, worked consistently with the Regional and Community Epidemiologists to compile a County-level MCH health profile for input starting in November, 2014. We met with the NMDOH tribal epidemiologist, Samuel Swift, the NW Regional Epidemiologist, Kelly Gallagher, and SE Regional Epidemiologist Ervin Garcia, several times to consolidate data and agree on topics potentially valued by community and tribal health councils. The profiles were released and shared with communities in March, 2015. The MCH Epidemiology staff then followed up gathering input from the statewide alliance of community health councils and at the New Mexico Public Health Association. The profiles are a living document which can be tailored to each county or small area, depending on statistical stability, and can be updated each year. We felt this was an important part of obtaining input early on because the county health councils represent and feed from a wide variety of community stakeholders in each county. Participants range from medical professionals to parents to school staff and health-related organizations working on many different initiatives. In New Mexico we have a centralized Health Department but our Public Health Regions are rural, expansive and diverse, both geographically and demographically. It is important that we connect to communities as much as possible in our planning stages, action-strategic design, implementation, and evaluation over the next five years. It is also paramount that we interact with tribal leadership and regional leadership as much as possible to align our goals and objectives across jurisdictions. Therefore, public input includes the continuous engagement with Navajo Nation, Albuquerque Area Indian Health Board and family advocacy groups, including those not always in our usual stakeholder communications.

Each domain group will distribute the final block grant and/or Executive Summary to stakeholders and requested input, specifically on the state selected priorities, the state performance measures, evidence or informed-based strategy measures and action plan for the application year. All existing public input will be compiled and summarized prior to grant submission. We will post the block grant on a page of the NMDOH Health website and agency-sponsored Facebook for feedback from the public. Our population domain groups will also share the developed action plans directly with stakeholders to assure we were articulating plans which reflected their initial input and brainstorming. As a result of these activities, most of the action plans were updated prior to the final updates to the block grant. We will continue to meet quarterly within the Family Health Bureau executive committee to assure we are

continuously working with stakeholders and engaging with public input processes over the next five years. This will allow us to address emerging issues and to follow up on or modify our action plans throughout the year.

Specific plans for the coming year include working with the NM Pediatric Society, the March of Dimes, Medicaid/Human Services Department and the Department of Health leadership to engage and interact with ongoing community health assessments conducted throughout the state. In particular, we are working with the University of New Mexico and the NM Alliance of Community Health Councils to assess community understanding of the ACA insurance options and how that relates to the Title V priorities over the next several years.

II.F.7. Technical Assistance

New Mexico is requesting technical assistance regarding ACA implementation and analysis of gaps in coverage for the maternal and child health population. We are asking for models and experts to guide us in how to best track and record this information to assure access to care for vulnerable populations in New Mexico. Additionally the State would like assistance completing the ACA Title V State Access to Care tool provided by the National MCH Workforce Development Center.

New Mexico would also like assistance with its CoIIN efforts, specifically enhancing its data linkages and geospatial analysis capabilities.

Behavioral health was identified as one of our MCH priority needs however strategies were difficult to implement and develop due to a broad definition and a lack of information and resources.

III. Budget Narrative

	2013		2014	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,359,436	$3,796,901	$3,812,187	$3,606,780
Unobligated Balance	$0	$0	$0	$0
State Funds	$3,579,742	$7,816,811	$3,087,900	$6,575,915
Local Funds	$0	$0	$0	$0
Other Funds	$6,523,648	$0	$0	$0
Program Funds	$3,200,400	$3,200,000	$0	$4,653,306
SubTotal	$17,663,226	$14,813,712	$6,900,087	$14,836,001
Other Federal Funds	$74,910,268	$49,174,523	$82,886,700	
Total	$92,573,494	$63,988,235	$89,786,787	$14,836,001

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,006,215	$3,783,840	$4,048,292	
Unobligated Balance	$0	$0	$0	
State Funds	$7,264,811	$6,669,159	$6,675,779	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$0	$6,501,745	$7,314,571	
SubTotal	$11,271,026	$16,954,744	$18,038,642	
Other Federal Funds	$68,379,602	$42,768,655	$53,072,414	
Total	$79,650,628	$59,723,399	$71,111,056	

	2017	
	Budgeted	Expended
Federal Allocation	$4,075,191	
Unobligated Balance	$0	
State Funds	$6,963,800	
Local Funds	$0	
Other Funds	$0	
Program Funds	$6,501,745	
SubTotal	$17,540,736	
Other Federal Funds	$45,775,263	
Total	$63,315,999	

III.A. Expenditures

For FY15 New Mexico spent $3,783,840 of federal funds from the Title V Grant during this project period. The state spent 39% of the Title V funds on preventive and primary care for children, including adolescent health, family planning services for adolescents and young adults up to 21, injury prevention, MCH Epidemiology work and child health programs addressing safe sleep, child development and preventing child maltreatment. Fifty seven percent of the grant was spent on Children's Medical Services, the NM Title V program for Children and Youth with Special Healthcare Needs. This program provides unduplicated services to this unique population and is a flagship program for the Dept. of Health in NM, with CMS social workers throughout the state providing care coordination and specialty outreach clinics to improve access to care for children with chronic medical conditions. Only 3.6% of the grant expenditures went to Administrative costs which included a portion of the salary of the Title V Director and Medical Director for the Family Health Bureau, an administrative position that oversees and assists all the MCH programs within the Bureau. The remaining funds were spent by the maternal health program to provide high risk prenatal services for pregnant women with no other source of coverage.

The FHB spent $738,027 of Title V funds on direct services, most of which ($440,453) was spent on the previously mentioned high risk prenatal services for pregnant women. The vast majority of the Title V funding for CSHCN ($2,455,197) provides enabling services rather than direct service, paying salaries for CMS social workers to provide care coordination to families and children with special healthcare needs and chronic medical conditions. Of the Federal funds to CMS, only $173,569 was spent on direct service which was some clinic services and the metabolic formula provided to clients with metabolic conditions who have no other source of payment for formula. The program utilizes primarily state general fund to pay for the services of Pediatric sub-specialists to staff the pediatric specialty outreach clinics providing access to specialty care to CSHCN in rural and frontier areas of the state; in general, Title V funds are not used for these services but in FY15 we did use federal funds for a small portion of the clinics. The remaining $590,616 supports public health services and systems by paying partial salaries for staff who support this work in a variety of ways. Examples include data surveillance and analysis, assisting with the development and implementation of a new Perinatal Collaborative for the state to improve birth outcomes, midwife

licensure, work on youth transition and teen pregnancy issues, and coalition building to address developmental screening, safe sleep, and child maltreatment.

State general fund support to the DOH and the Public Health Division/Family Health Bureau has been cut over the past several years and continues to be cut annually. The state has invested significantly in children through funding of home visiting but this funding goes to the Children Youth and Families Department. The FHB programs continue to struggle to meet the needs of our MCH population with the funding limitations we have. Children's Medical Services staff are overloaded in several areas carrying high case loads and stretching to cover areas where positions have been lost or are currently vacant. Safety net services including the High Risk Prenatal Care Fund, Maternal Health, and Children with Special Healthcare Needs clinics continue to be funded; however, it is always a stretch to try to meet all the needs in such a large and rural state.

Many of the FHB programs have worked diligently to increase their program revenues in order to supplement the federal and state funds to better meet the needs of the populations they serve. The Bureau continues to try to proactively address factors impacting birth outcomes and infant mortality, including prenatal care utilization, substance abuse, tobacco use, mental health, unintended pregnancy, and disparities among populations such as the undocumented and the Native American population. The Family Planning Program continues to receive funding via Title X, Teen Outreach program (TOP), and Personal Responsibility Education Program (PREP). A separate Title V Abstinence grant is administered out of the PHD Director's office and focuses on counties in the southwest with some of the highest teen birth rates.

The expenditures show that the amount spent on direct services has been decreasing over the years and the amounts spent on enabling services and public health services and systems have increased. This reflects a general nationwide trend of funding for direct services being increasingly available through Medicaid or private insurance, due in part to effects of the ACA and Medicaid expansion. At the same time, costs of medical services are escalating, requiring more funding to maintain previous levels of safety net services, especially with regards to children with special health care needs. There is an ever-increasing demand for more specialty clinics, especially in the areas of asthma and cardiology. Increased revenues allowed the CMS program to increase payment for clinics going into FY17, adding more cardiology and neurology clinics and increasing the UNM asthma clinics to make up for losing the Presbyterian clinic provider. For FY17 we are also adding a few Cystic Fibrosis clinics, the first time this has been offered.

Salaries for critical positions such as nurses and social workers remain well below market value, although the CMS social workers did get reclassified to begin to address this issue. Low salaries directly impact the ability of the programs to recruit and retain staff resulting in a large number of vacancies throughout the state. This results in the variance between budgeted funds and expended as funds allocated to salaries cannot easily be used for other purposes.

III.B. Budget

The budgeted amounts for FY16 and 17 reflect a continued commitment on the part of the state to meet the matching requirements of the Title V grant, and to comply with the 30/30/10 target percentages for Preventive and Primary Care for Children, Children with Special Healthcare Needs, and Administration. The proposed budget for FY17 also reflects the department's commitment to CSHCN, with CMS receiving over 50% of the Title V block grant funds rather than the minimum requirement of 30%. The state general fund is predicted to be somewhat lower in the coming budget cycles. Declining oil and gas revenues led to a much smaller state budget than had been predicted

and DOH was again cut for FY17, although the cut to PHD was less than in FY16. The Title V funding for 2016 reflects an increase over FY15 amounts, but is still not restored to the 2012-2013 funding levels. Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component is comprised of the Family Health Medical Director/Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintenance, strategic planning, and advocacy.

