Maternal and Child Health Services Title V Block Grant

New Mexico

FY 2019 Application/ FY 2017 Annual Report

Created on 9/26/2018 at 10:55 PM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

LYNN GALLAGHER, CABINET SECRETARY

July 16, 2018

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

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 2017 and application for Federal Fiscal Year 2019.

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

Sincerely,

Janis Gonzales, MD, MPH, Title V Director
2040 S. Pacheco St. NW
Santa Fe, NM 87505
505-476-8901
janis.gonzales@state.nm.us

PUBLIC HEALTH DIVISION
1190 St. Francis Dr., Suite 1050 • P.O. Box 26110 • Santa Fe, New Mexico • 87502
(505) 827-2389 • FAX: (505) 827-2329 • www.nmhealth.org

ACCREDITED HEALTH DEPARTMENT • PHAB • PUBLIC HEALTH ACCREDITATION BOARD

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 F of the 2018 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 *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Executive Summary:

The Title V grant is the only source of federal funding specifically dedicated to improving health outcomes in the maternal and child populations. In New Mexico, these federal funds are blended with state funds and program revenues to allow a broader scope of program activities. Even so, there is still much more that could be done, and difficult decisions about funding must be made. All the Title V funded programs struggle with acknowledging the unmet needs and trying to balance breadth with depth. Information gathered from communities and stakeholders reveals that there are a wide variety of needs in this population; yet we also must focus our limited energy and resources on specific areas if we are going to have an impact and achieve real improvement. A renewed focus on health equity and family-consumer partnerships throughout all the programs has strengthened the Title V program in NM. In addition, we have made a concerted effort to partner with other agencies and entities in the past couple of years in order to expand our reach and leverage opportunities.

Maternal Health

The Maternal Health Program (MHP) is the regulating agency for licensing both certified nurse-midwives (CNMs) and licensed midwives (LMs), in New Mexico. Recently, the CNM Practice Rule was revised to help clarify processes in regulatory and disciplinary actions, and to include guidance on opioid and controlled substance prescriptions. In 2017, plans were made to re-launch the Maternal Mortality Review committee (MMRC) whose purpose is to examine maternal deaths occurring in the perinatal period and make recommendations to improve the system of care for pregnant and postpartum women. The MMRC committee receives organizational support from the MHP staff and received technical assistance from CDC Foundation. Title V staff also collaborated with the University of New Mexico on the New Mexico Maternal and Infant Oral Health Project to train primary care practices to incorporate oral health. Implementation phases were developed throughout 2016-2017 and activities were developed with home visiting sites, federally qualified health centers, and school-based health centers.

Maternal health is moving forward with the priorities of improving access and continuity of healthcare services to women in the perinatal period through direct programming and systems level changes. Implementation of a project regarding follow up care for mothers diagnosed with gestational diabetes will be piloted at one site in 2019. Also underway is the launch of the New Mexico Perinatal Mental Health Collaborative, which aims to improve perinatal mental health, provide stakeholders with subject matter expertise and work with prenatal and pediatric providers to support assessment and care of mothers with perinatal mental health concerns.

Title V staff are also collaborating with staff from the Children, Youth and Families Department (CYFD) to draft a state plan for care of infants born exposed to substances, including but not limited to opioids. Like many states, NM has seen a surge in babies born with Neonatal Opioid Withdrawal Syndrome (NOWS). CYFD has a federal mandate to ensure safe plans of care are developed for all babies born exposed. As we work together to achieve this mandate we are also going upstream to develop recommendations for prenatal screening and protocols for hospitals regarding screening, diagnosis and reporting.

Perinatal/Infant Health

In addition to the work on NOWS, safe sleep promotion and breastfeeding initiation and duration are top priorities in perinatal/infant health. Along with the Office of Injury Prevention and the Office of the Medical Investigator, we established short-term goals to present data with the NM Injury Prevention Coalition and shaken baby training staff at UNM. Regulation of shaken baby education training shifted to DOH at the close of 2017 and we started the planning process with the Office of Injury Prevention to designate roles within our partnering programs. CYFD has

simultaneously been working on training their staff in safe sleep and has piloted the distribution of baby boxes. We are working to align our efforts and to develop a state plan for safe sleep that includes shared goals, objectives and strategies. Additionally, the Child Health Program funded and distributed over 10,000 Back to Sleep books to home visitors, child care providers and parents.

The MCH Epidemiology program and the Breastfeeding Taskforce collaborated on the workplace breastfeeding initiative with ASTHO through 2017. Qualitative community-level data and health-provider survey data were collected to assess clinical familiarity with and practice of breastfeeding support consistent with Baby-Friendly USA designation standards. Continuation of the longitudinal 2-year follow-up (toddler survey) to PRAMS was strengthened with partnerships through the College of Population Health at UNM and NMDOH epidemiology staff. WIC expanded peer counseling models to engage mothers in the U.S.-Mexico border communities who were not previously served, providing breastfeeding education and support.

To support quality improvement efforts in perinatal regionalization, Maternal Health staff conducted the CDC LOCATe survey among all facilities delivering NM resident births. This survey allows us to compare hospital designated levels of care with CDC standards, and the results will be discussed with each hospital going forward. Ultimately the goal is to develop quality improvement strategies and work with birthing hospitals to measure improvements in both neonatal and maternal levels of care over the next three years.