Budgeted amounts for other federal funds including the PREP grant, the EHDI grant, the Universal Newborn Hearing Grant, Title X, SSDI, PRAMS, ECCS and WIC are an estimate of the projected funding that will be available in 2016 from these sources, which is of course subject to change on the federal level. The majority of the Title V funding continues to be budgeted for enabling services as this reflects the work of the CMS program staff in the field providing care coordination to children and youth with special healthcare needs. Approximately $400,000 continues to be budgeted for direct services to address the gaps in services (mostly prenatal and high risk) where other funding sources are not available. The FY17 Federal Title V funding by population group is budgeted as follows: $497,329 to pregnant women (including maternal health contracts and adolescent pregnancy); $782,852 to infants under a year (including some funding to CMS, child health, injury prevention and MCH Epi); $880,037 to children 1-22 years (family planning program, adolescent health, and some funding to child health, injury prevention and MCH Epi) and $1,652,042 to CSHCN. The state matching funds are budgeted in the same way, in order to reflect the work of the programs in these areas.

The Department of Health's accounting system contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail. Programs are allocated shares of the Title V block grant along with the required state match. Budgeted Title V amounts for FY17 are expected to be similar to FY16 as Title V and match supports salaries which are not expected to change dramatically. The summary budgets for FHB programs are an aggregation of all of the Project Identification Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Project Identification Codes are program specific: e.g., Maternal Health, Title V, Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Project I.D. is allocated funding showing the federal/state distribution. The state match amount is the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of $3,087,900.

The Department of Health, including the CMS and Families FIRST case management programs, has contracted with the four managed care organizations under the Human Services State Medicaid program (MCO's) . However, there is no guarantee that the contracts will continue, which is disconcerting as general fund decreases and we are relying increasingly on the revenues from these contracts to maintain services and salaries. These services cover Medicaid eligible clients and the billing is kept separate from that of the Title V funded clients. However, the more clients that can be determined Medicaid eligible the more it benefits the Title V population. A couple of the MCOs initially expressed concern with the possible duplication of services and requested an initial one year trial period with CMS and Families FIRST. Due to the uncertainty after the first year trial, the programs budgeted revenue cautiously. Now that the one year trial period is passed programs will be working on better assessing expected revenues for budget purposes. CMS and Families FIRST, the two programs generating the most revenue, are moving into a new case management/billing system in the summer of 2016, which has the potential to increase revenues somewhat if tracking of billing and payments can be improved and submission errors reduced.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - NM NPM Change.pdf

Supporting Document #02 - ER Birth Outcomes in NM 060816.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New Mexico

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,075,191	
A. Preventive and Primary Care for Children	$ 1,609,537	(39.5%)
B. Children with Special Health Care Needs	$ 2,202,722	(54.1%)
C. Title V Administrative Costs	$ 262,932	(6.5%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,963,800	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 6,501,745	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,465,545	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,087,900		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 17,540,736	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 45,775,263	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 63,315,999	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 117,154
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 140,123
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 128,582
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 227,280
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,239,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 41,493,779
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 333,971

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,006,215		$ 3,783,840	
A. Preventive and Primary Care for Children	$ 2,283,543	(57%)	$ 1,478,738	(39.1%)
B. Children with Special Health Care Needs	$ 1,322,051	(33%)	$ 2,169,616	(57.3%)
C. Title V Administrative Costs	$ 400,621	(10%)	$ 135,486	(3.6%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,264,811		$ 6,669,159	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 0		$ 6,501,745	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 7,264,811		$ 13,170,904	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,087,900				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 11,271,026		$ 16,954,744	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 68,379,602		$ 42,768,655	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 79,650,628		$ 59,723,399	

OTHER FEDERAL FUNDS	FY15 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 317,636
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 81,141
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 112,165
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 109,232
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Implementation Grants for Systems of Services for CYSHCN	$ 241,456
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 81,607
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 185,680
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,569,960
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 37,932,520
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 1,137,258

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

1.	The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
2.	The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
3.	The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
4.	The value in Line 6, Program Income, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: New Mexico

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 497,329	$ 440,453
2. Infants < 1 year	$ 782,852	$ 763,244
3. Children 1-22 years	$ 880,037	$ 817,444
4. CSHCN	$ 1,652,042	$ 1,627,212
5. All Others	$ 237,762	$ 135,486
Federal Total of Individuals Served	$ 4,050,022	$ 3,783,839

IB. Non Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Pregnant Women	$ 1,400,956	$ 1,400,956
2. Infants < 1 year	$ 3,119,421	$ 3,119,421
3. Children 1-22 years	$ 2,952,832	$ 2,952,832
4. CSHCN	$ 5,449,252	$ 5,449,252
5. All Others	$ 111,748	$ 111,748
Non Federal Total of Individuals Served	$ 13,034,209	$ 13,034,209
Federal State MCH Block Grant Partnership Total	$ 17,084,231	$ 16,818,048

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: Med Director Indirect not included	

Data Alerts:

1.	Children 1 to 22 Years, Application Budgeted does not equal Form 2, Line 1A, preventive and Primary Care for Children Application Budgeted. Please add a field level note to explain.
2.	CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. Please add a field level note to explain.
3.	Children 1 to 22 Years, Annual Report Expended does not equal Form 2, Line 1A, preventive and Primary Care for Children, Annual Report Expended. Please add a field level note to explain.
4.	CSHCN, Annual Report Expended does not equal Form 2, Line 1B, Children with Special Health Care Needs, Annual Report Expended. Please add a field level note to explain.

Form 3b
Budget and Expenditure Details by Types of Services

State: New Mexico

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 639,446	$ 738,027
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 497,329	$ 440,453
B. Preventive and Primary Care Services for Children	$ 142,117	$ 124,005
C. Services for CSHCN	$ 0	$ 173,569
2. Enabling Services	$ 2,738,854	$ 2,455,197
3. Public Health Services and Systems	$ 696,891	$ 590,616
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 73,700
Physician/Office Services		$ 337,430
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 70,499
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 10,944
Laboratory Services		$ 245,454
Direct Services Line 4 Expended Total		$ 738,027
Federal Total	$ 4,075,191	$ 3,783,840

IIB. Non-Federal MCH Block Grant	FY17 Application Budgeted	FY15 Annual Report Expended
1. Direct Services	$ 1,993,176	$ 1,850,247
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 472,200	$ 427,049
B. Preventive and Primary Care Services for Children	$ 934,221	$ 841,944
C. Services for CSHCN	$ 586,755	$ 581,254
2. Enabling Services	$ 8,977,779	$ 8,941,327
3. Public Health Services and Systems	$ 2,494,590	$ 2,379,332
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 845,591
Physician/Office Services		$ 548,139
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 35,000
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 119,321
Laboratory Services		$ 302,196
Direct Services Line 4 Expended Total		$ 1,850,247
Non-Federal Total	$ 13,465,545	$ 13,170,906

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: In FY15 some Title V was used for CMS clinics but for 16 and 17 no federal used - moved to enabling	
2.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2017**
	Column Name:	**Application Budgeted**
	Field Note: Add indirect to this so totals for this page and form 2 will match	

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New Mexico

Total Births by Occurrence: 23,872

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	23,609 (98.9%)	699	47	35 (74.5%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methyglutaric aciduria	Holocarboxylase synthase deficiency	ß-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, βeta-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiences
Classic galactosemia	Adrenoleukodystrophy	Mucopolysaccharidosis, type I		

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Screening	22,745 (95.3%)	974	46	38 (82.6%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

New Mexico long-term follow-up starts at the time of diagnosis up to the age of 21. Any client diagnosed with a condition identified by Newborn Screening is offered services for long-term follow-up. New Mexico long-term follow-up is a case management system set up to support parents/client after diagnosis. New Mexico has social workers though out the state based in public health offices. Once a client is referred the social worker will make contact with the parent quarterly for the first five years then every 6 months up until the age of 21 and after the age of 21, social workers will follow-up as needed. The Newborn Screening program aims to eliminate barriers to health care services. A follow-up form is completed by the social worker at the time of visit consisting of a series of questions about frequency of visits to PCP and specialists, insurance status, developmental milestones, and barriers/challenges in housing, financial, transportation, obtaining medication, etc.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2015**
	Column Name:	**Core RUSP Conditions**
	Field Note: All but one of the 36 cases needing treatment received treatment. The one case that did not receive treatment moved out of state right after being screened. The remaining 11 identified cases were traits or variants that do not require treatment.	
2.	**Field Name:**	**Newborn Screening - Referred For Treatment**
	Fiscal Year:	**2015**
	Column Name:	**Other Newborn**
	Field Note: This is the number of children enrolled in early intervention that was reported back to newborn screening program.	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: New Mexico

Reporting Year 2015

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,963	47.0	0.0	0.0	53.0	0.0
2. Infants < 1 Year of Age	699	76.0	0.0	18.0	6.0	0.0
3. Children 1 to 22 Years of Age	29,193	75.0	0.0	20.0	5.0	0.0
4. Children with Special Health Care Needs	1,000	57.0	0.0	10.0	33.0	0.0
5. Others	0	0.0	0.0	0.0	100.0	0.0
Total	33,855					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2015**
	Field Note: This number includes clients from Family First, High Risk Pregnancy Fund, and Prenatal related medications (including multivitamins) program.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2015**
	Field Note: Medicaid is combined with SCHIP and number of infants are estimated from CMS416 since NM vital records doesn't break down births by health payer source.	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2015**
	Field Note: Include FPP, SBHC visits	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: 13% of the birth to 18 population. *Note: Medicaid and SCHIP numbers are combined because New Mexico houses and manages both programs under Medicaid. For CSHCN, those who were only insured by Children's Medical Services were categorized as having no insurance because the program acts as safety net for individuals who cannot be insured through Medicaid.	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: New Mexico

Reporting Year 2015

Types Of Individuals Served	Total Served
1. Pregnant Women	12,005
2. Infants < 1 Year of Age	23,621
3. Children 1 to 22 Years of Age	38,757
4. Children with Special Health Care Needs	68,052
5. Others	5,361
Total	147,796

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2015**
	Field Note: Includes WIC and Families First which are both administered by Title V. This counts also includes the High Risk Fund, Prenatal Medications Program and inter-conception care.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2015**
	Field Note: This number includes all infants screened or who refused screening. Certain populations are not present in the occurrence birth counts because Indian Health Service reports to a different entity and many midwives are just now beginning to screen.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2015**
	Field Note: Includes WIC (which is administered by Title V), Families First, Title X (which is administered by Title V),Home visiting (CYFD), and injury prevention (safe-sleep education.)	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2015**
	Field Note: The estimate is from the population definition of Children with Special Health Care Needs and accounted for the fact that this is 25 percent of the Child population.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2015**
	Field Note: This represents the adolescent population 15-19 years, receiving services pertaining to family planning in Title V,outside of Title X and those who received educational services and enrolled in an evidence-based teen pregnancy prevention program.	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New Mexico

Reporting Year 2015

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	22,779	17,769	560	3,454	395	148	0	453
Title V Served	12,004	9,364	295	1,820	208	78	0	239
Eligible for Title XIX	14,756	11,500	364	2,245	257	96	0	294
2. Total Infants in State	26,594	21,089	1,162	3,751	591	0	0	1
Title V Served	26,300	20,857	1,149	3,709	584	0	0	1
Eligible for Title XIX	17,286	13,708	755	2,438	384	0	0	1

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	10,018	12,478	283	22,779
Title V Served	5,279	6,576	149	12,004
Eligible for Title XIX	6,461	8,111	184	14,756
2. Total Infants in State	10,966	15,628	0	26,594
Title V Served	10,846	15,454	0	26,300
Eligible for Title XIX	7,128	10,158	0	17,286

Form Notes for Form 6:

This form was populated with 2014 birth data since 2015 data will not been finalized until late July 2016 and provisional data is not available.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2015**
	Column Name:	**Total All Races**
	Field Note: Retrieved from New Mexico Department of Health,Bureau of Vital Record and Health Statistics.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2015**
	Column Name:	**Total All Races**
	Field Note: Include WIC and Families First, which are both administered by Title V.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2015**
	Column Name:	**Total All Races**
	Field Note: This was estimated using the federal poverty level cutoff for Title XIX eligibility and using the population estimates under the federal poverty level for each race/ethnicity.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2015**
	Column Name:	**Total All Races**
	Field Note: Native Hawaiian or Other Pacific Islander included with Asian. Retrieved from New Mexico Department of Health, Indicator-Based Information System for Public Health Web site: http://ibis.health.state.nm.us.	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2015**
	Column Name:	**Total All Races**
	Field Note: Includes all infants screened or who refused screening. Certain populations are not present in the total infants in state because Indian Health Service reports to a different entity and many midwives are just beginning to screen.	

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2015**
	Column Name:	**Total All Races**

Field Note:
This was estimated using the federal poverty level cutoff for Title XIX eligibility and using the population estimates under the federal poverty level for each race/ethnicity

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: New Mexico

A. State MCH Toll-Free Telephone Lines	2017 Application Year	2015 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 725-2552	(877) 725-2552
2. State MCH Toll-Free "Hotline" Name	Nurse Advice NM	Nurse Advice NM
3. Name of Contact Person for State MCH "Hotline"	Connie B. Fiorenzio	Connie B. Fiorenzio
4. Contact Person's Telephone Number	(505) 855-7744	(505) 855-7744
5. Number of Calls Received on the State MCH "Hotline"		28,931

B. Other Appropriate Methods	2017 Application Year	2015 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: New Mexico

1. Title V Maternal and Child Health (MCH) Director	
Name	Janis Gonzales, MD, MPH
Title	Family Health Bureau Chief, Title V Director
Address 1	2040 S. Pacheco St. NW
Address 2	
City/State/Zip	Santa Fe / NM / 87505
Telephone	(505) 476-8854
Extension	
Email	janis.gonzales@state.nm.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Susan Chacon, MSW, LISW
Title	CMS Director Title V CSCHN
Address 1	2040 S. Pacheco St NW
Address 2	
City/State/Zip	Santa Fe / NM / 87505
Telephone	(505) 476-8860
Extension	
Email	susan.chacon@state.nm.us

3. State Family or Youth Leader (Optional)	
Name	Trish Thomas (Family Voices)
Title	National Director of Diversity and Outreach
Address 1	3701 San Mateo Blvd, NE
Address 2	Suite 103
City/State/Zip	Albuquerque / NM / 87110
Telephone	(505) 872-4774
Extension	102
Email	tthomas@familyvoices.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New Mexico

Application Year 2017

No.	Priority Need
1.	To maintain and increase breastfeeding initiation and duration
2.	To increase the percentage of children receiving a developmental screen
3.	Increase access to care to a family-centered comprehensive medical home for children and adolescents
4.	To increase the amount of services available to assist adolescents to make successful transitions to adult health care services
5.	To reduce birth rates among teens 15-19
6.	To improve access and quality of comprehensive well exams for adolescents
7.	Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.
8.	To improve safe sleep practices among home visiting participants and birthing facility medical staff
9.	To decrease abuse and maltreatment of children
10.	To increase and improve access to preventive dental care in pregnant women and children

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	To maintain and increase breastfeeding initiation and duration	New	
2.	To increase the percentage of children receiving a developmental screen	New	
3.	Increase access to care to a family-centered comprehensive medical home for children and adolescents	New	
4.	To increase the amount of services available to assist adolescents to make successful transitions to adult health care services	New	
5.	To reduce birth rates among teens 15-19	New	A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application
6.	To improve access and quality of comprehensive well exams for adolescents	New	
7.	Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.	New	
8.	To increase access to resources and increase awareness on bullying prevention	New	
9.	To improve safe sleep practices among home visiting participants and birthing facility medical staff	New	A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application
10.	To decrease abuse and maltreatment on children	New	A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 10

Field Note:

This is a new priority identified in FFY 2016 as an emerging priority need.

Form 10a
National Outcome Measures (NOMs)

State: New Mexico

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	71.5 %	0.3 %	17,633	24,674
2013	67.1 %	0.3 %	16,677	24,862
2012	68.8 %	0.3 %	17,154	24,946
2011	67.7 %	0.3 %	17,401	25,694
2010	68.9 %	0.3 %	17,935	26,046
2009	66.4 %	0.3 %	16,863	25,394

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	201.2	9.4 %	466	23,158
2012	221.7	9.8 %	524	23,641
2011	186.7	9.0 %	439	23,517
2010	166.5	8.4 %	400	24,031
2009	154.0	7.9 %	390	25,319

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2014	23.0	4.1 %	31	134,613
2009_2013	21.1	3.9 %	29	137,561
2008_2012	23.3	4.1 %	33	141,380
2007_2011	26.9	4.3 %	39	144,928
2006_2010	24.4	4.1 %	36	147,575

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.8 %	0.2 %	2,282	25,950
2013	8.9 %	0.2 %	2,333	26,283
2012	8.8 %	0.2 %	2,381	26,948
2011	8.8 %	0.2 %	2,385	27,227
2010	8.7 %	0.2 %	2,427	27,828
2009	8.3 %	0.2 %	2,416	28,969

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.3 %	0.1 %	349	25,950
2013	1.3 %	0.1 %	346	26,283
2012	1.2 %	0.1 %	330	26,948
2011	1.3 %	0.1 %	359	27,227
2010	1.3 %	0.1 %	371	27,828
2009	1.2 %	0.1 %	355	28,969

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.5 %	0.2 %	1,933	25,950
2013	7.6 %	0.2 %	1,987	26,283
2012	7.6 %	0.2 %	2,051	26,948
2011	7.4 %	0.2 %	2,026	27,227
2010	7.4 %	0.2 %	2,056	27,828
2009	7.1 %	0.2 %	2,061	28,969

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

NOM 5.1 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	9.2 %	0.2 %	2,387	26,017
2013	9.3 %	0.2 %	2,439	26,255
2012	9.6 %	0.2 %	2,576	26,983
2011	9.7 %	0.2 %	2,648	27,229
2010	9.1 %	0.2 %	2,534	27,747
2009	9.3 %	0.2 %	2,682	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

NOM 5.2 - Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.5 %	0.1 %	657	26,017
2013	2.7 %	0.1 %	707	26,255
2012	2.5 %	0.1 %	682	26,983
2011	2.6 %	0.1 %	707	27,229
2010	2.6 %	0.1 %	710	27,747
2009	2.6 %	0.1 %	762	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

NOM 5.3 - Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.7 %	0.2 %	1,730	26,017
2013	6.6 %	0.2 %	1,732	26,255
2012	7.0 %	0.2 %	1,894	26,983
2011	7.1 %	0.2 %	1,941	27,229
2010	6.6 %	0.2 %	1,824	27,747
2009	6.6 %	0.2 %	1,920	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	26.9 %	0.3 %	6,986	26,017
2013	27.3 %	0.3 %	7,162	26,255
2012	26.9 %	0.3 %	7,254	26,983
2011	26.8 %	0.3 %	7,309	27,229
2010	27.0 %	0.3 %	7,492	27,747
2009	28.1 %	0.3 %	8,140	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	3.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.0	0.4 %	133	26,404
2012	5.8	0.5 %	157	27,130
2011	4.8	0.4 %	131	27,348
2010	4.8	0.4 %	133	27,908
2009	5.1	0.4 %	148	29,081

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.3	0.5 %	139	26,354
2012	6.8	0.5 %	184	27,068
2011	5.6	0.5 %	152	27,289
2010	5.6	0.5 %	156	27,850
2009	5.3	0.4 %	154	29,000

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.9	0.4 %	103	26,354
2012	4.7	0.4 %	126	27,068
2011	3.4	0.4 %	92	27,289
2010	3.4	0.4 %	95	27,850
2009	3.2	0.3 %	92	29,000

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4	0.2 %	36	26,354
2012	2.1	0.3 %	58	27,068
2011	2.2	0.3 %	60	27,289
2010	2.2	0.3 %	61	27,850
2009	2.1	0.3 %	62	29,000

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	223.9	29.2 %	59	26,354
2012	247.5	30.3 %	67	27,068
2011	216.2	28.2 %	59	27,289
2010	161.6	24.1 %	45	27,850
2009	151.7	22.9 %	44	29,000

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	60.7	15.2 %	16	26,354
2012	92.4	18.5 %	25	27,068
2011	77.0	16.8 %	21	27,289
2010	43.1	12.4 %	12	27,850
2009	86.2	17.3 %	25	29,000

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.5 %	0.6 %	1,310	24,003
2012	4.5 %	0.8 %	1,111	24,695
2011	6.6 %	0.6 %	1,668	25,192

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	16.3	0.9 %	377	23,158
2012	12.7	0.7 %	299	23,642
2011	10.8	0.7 %	253	23,517
2010	7.8	0.6 %	187	24,033
2009	6.2	0.5 %	156	25,319

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.9 %	1.7 %	115,158	482,872

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	17.0	2.6 %	43	252,620
2013	19.9	2.8 %	51	256,147
2012	22.0	2.9 %	57	259,441
2011	27.8	3.3 %	73	262,232
2010	21.1	2.9 %	55	260,110
2009	22.2	2.9 %	57	256,535

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	43.9	4.0 %	122	278,105
2013	35.5	3.6 %	100	281,413
2012	43.3	3.9 %	123	284,233
2011	39.3	3.7 %	113	287,793
2010	49.7	4.1 %	145	291,552
2009	53.6	4.3 %	156	291,043

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	17.1	2.0 %	72	420,608
2011_2013	14.5	1.8 %	62	427,695
2010_2012	17.8	2.0 %	78	437,214
2009_2011	19.1	2.1 %	85	446,029
2008_2010	22.8	2.3 %	103	451,937
2007_2009	24.9	2.4 %	113	453,253

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2014	16.2	2.0 %	68	420,608
2011_2013	17.5	2.0 %	75	427,695
2010_2012	19.2	2.1 %	84	437,214
2009_2011	17.5	2.0 %	78	446,029
2008_2010	19.7	2.1 %	89	451,937
2007_2009	20.5	2.1 %	93	453,253

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.0 %	1.4 %	92,930	517,036
2007	16.2 %	1.2 %	79,908	493,495
2003	17.7 %	1.1 %	88,375	499,905

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	12.3 %	1.3 %	7,735	63,029

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	0.8 %	0.4 %	3,587	430,746
2007	1.0 %	0.4 %	3,871	405,714

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	5.8 %	0.9 %	24,769	429,287
2007	4.1 %	0.6 %	16,430	405,155

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	58.0 %	6.7 %	20,730	35,727
2007	53.1 %	6.6 %	16,425	30,924
2003	58.2 %	5.9 %	18,741	32,179

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	81.4 %	1.5 %	421,029	517,036
2007	85.1 %	1.2 %	420,042	493,495
2003	81.9 %	1.1 %	409,326	499,905

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.9 %	2.6 %	72,205	219,833
2007	32.7 %	2.6 %	69,914	214,080
2003	28.9 %	2.0 %	62,347	215,788

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	28.5 %	0.3 %	6,038	21,226

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	27.6 %	1.9 %	25,408	91,951
2011	27.3 %	1.4 %	25,094	92,021
2009	28.0 %	1.5 %	25,677	91,635
2007	24.3 %	1.6 %	22,038	90,582
2005	26.6 %	1.9 %	24,749	92,966

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	7.6 %	0.6 %	37,982	497,539
2013	9.0 %	0.8 %	45,457	506,345
2012	8.0 %	0.8 %	41,412	514,814
2011	9.1 %	0.7 %	47,170	518,003
2010	10.0 %	0.7 %	51,481	517,558
2009	12.0 %	0.8 %	61,415	513,468

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	75.9 %	3.5 %	29,643	39,058
2013	65.7 %	3.7 %	25,879	39,405
2012	71.6 %	3.4 %	28,790	40,234
2011	69.8 %	3.4 %	29,615	42,427
2010	53.1 %	3.4 %	23,204	43,706
2009	45.8 %	3.4 %	19,433	42,442

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2015	65.4 %	2.0 %	318,477	486,893
2013_2014	66.6 %	2.0 %	325,864	489,437
2012_2013	66.9 %	2.3 %	326,700	488,661
2011_2012	60.8 %	2.4 %	291,085	478,706
2010_2011	57.2 %	3.9 %	271,893	475,337
2009_2010	51.8 %	3.0 %	254,462	491,239

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	59.0 %	4.5 %	40,822	69,208
2013	67.1 %	4.4 %	47,255	70,410
2012	51.1 %	5.1 %	35,880	70,235
2011	58.1 %	4.4 %	40,768	70,188
2010	48.4 %	4.3 %	32,952	68,025
2009	53.1 %	4.1 %	36,140	68,124

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	42.8 %	4.7 %	30,712	71,752
2013	31.4 %	3.9 %	22,858	72,775
2012	20.2 %	4.1 %	14,752	72,871
2011	11.3 %	2.5 %	8,224	73,055

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	83.3 %	2.7 %	117,458	140,960
2013	85.6 %	2.3 %	122,630	143,185
2012	82.6 %	2.9 %	118,201	143,106
2011	81.3 %	2.6 %	116,512	143,243
2010	71.8 %	2.9 %	99,579	138,689
2009	63.5 %	2.8 %	88,052	138,699

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	75.1 %	2.8 %	105,921	140,960
2013	70.9 %	2.9 %	101,451	143,185
2012	54.2 %	3.6 %	77,578	143,106
2011	64.8 %	3.1 %	92,755	143,243
2010	52.9 %	3.2 %	73,319	138,689
2009	51.2 %	2.9 %	71,032	138,699

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New Mexico

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	58.7	59.9	61.1	62.3	63.5	64.7

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	58.6 %	2.0 %	204,130	348,213
2013	57.5 %	1.8 %	202,217	351,422
2012	53.0 %	1.6 %	188,045	354,589
2011	56.0 %	1.6 %	200,052	357,171
2010	62.5 %	2.1 %	217,904	348,900
2009	61.3 %	1.9 %	217,134	353,971

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - A) Percent of infants who are ever breastfed

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.5	80.0	81.7	83.2	85.0	86.8

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	80.4 %	3.3 %	19,215	23,889
2011	76.9 %	3.5 %		
2010	80.3 %	3.4 %		
2009	75.0 %	3.2 %		
2008	75.4 %	2.8 %		
2007	78.4 %	2.6 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 4 - B) Percent of infants breastfed exclusively through 6 months

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	25.6	27.2	21.0	28.8	30.4	32.0

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	24.5 %	3.3 %	5,724	23,408
2011	16.1 %	2.6 %		
2010	17.4 %	2.7 %		
2009	21.8 %	2.9 %		
2008	16.9 %	2.1 %		
2007	16.8 %	2.1 %		

Legends:

Indicator has an unweighted denominator <50 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	39.3	40.0	41.0	42.0	43.0	45.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.3 %	3.6 %	54,323	141,890
2007	29.7 %	3.6 %	38,679	130,465

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	78.2	79.4	80.8	82.2	83.5	84.7

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.7 %	2.7 %	130,533	168,106
2007	82.9 %	2.0 %	143,481	173,056
2003	66.3 %	2.3 %	118,111	178,026

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	38.9	40.0	41.1	43.1	45.0	47.0

Data Source: National Survey of Children's Health (NSCH) - CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	38.6 %	4.0 %	34,748	90,144
2007	43.0 %	3.8 %	33,398	77,684

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH) - NONCSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	50.1 %	2.1 %	204,506	408,109
2007	50.1 %	2.0 %	198,036	395,065

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

1.	**Field Name:**	**2016**
	Field Note: This objective is specifically for children with special health care needs!	
2.	**Field Name:**	**2017**
	Field Note: This objective is specifically for children with special health care needs!	

3.	**Field Name:**	**2018**
	Field Note: This objective is specifically for children with special health care needs!	
4.	**Field Name:**	**2019**
	Field Note: This objective is specifically for children with special health care needs!	
5.	**Field Name:**	**2020**
	Field Note: This objective is specifically for children with special health care needs!	
6.	**Field Name:**	**2021**
	Field Note: This objective is specifically for children with special health care needs!	

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	36.8	38.6	40.0	41.4	42.8	44.2

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	35.7 %	3.8 %	9,776	27,412
2005_2006	33.7 %	2.7 %	8,126	24,117

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - A) Percent of women who had a dental visit during pregnancy

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	46.9	48.3	49.6	51.0	52.0	52.0

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	45.6 %	1.4 %	10,957	24,011
2012	47.6 %	1.8 %	11,791	24,766

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	82.7	84.3	85.9	87.5	89.2	90.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	81.1 %	1.5 %	389,669	480,550
2007	79.3 %	1.6 %	364,581	460,038

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

NPM 15 - Percent of children ages 0 through 17 who are adequately insured

Annual Objectives						
	2016	2017	2018	2019	2020	2021
Annual Objective	82.0	84.0	85.7	87.3	89.0	90.0

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	80.4 %	1.5 %	386,077	480,422
2007	78.8 %	1.6 %	342,599	434,778

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: New Mexico

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	71.4	74.8	78.2	81.6	85.0

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Percent of infants placed to sleep on their backs

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	80.3	81.9	83.5	85.1	86.7

Field Level Notes for Form 10a SPMs:

None

SPM 3 - Ratio of Victims of Child Abuse per 1,000 Children in the Population

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	15.9	15.1	14.3	13.5	12.7

Field Level Notes for Form 10a SPMs:

None

SPM 4 - Teen Birth Rate, ages 15 to 19 years

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	31.6	28.8	26.1	23.4	20.7

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or-Informed Strategy Measures (ESMs)

State: New Mexico

ESM 1.1 - Number of completed postpartum visits by maternal clients followed by Licensed Midwife providers

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	150.0	165.0	190.0	205.0	210.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - Number of licensed midwives trained in appropriate medical billing/coding

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	20.0	35.0	50.0	65.0	80.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - Percentage of mothers who report a baby-friendly experience at a New Mexico birthing facility

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	65.0	67.0	68.5	70.0	71.5

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**

Field Note:
This is a New Measure in New Mexico and there is no baseline data available. The annual objectives are all estimates of PRAMS data.

ESM 6.1 - Number of early childhood professionals and medical providers trained to administer and score developmental screening instruments

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	300.0	350.0	400.0	450.0	500.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.1 - The number of policies/or practices implemented at a clinical system, that helps improve access to or quality of the adolescent well visit.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	5.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
The goal is the implement at least 5 policies and/or practices each year.

ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	76.5	78.5	81.0	83.0	85.0

Field Level Notes for Form 10a ESMs:

1. **Field Name:** **2017**

Field Note:
These annual objectives are estimates since there is no baseline data available for this measure.

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care and family engagement

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	10.0	15.0	20.0	25.0	30.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - The number of Health Care providers participating in health care transition education and training on the 6 core elements of transition

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	75.0	100.0	125.0	150.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1 - Number of interagency partnerships implemented to coordinate dental and other services

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

ESM 15.1 - Develop at least one cross-agency agreement or policy developed to address insurance gaps for prenatal and child coverage.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

ESM 15.2 - Percent of children 0-17 previously uninsured at baseline who are insured at period end, among Medicaid-eligible, insurance pool/high risk and private insurance populations.

Annual Objectives					
	2017	2018	2019	2020	2021
Annual Objective	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: New Mexico

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Population Domain(s) – Perinatal/Infant Health, Women/Maternal Health

Goal:	To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.
Definition:	**Numerator:** Number of VLBW infants born in a hospital with a level III or higher NICU **Denominator:** Number of VLBW infants (< 1500 grams) **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 33: Increase the proportion of VLBW infants born at level III hospitals or sub-specialty perinatal centers (Baseline: 75%, Target: 83.7%)
Data Sources and Data Issues:	NM Bureau of Vital Records and Health Statistics. NM is involved in implementing the CDC LoCATe tool, an assessment tool that CDC is developing to build state capacity for understanding neonatal and maternal risk appropriate care capacity (based on AAP and ACOG criteria).
Significance:	Low birthweight increases the risk for infant mortality and morbidity. As birthweight decreases, the risk for death increases. Low birthweight infants who survive often require intensive care at birth, may develop chronic illnesses, and later may require special education services. Health care costs and length of hospital stay are higher for low birthweight infants. VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a sub-specialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (sub-specialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).

SPM 2 - Percent of infants placed to sleep on their backs
Population Domain(s) – Perinatal/Infant Health

Goal:	To improve safe sleep practices among home visiting participants and birthing facility medical staff.
Definition:	**Numerator:** Number of mothers reporting that they most often place their baby to sleep on their back only **Denominator:** Number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 20: Increase the proportion of infants placed to sleep on their backs (Baseline: 69.0%, Target: 75.9%)
Data Sources and Data Issues:	New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the AAP has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

SPM 3 - Ratio of Victims of Child Abuse per 1,000 Children in the Population
Population Domain(s) – Child Health

Goal:	To reduce the physical, psychological, and behavioral impact of child maltreatment on not just the child and family, but society as a whole.
Definition:	**Numerator:** Number of substantiated victims or allegations of child abuse and/or neglect. **Denominator:** Number of children under age 18 **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 3.2: Reduce the rate of deaths among children aged 5 to 9 years (Baseline: 29.4 deaths per 100,000 in 2007, Target: 26.5 deaths per 100,000) Related to Maternal, Infant, and Child Health (MICH) Objective 3.2: Reduce the rate of deaths among children aged 1 to 4 years (Baseline: 13.8 deaths per 100,000 in 2007, Target: 12.4 deaths per 100,000)
Data Sources and Data Issues:	NM CYFD, Population Estimates: University of New Mexico, Geospatial and Population Studies (GPS) Program
Significance:	In New Mexico, child maltreatment includes physical neglect, sexual abuse and physical abuse. Child maltreatment can range from relatively minor (bruises or cuts) to severe (broken bones, acute subdural hematoma, or even death). In addition to these physical effects, additional outcomes of abuse or neglect may include behavioral changes, developmental delays or life-long disabilities. Regardless of the physical effects, the emotional pain and suffering they cause a child should not be minimized. Additionally, adults who experienced abuse or neglect during childhood are more likely to suffer from physical ailments such as allergies, arthritis, asthma, bronchitis, high blood pressure, and ulcers. The effects vary depending on the circumstances of the abuse or neglect and personal characteristics of the child. Also impactful is the child's environment, including the array of services available to the child and family to address the underlying issues which lead to child maltreatment. Consequences of abuse might be mild or severe, may disappear after a short period or last a lifetime. Child maltreatment can impact the child physically, psychologically, behaviorally, or in some combination of all three ways. Ultimately, due to related costs to public entities such as the health care, human services, and educational systems, abuse and neglect impact not just the child and family, but society as a whole.

SPM 4 - Teen Birth Rate, ages 15 to 19 years
Population Domain(s) – Adolescent Health, Women/Maternal Health

Goal:	To reduce birth rates among adolescent females 15 to 19 years
Definition:	**Numerator:** Births to adolescent females aged 15 to 19 years **Denominator:** Number of adolescent females aged 15 to 19 years **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Family Planning (FP) Objective 9.1: Reduce pregnancies among adolescent females aged 15- to 17 years Related to Family Planning (FP) Objective 9.2: Reduce pregnancies among adolescent females aged 17- to 19 years
Data Sources and Data Issues:	NM birth certificate database, Bureau of Vital Records and Health Statistics, NM Department of Health; Population Estimates: University of New Mexico, Geospatial and Population Studies (GPS) Program. This rate includes New Mexico RESIDENT births only. Birth records are filed electronically by hospitals. Medical records staff use standard mother and facility worksheets and medical charts to complete the birth registration. Population estimates use decimal fractions. This may cause totals to vary slightly due to rounding. These estimates are considered the most accurate estimates for the state of New Mexico.
Significance:	Teen birth rate is a significant indicator for population health. It is one of the three goals for NM's Title X program and it is a super-priority for the NM Department of Health. Factors in New Mexico's high teen birth rates are poverty, education, rural vs. urban population and access to services. There is a lack of access to family planning services with all but one of NM counties classified as a health professional shortage area. Poverty is one of the most important contributing factors to teenage pregnancy. In 2014, New Mexico ranked 1st among all states and the District of Columbia in percentage of children living in poverty (30% of children age 0-17 in poverty). Teens who have dropped out of school are more likely to become pregnant and have a child than their peers who stay in school. The NM high school dropout rate in 2012 was 29.6%, compared to 24.5% nationally. Teen parenthood is most common in rural areas. In the 26 rural counties in NM, the teen birth rate was 51.1/1,000, whereas the teen birth rate in the seven urban counties, the teen birth rate was 33.8/1,000

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: New Mexico

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheets

State: New Mexico

ESM 1.1 - Number of completed postpartum visits by maternal clients followed by Licensed Midwife providers
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	To increase the completion postpartum visit under the care of midwives to increasing the likelihood of comprehensive well exam in the maternal population.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	Maternal Health Program quarterly survey of midwives.
Significance:	The postpartum visit is an opportunity for review of medical, and behavioral, issues that may have been present in the pregnancy, with a referral for appropriate ongoing follow-up care. It is also an opportunity for contraceptive planning, birth-spacing discussion and for general women's health care assessment. These areas are covered by direct entry midwife providers in accordance with their practice guidelines, and are reimbursable under Medicaid. In a 2016 publication by the Centers for Medicare and Medicaid Services, titled Perinatal Care in Medicaid and CHIP, NM had a 29.5 % rate of postpartum visit completion in the Medicaid and CHIP population (data from CY2013). The target goal for this ESM would be to reach 50% of the Medicaid population served by licensed midwife (LM) providers. This has not been measured in our state up to this point, so first year (CY17) data collection will establish baseline. If baseline meets the 50% target goal, then we will reassess whether a new target goal should be established for CY18.

ESM 1.2 - Number of licensed midwives trained in appropriate medical billing/coding
NPM 1 – Percent of women with a past year preventive medical visit

Goal:	To increase access to home birthing options in New Mexico, especially among Medicaid-insured women
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	Medicaid
Significance:	The Medicaid-carrying clients seen by direct entry midwives are often clients who do not easily access the health care system, or they may desire and utilize the NM Birthing Options Program which allows for a home-birth attended by a direct entry midwife. Direct entry midwives in NM can accept and be reimbursed for Medicaid clients however issues in billing, coding and seamless reimbursement have been identified over the past year in a project between the Maternal Health Program, Medicaid and the direct-entry midwives. A training will provide an opportunity to present the Birthing Options Program to the entities that need the information as well as educate the direct entry midwives on appropriate and accurate coding/billing to facilitate seamless reimbursement. This will promote greater cooperation between all the entities as well as maintain accessibility to the home-birth option for Medicaid clients.

ESM 4.1 - Percentage of mothers who report a baby-friendly experience at a New Mexico birthing facility NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Goal:	To increase the number of birth facilities that have achieved baby-friendly status
Definition:	**Numerator:** Number of PRAMS respondent mothers who report experiencing 10 baby friendly steps at the hospital where they gave birth **Denominator:** Number of PRAMS respondent mothers who gave birth at a birthing facility **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	The New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Advantages of breastfeeding are indisputable and baby friendly hospitals provide an opportunity and for mothers to initiate breastfeeding by encouraging and recognizing hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. It recognizes and awards birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes. The New Mexico PRAMS survey includes 10 questions that correspond to baby friendly experience, this ESM will allow New Mexico to compare the mother's self reported experience with the percentage of births at baby friendly facilities thereby utilizing PRAMS to measure the correspondence between self-reported experience and the facility identification as baby-friendly.

ESM 6.1 - Number of early childhood professionals and medical providers trained to administer and score developmental screening instruments
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Goal:	To increase the number of early childhood professionals and medical providers trained to administer and score developmental screening instruments
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 9,999
Data Sources and Data Issues:	These numbers come from the attendance/sign-in sheets from the training sessions presented by the Child Health Program (funding from Project LAUNCH and Early Childhood Comprehensive Systems grants).
Significance:	Early childhood professionals which include educators, social workers, and medical providers are individuals who have early and frequent contact with children. Early childhood professionals should have access to developmental tools and resources and New Mexico seeks to increase this access through training and promoting the appropriate administration and scoring of developmental screening tools. These tools will contribute to improved health outcomes for young children by identifying developmental and social-emotional delays early. In the US, 17% of children have a developmental or behavioral disability. Less than half of children with developmental delays are identified before starting school. Research shows that when delays are identified and children and families are referred for appropriate early intervention treatment services, the child's development can be greatly improved and the child is better prepared to enter school ready to learn

ESM 10.1 - The number of policies/or practices implemented at a clinical system, that helps improve access to or quality of the adolescent well visit.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Goal:	To Improve State- and Systems-Level Policies and Practices
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	Details of the policy/practice implemented provided by Office of School and Adolescent Health will be documented and the number of partnerships will counted.
Significance:	The quality of the adolescent well is great importance and can impact the likelihood of an adolescents returning to an annual well visit. Each year New Mexico will develop or adopt at least one youth-centered policy and/or practice at the state, clinical system, or HMO level that helps improve access to or quality of the adolescent well visit.

ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Goal:	To improve the quality of preventive services among adolescents
Definition:	<table><tr><td>**Numerator:**</td><td>Total number of well-visit patients 10-17 that report they are satisfied or very-satisfied with their well visit/clinic encounter at a CoIIN site clinic.</td></tr><tr><td>**Denominator:**</td><td>Total number of surveys administered to patients 10-17 visiting for a well visit at a CoIIN site clinic.</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table>
Data Sources and Data Issues:	AYAH CoIIN site clinic visit clinic encounter data.
Significance:	The quality of the adolescent well-visit/encounter is of great importance to the improving the uptake and access to preventive services. Adolescents are more likely to return to high quality visit. Improving education and marketing about the value of the preventive visit to adolescents will increase the value adolescents place on well-visits.

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care and family engagement
NPM 11 – Percent of children with and without special health care needs having a medical home

Goal:	Increase the percentage of families who have access to patient and family centered care coordination that respects the culture and primary language of the family to assist in integrating physical, oral and behavioral health issues into the care plan.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	The CMS QI initiative roll.
Significance:	Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Pediatric clinicians in New Mexico who have effective policies and procedures in place to provide effective integration of physical health, oral and behavioral health care and have an effective method for cross-provider communication are needed to increase the percentage of children with a medical home. The QI initiative will increase the likelihood that pediatric providers utilize the appropriate policies and procedures.

ESM 12.1 - The number of Health Care providers participating in health care transition education and training on the 6 core elements of transition
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Goal:	Increase the number of adult primary and specialty care practices that report they have a written health care policy or approach to support youth with special health care needs to integrate into the adult health care practice.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	CMS Training roll.
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families.Collaborate with the NM Family to Family Health Information Center and the Center for Development and Disability to provider resources, supports and training to adult health care providers, and to families and youth on physical and behavioral health care transition will invariably increase the the number of Health Care providers participating in health care transition education and training on the 6 core elements of transition.

ESM 13.1 - Number of interagency partnerships implemented to coordinate dental and other services
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Goal:	Form inter-agency partnerships to improve coordination between services
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Title V community-based services list
Significance:	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases. In New Mexico inter-agency partnerships are essential to improving coordination of services and establishing programs and policies to increase access to oral health care. Promoting the importance of oral health via a state wide health education campaign will increase New Mexico's inter-agency partnerships.

ESM 15.1 - Develop at least one cross-agency agreement or policy developed to address insurance gaps for prenatal and child coverage.
NPM 15 – Percent of children ages 0 through 17 who are adequately insured

Goal:	Improve access to and navigation of health insurance coverage and resulting services.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Cross-agency agreements or policies developed will be in writing. The number of agreements and policies will be counted.
Significance:	Inter-agency agreements are the of utmost importance in improving access to care and ensuring that children are adequately insured. In New Mexico approximately 10% of children are uninsured. The American Academy of Pediatrics highlighted the importance of this issue with a policy statement. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services.

ESM 15.2 - Percent of children 0-17 previously uninsured at baseline who are insured at period end, among Medicaid-eligible, insurance pool/high risk and private insurance populations.
NPM 15 – Percent of children ages 0 through 17 who are adequately insured

Goal:	To measure the proportion of women and children experiencing insurance gaps before and after targeted coordination of navigation
Definition:	<table><tr><td>**Numerator:**</td><td>Number of children (0-17) previously uninsured at baseline who are insured at period end among medicaid eligible, insurance pool/high risk, and private insurance populations</td></tr><tr><td>**Denominator:**</td><td>Number of children (0-17) who are uninsured at baseline in the medicaid eligible, insurance pool/high risk and private insurance populations.</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table>
Data Sources and Data Issues:	Baseline is 2014 Medicaid Medicaid-eligible, insurance pool/high risk and private insurance populations. Period end is 2016.
Significance:	New Mexico's need assessment found that people were confused about new or developing healthcare coverage options through Medicaid (Centennial Care). The strategies to increase insurance coverage tie to specific improvements in coordinated efforts to help people with insurance navigation during different stages of the life course. Of particular concern is access and healthcare utilization among women and children who do not qualify for Medicaid (by income or residence status) and cannot afford to purchase insurance, outright. There are periods of time when families are particularly susceptible to these gaps. For example, women who are eligible for Medicaid during pregnancy and then fall out of insured population when that category of coverage ends, 6-8 weeks postpartum, may not have any form of healthcare coverage until their next pregnancy. Another example is for children whose family (parents or guardians) may be undocumented or who may not recognize what they can and cannot access based on that barrier. In addition, families whose income prohibits qualifying for Medicaid or SCHIP but may not work for an employer with affordable insurance. We do not yet know what portion of those families actually obtain health exchange plans and if they are able to maintain that coverage for over one year.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: New Mexico

Form Notes for Form 10d NPMs and SPMs

None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	89.2	97.2
Numerator	36	36	35	66	35
Denominator	36	36	35	74	36
Data Source	CMS	CMS	CMS	New Mexico Department of Health. Children's Medical Services. Newborn Screening Program Data. 2014.	New Mexico Department of Health. Children's Medical Services. Newborn Screening Program Data. 2014.
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Data does not include newborn hearing screening data. Data will be available spring of 2016.	
2.	**Field Name:**	**2014**
	Field Note: Data excludes newborn screening as 2014 data is not available.	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	55.0	70.0	70.0	70.0	70.0
Annual Indicator	67.9	67.9	67.9	67.9	67.9
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	43.0	36.0	36.0	38.0	38.0
Annual Indicator	34.9	34.9	34.9	34.9	34.9
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Provisional Or Final ?				Provisional	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	59.0	62.0	62.0	64.0	64.0
Annual Indicator	60.6	60.6	60.6	60.6	60.6
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
4.	**Field Name:**	**2012**

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

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

5.	**Field Name:**	**2011**

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	90.0	57.0	57.0	60.0	60.0
Annual Indicator	55.5	55.5	55.5	55.5	55.5
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
2.	**Field Name:**	**2014**
	Field Note: For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.	
3.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	36.0	37.0	37.0	39.0	39.0
Annual Indicator	35.7	35.7	35.7	35.7	35.7
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCHCN	NSCHCN	NSCHCN
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2012**

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

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

5. **Field Name:** **2011**

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

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

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	75.0	82.0	82.0	84.0	84.0
Annual Indicator	82.0	80.2	80.2	79.1	79.1
Numerator					
Denominator					
Data Source	NIS	NIS	NIS	NIS	NIS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: This output from the National Immunization Survey is for 2014, and is the most recent, provisional data available.	
2.	**Field Name:**	**2013**
	Field Note: This output from the National Immunization Survey is for 2012, and is the most recent, provisional data available.	
3.	**Field Name:**	**2012**
	Field Note: 2012 Data are not yet available.	
4.	**Field Name:**	**2011**

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

2010 and 2011 measure the 4:3:1:3:3:1PS.
2009 measures 4:3:1:3:3:1
Using the 4:3:1:3:3:1 measure:

2007 = 76
2008 = 77
2009= 68.2
2010 = 70.9.

2011 Data represent the 4:3:1:3:3*: 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Haemophilus influenzae type b (Hib) vaccine, and 3 or more doses of hepatitis B vaccine.

Data Alerts: None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	25.0	24.0	24.0	20.0	19.0
Annual Indicator	25.5	22.7	22.1	18.8	16.8
Numerator	1,107	998	904	764	689
Denominator	43,422	44,017	40,974	40,675	40,916
Data Source	NMVRHS	NMVRHS	NMVRHS	NMVRHS 2014.	NMVRHS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: New Mexico Vital Records and Health Statistics. 2015	
2.	**Field Name:**	**2011**
	Field Note: 2011 birth data not yet available New Mexico released new population estimates in February, 2012. Correct denominators to: 2007=43666; 2008=43788; 2009=43910; New rates: 2007 36.8 2008 36.5 2009 29.3	

Data Alerts: None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	50.0	50.0	50.0	50.0	50.0
Annual Indicator	48.0	48.0	48.0	48.0	48.0
Numerator					
Denominator					
Data Source	NM Oral Health	NM Oral Health Program	NM Oral Health	NM Oral Health	NM Oral Health Program
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   2013 data, 2014 not yet available.

2. **Field Name:** **2013**

   Field Note:
   NM is in the process of preparing a third grade survey, statewide. Data will not be available until next year.

3. **Field Name:** **2012**

   Field Note:
   NM Oral Health Program does not collect data for this indicator. The estimate is based on reports from the school based dental sealant program. OOH staff conducts a school based dental sealant program. OOH provides this service to over 125 schools participating in the Federal Free or Reduced School Lunch Program. The program consists of providing oral health education, dental screening, application of the dental sealant, notifies the parent or guardian of the oral health status of the child and in Santa Fe County and Rio Arriba County participates in a dental case manager program.

   NM has submitted a data development technical request to inform this indicator.

4. **Field Name:** **2011**

   Field Note:
   NM Oral Health Program does not track this indicator.

Data Alerts: None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	4.0	4.0	4.5	2.5	2.5
Annual Indicator	5.7	3.5	3.5	3.6	5.5
Numerator	24	15	15	15	23
Denominator	423,624	431,788	425,366	421,196	416,495
Data Source	NMVRHS	NMVRHS	NMVRHS	New Mexico Department of Health. Office of Vital Records and Statistics. New Mexico Death Certificate Database, IBIS. Injury Mortality Data, Motor Vehicle Injury Mortality. 2014.	ew Mexico Department of Health. Office of Vital Records and Statistics. New Mexico Death Certificate Database, IBIS. Injury Mortality Data, Motor Vehicle Injury Mortality. 2014.
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**

Field Note:
Data are final for 2012.

Data Alerts: None

NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.

	2011	2012	2013	2014	2015
Annual Objective	53.0	53.0	53.0	50.0	55.0
Annual Indicator	49.0	49.0	49.0	49.0	51.7
Numerator		144	144	144	
Denominator		294	294	294	
Data Source	NIS	NIS	NIS	NIS	NIS2012
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: 2012 Data NIS did not provide numerators and denominators for 2012.	
2.	**Field Name:**	**2012**
	Field Note: Data from NIS.	
3.	**Field Name:**	**2011**
	Field Note: 2008 birth cohort not available. 2010 data reports cohort born in 2007.	

Data Alerts: None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	97.0	97.0	97.0	97.0	97.0
Annual Indicator	95.0	95.0	90.2	91.0	91.0
Numerator	25,888	25,888	22,799	22,745	21,723
Denominator	27,251	27,251	25,284	24,991	23,872
Data Source	CMS	CMS	CMS	Children Medical Services. Newborn Hearing Program data.	Children Medical Services. Newborn Hearing Program data.
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2015**

   Field Note:
   2015 data is not available so 2014 data was used to populate this field.

2. **Field Name:** **2012**

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

   As of 2/2012, Children's Medical Services has hired a contractor to assess issues around recording hearing screening on the birth certificates. The data have not yet been analyzed.

   The true estimate for 2012 is not available. For 2013 births forward this data will be available.

3. **Field Name:** **2011**

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

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

Data Alerts: None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	10.0	8.0	5.0	8.0	8.0
Annual Indicator	11.9	8.7	8.7	8.7	8.7
Numerator	58,681	46,562	46,562	46,652	46,652
Denominator	493,549	536,553	536,553	536,553	536,553
Data Source	2007 NSCH	2012 SAHIE	2012 SAHIE	2012 SAHIE	2012 SAHIE
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: 2014 SAHIE data release is planned for 2016	
2.	**Field Name:**	**2012**
	Field Note: Previously we used the National Survey of Children's Health for this measures, but the CDC produces annual estimates of health insurance called Small Area Health Insurance Estimates (SAHIE)	
3.	**Field Name:**	**2011**
	Field Note: NM set its target at 10 for the period 2004 through 2010, and during that time it was not reasonable to set it lower. We are not yet able to determine how the Patient Protection and Affordable Care Act (PPACA) is currently affecting child insurance coverage rates, nor are we able to determine how it will affect those rates in the future. Should he act be upheld, we expect that the number of uninsured children in New Mexico will decrease.	

Data Alerts: None

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

	2011	2012	2013	2014	2015
Annual Objective	24.0	35.0	27.0	24.0	24.0
Annual Indicator	25.4	25.4	24.6	23.7	23.2
Numerator	7,885	7,885	5,840	6,549	7,818
Denominator	31,043	31,043	23,721	27,643	33,769
Data Source	eWIC Client Obesity 9197 S	WIC Program Data	WIC Program Data	New Mexico Department of Health. New Mexico The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Program Data. FFY2014.	New Mexico Department of Health. New Mexico The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Program Data. FFY2015.
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Epi was given full access to data and was able to analyze any participant open or closed to wic services in 2015. Previous years relied on the certification start date.	
2.	**Field Name:**	**2013**
	Field Note: National WIC caseloads are down in FY13, and this is reflected in the denominator.	

Data Alerts: None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	8.0	6.5	7.0	7.0	7.0
Annual Indicator	9.0	9.0	9.0	4.9	4.3
Numerator	2,277	2,277	2,277	1,236	1,063
Denominator	25,269	25,269	25,269	25,407	24,585
Data Source	NM PRAMS	NM PRAMS	NM PRAMS	NMVRHS 2014.	NMVRHS 2014.
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2011**

Field Note:
2011 Data not yet available.

Data Alerts: None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	14.0	15.0	15.0	15.0	15.0
Annual Indicator	16.9	20.6	12.8	12.9	18.7
Numerator	25	31	18	18	26
Denominator	147,705	150,352	141,153	139,483	138,991
Data Source	NMVRHS	NMVRHS	NMVRHS	New Mexico Department of Health. Office of Vital Records and Statistics. New Mexico Death Certificate Database, IBIS. Injury Mortality Data, suicide. 2014.	New Mexico Department of Health. Office of Vital Records and Statistics. New Mexico Death Certificate Database, IBIS. Injury Mortality Data, suicide. 2014.
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: Data are final for 2012.	
2.	**Field Name:**	**2011**
	Field Note: 2011 data not yet available. New Mexico revised it's population estimates in 2010. Denominators and rates from previous years should be corrected as follows: 2007=148606 20.18 2008=149024 22.14 2009=149443 17.4	

Data Alerts: None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	70.0	84.0	88.0	85.0	85.0
Annual Indicator	84.1	81.9	77.3	66.0	66.0
Numerator	222	312	420	229	229
Denominator	264	381	543	347	347
Data Source	NMVRHS	NMVRHS	NMVRHS	NMVRHS	NMVRHS
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2015**
	Field Note: Fields populated with 2014 data. NMVRHS 2015 data will be finalized in July 2016	
2.	**Field Name:**	**2012**
	Field Note: This proportion of infants born in the right level of facility indicates a great area of need for NM. Data source: NMVRHS - denominator includes all occurrent births.	
3.	**Field Name:**	**2011**
	Field Note: Includes NM resident out of state births.	

Data Alerts: None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	68.0	70.0	70.0	70.0	70.0
Annual Indicator	63.5	63.2	63.0	63.9	65.9
Numerator	17,302	17,060	16,535	16,609	16,948
Denominator	27,251	26,992	26,242	25,985	25,730
Data Source	NMVRHS	NMVRHS	NMVRHS	New Mexico Department of Health. Office of Vital Records and Statistics. New Mexico Birth Certificate Database, IBIS. Prenatal Care.	New Mexico Department of Health. Office of Vital Records and Statistics. New Mexico Birth Certificate Database, IBIS. Prenatal Care.
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2012**
	Field Note: 2012 Birth data are not yet available.	
2.	**Field Name:**	**2011**
	Field Note: Denominator is not equal to total births in NM. It represents only resident births and eliminates births for which prenatal care status is unknown.	

Data Alerts: None

Form 10d
State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: New Mexico

SPM 1 - The percent of women with a live birth who had no health care coverage for prenatal care.

	2011	2012	2013	2014	2015
Annual Objective	5.0	6.0	6.0	2.0	2.0
Annual Indicator	8.7	8.7	8.7	7.8	7.2
Numerator	2,061	2,061	2,061	1,407	1,707
Denominator	23,559	23,559	23,559	18,060	23,779
Data Source	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: NM PRAMS 2013 dataset. Insurance questions varied somewhat from other survey years in their format, but estimates are fairly stable between 2011 and 2013 data results.	
2.	**Field Name:**	**2014**
	Field Note: NM PRAMS 2012 dataset. Insurance questions varied somewhat from other survey years in their format, but estimates are fairly stable between 2011 and 2012 data results.	
3.	**Field Name:**	**2013**
	Field Note: NM PRAMS 2011 dataset	
4.	**Field Name:**	**2012**
	Field Note: The 2012 PRAMS data are not available from the CDC.	
5.	**Field Name:**	**2011**
	Field Note: 2011 PRAMS data are not yet available.	

Data Alerts: None

SPM 2 - The percent of pregnant women and new mothers receiving support services through community home visiting programs.

	2011	2012	2013	2014	2015
Annual Objective	18.0	18.0	17.0	17.0	17.0
Annual Indicator	15.6	15.6	15.6	21.3	6.8
Numerator	3,880	3,880	3,880	5,295	1,652
Denominator	24,848	24,848	24,848	24,877	24,160
Data Source	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2013 PRAMS Dataset	
2.	**Field Name:**	**2014**
	Field Note: 2012 NM PRAMS dataset.	
3.	**Field Name:**	**2012**
	Field Note: The 2012 PRAMS data are not yet available from the CDC.	
4.	**Field Name:**	**2011**
	Field Note: 2011 PRAMS data are not yet available.	

Data Alerts: None

SPM 3 - The percent of births resulting from pregnancies that were unintended.

	2011	2012	2013	2014	2015
Annual Objective	41.0	45.0	45.0	43.0	43.0
Annual Indicator	47.5	47.5	47.5	42.1	50.8
Numerator	11,786	11,786	11,786	8,571	12,135
Denominator	24,792	24,792	24,792	20,364	23,868
Data Source	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2013 PRAMS Dataset	
2.	**Field Name:**	**2014**
	Field Note: 2012 NM PRAMS dataset. The question changed from 2011 to 2012, and therefore the two periods are not comparable. Prior to the 2012 data collection, there were only four response options for desired timing of pregnancy: 1. later, 2. sooner, 3. then, 4. not then or in the future. Starting with 2012, there was an additional option: I wasn't sure what I wanted. This estimate does not attempt to recode for that difference.	
3.	**Field Name:**	**2013**
	Field Note: 2011 NM PRAMS dataset	
4.	**Field Name:**	**2011**
	Field Note: 2011 PRAMS data are not yet available.	

Data Alerts: None

SPM 4 - The percent of women initiating prenatal care after 10 weeks that did not get care as early as they wanted

	2011	2012	2013	2014	2015
Annual Objective	45.0	40.0	40.0	60.0	0.0
Annual Indicator	57.2	57.2	57.2	0.0	0.0
Numerator	4,282	4,282	4,282		
Denominator	7,482	7,482	7,482		
Data Source	NM PRAMS	NM PRAMS	NM PRAMS	N/A	N/A
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: When NM chose this performance measure it was based on a different phase of the PRAMS survey. NM no longer asks if women if they had prenatal care as early as they wanted. We cannot update this estimate.	
2.	**Field Name:**	**2014**
	Field Note: When NM chose this performance measure it was based on a different phase of the PRAMS survey. NM no longer asks if women if they had prenatal care as early as they wanted. We cannot update this estimate.	
3.	**Field Name:**	**2012**
	Field Note: PRAMS data for 2012 are not yet available from the CDC.	
4.	**Field Name:**	**2011**
	Field Note: 2011 PRAMS data are not yet available.	

Data Alerts: None

SPM 6 - The percent of middle school students that report using alcohol within the past 30 days.

	2011	2012	2013	2014	2015
Annual Objective	15.0	15.0	13.0	13.0	13.0
Annual Indicator	14.7	14.7	8.8	8.8	8.5
Numerator	551	551	431	431	392
Denominator	3,744	3,744	4,921	4,921	4,622
Data Source	NM YRRS 2009	NM YRRS 2011	NM YRRS 2013	NM YRRS 2013	NM YRRS 2015
Provisional Or Final ?				Final	Provisional

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2015 data will be available in July 2016	
2.	**Field Name:**	**2014**
	Field Note: Provisional from 2013 data	
3.	**Field Name:**	**2012**
	Field Note: The percentage for 2012 is based on the percent reported in 2011 since the middle school survey is conducted every other year, in 2009, 2011, 2013.	

Data Alerts: None

SPM 7 - The proportion of women who report being physically abused by husband or partner during pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	4.0	4.0	3.0	3.0	2.5
Annual Indicator	3.5	3.5	3.5	2.3	3.1
Numerator	892	892	892	583	746
Denominator	25,235	25,235	25,235	24,982	24,285
Data Source	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS	NM PRAMS
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: 2013 PRAMS Dataset	
2.	**Field Name:**	**2014**
	Field Note: 2012 NM PRAMS dastaset	
3.	**Field Name:**	**2013**
	Field Note: 2011 NM PRAMS dataset	
4.	**Field Name:**	**2012**
	Field Note: The 2012 PRAMS data are not yet available from the CDC.	
5.	**Field Name:**	**2011**
	Field Note: 2011 PRAMS data are not yet available.	

Data Alerts: None

SPM 8 - The proportion of women who exclusively breastfeed their babies through six months.

	2011	2012	2013	2014	2015
Annual Objective	20.0	16.0	16.0	16.0	18.0
Annual Indicator	14.9	22.8	19.3	16.1	24.5
Numerator					
Denominator					
Data Source	CDC NIS 06-08 cohort	CDC NIS 06-08	CDC NIS, 2009 births	CDC NIS, 2011 births	CDC NIS, 2012 births
Provisional Or Final ?				Final	Final

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2015**
	Field Note: NIS does not provide numerators and denominators, estimates based on 2012 births.	
2.	**Field Name:**	**2014**
	Field Note: NIS does not provide numerators and denominators, estimates based on 2011 NIS data, reported in the CDC Breastfeeding Report Card, 2014.	
3.	**Field Name:**	**2013**
	Field Note: NIS does not provide numerators and denominators, estimates based on 2009 NIS data, reported in the CDC Breastfeeding Report Card, 2013.	
4.	**Field Name:**	**2012**
	Field Note: CDC NIS does not provide numerators and denominators. Methods for sampling changed for this year. That may explain some of the differences from previous and latter reports.	
5.	**Field Name:**	**2011**
	Field Note: CDC NIS does not provide numerators and denominators.	

Data Alerts: None

Form 11
Other State Data

State: New Mexico

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the current application/annual report.

State Action Plan Table

State: New Mexico

Please click the link below to download a PDF of the full version of the State Action Plan Table.
State Action Plan Table

Abbreviated State Action Plan Table

State: New Mexico

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2	
			SPM 1

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
To maintain and increase breastfeeding initiation and duration	NPM 4 - Breastfeeding	ESM 4.1	
To improve safe sleep practices among home visiting participants and birthing facility medical staff			SPM 2

Child Health

State Priority Needs	NPMs	ESMs	SPMs
To increase the percentage of children receiving a developmental screen	NPM 6 - Developmental Screening	ESM 6.1	
To decrease abuse and maltreatment of children			SPM 3

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
To improve access and quality of comprehensive well exams for adolescents	NPM 10 - Adolescent Well-Visit	ESM 10.1 ESM 10.2	
To reduce birth rates among teens 15-19			SPM 4

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase access to care to a family-centered comprehensive medical home for children and adolescents	NPM 11 - Medical Home	ESM 11.1	
To increase the amount of services available to assist adolescents to make successful transitions to adult health care services	NPM 12 - Transition	ESM 12.1	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.	NPM 15 - Adequate Insurance	ESM 15.1 ESM 15.2	
To increase and improve access to preventive dental care in pregnant women and children	NPM 13 - Preventive Dental Visit	ESM 13.1	