Child Health

In addition to funding programs in the Family Health Bureau, some Title V funds are distributed to other Bureaus and Divisions who share our goals, including Injury Prevention, the Adolescent Health Program, and the Office of Oral Health (OOH). OOH continues to provide preventive care to preschool and school-aged children throughout New Mexico. Preventive care includes oral health promotion activities, dental examinations, providing sealants, fluoride varnish and dental health case management. The OOH has a large network in New Mexico and reaches out to organizations such as WIC, the University of New Mexico, local news stations, school systems and dental providers to complete this work. Since 2014, the Albuquerque water authority ceased providing community water fluoridation for the largest municipal region in the state. In 2017, after much advocacy work, the water authority voted to reinstate water fluoridation. OOH has applied for a CDC grant, Improving Oral Health Outcomes. The grant is to provide funding for five years to: increase the number of elementary and middle schools having a dental sealant program, increase the number of communities providing water fluoridation/increase consumption and to establish a surveillance system. The grant also requires the grantee to develop and publish a “NM Oral Health Burden” document.

Additionally, the Child Health Program Manager partners with the J Paul Taylor Task Force and other stakeholders to work on issues such as increasing developmental and socioemotional screening in early childhood and increasing parent access to early childhood information and resources. The Child Health program health educator continues to conduct ASQ and ASQ-SE trainings to increase the capacity for developmental screening, and continues to advocate for the use of standardized screening tools.

Adolescent Health

Adolescent health priorities for 2017 were to reduce unintended teen birth rates and to increase adolescent well visits. The NM Family Planning Program (FPP), Family Health Bureau and PHD/DOH have been working to decrease the unintended teen birth rate through increasing access to reproductive clinical services, increasing awareness of birth control options, and educational programming. 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 bring about measurable reductions in unintended teen births. NM Title V continues to support the implementation of two evidence-based unintended teen pregnancy prevention programs: Teen Outreach Program (TOP) and Project AIM (Adult Identifying Mentoring). Since 2017, TOP has expanded in NM and is now implemented in nine counties at thirteen sites statewide by seven different organizations.

New Mexico participated in the Adolescent and Young Adult Health (AYAH) CoIIN collaborative to increase comprehensive well exams among adolescents and young adults. The AYAH CoIIN brought together Title V, the Office of School and Adolescent Health (OSAH), and various partners to increase well exams among adolescents. The AYAH CoIIN, in partnership with local and national organizations, developed the "*Know Your Health Toolkit*" which is intended to be used in clinics that serve young adults. The toolkit emphasizes increasing youth-friendly services, preventative services and youth-specific health literacy. By 2019, there will be enough data gathered from the pilot period of the "*Know Your Health Toolkit*" to begin evaluation and understand the strengths and weaknesses of the toolkit. After adjustments have been made, plans are in place to connect with appropriate health organizations to begin distribution of the toolkit.

Children with Special Health Care Needs (CSHCN)

The Children with Special Health Care Needs (CSHCN) program in NM, Children's Medical Services (CMS), has been specifically focused on increasing numbers of CSHCN who receive care in a Medical Home and ensuring successful transitions to adult healthcare. CMS social workers work on an individual basis to connect all their clients to a Medical Home, and in addition, the program has worked on population based strategies to expand the number of CSHCN served. In the summer of 2017, CMS submitted a proposal to the Association of Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) that was accepted for participation in an Action Learning Collaborative (ALC) around "Strengthening Medicaid Managed Care for Children with Chronic and Complex Health Care Needs". The ALC work began in the fall of 2017 and will end in fall of 2018. CMS is contracting with the Center for Development and Disability at the University of New Mexico to evaluate the effectiveness of care coordination that is provided in New Mexico. Also in 2019, the Newborn Hearing (NBH) and Newborn Genetic Screening (NGS) Programs will continue to include the medical home during follow-up services. The Newborn Hearing program will enter the third year of funding and will continue the Sandoval Learning Community project that is developing a shared plan of care to be used by the Medical Home and to assist families in accessing resources.

Since 2002, CYSHCN Social Workers have provided service coordination and transition planning to youth aged 14-21 using the "CMS Youth Transition Plan." Transition continued to be a challenge in some areas of the state where there were not existing relationships between youth and adult providers. To try and address this, CMS social workers committed to a 'warm hand off' between providers. This will continue to be an ongoing relationship building process. The third year of a contract with Envision, an initiative for childhood healthcare quality, is in progress. The upcoming year will include work on a needs assessment done by pediatricians that focuses on identification of barriers and successes in the transition process from child to adult medical care. In addition, the CHUMS tool that is currently being used to aid in transition will be updated into a new electronic format.

Cross-Cutting/Adequate Insurance

A new focus of Title V in NM has been exploring the connections between racism, provider bias and pregnancy outcomes, and developing strategies to address the tremendous gaps in maternal and infant mortality between Black women, Native women and other women in our state. Although Hispanic women, in general, have experienced more favorable birth and early post-partum outcomes compared to Black and Native American women, they are still at a disadvantage in terms of chronic stress and access to care across the lifespan. The work to address these disadvantages is complex and requires more than rates or prevalence ratios to understand. To tie our data resources with more informed and sustainable interventions, Title V staff have been working directly with the Office of African American Affairs and Southwest Women's Law Center to pool efforts on paid family leave research and to study the economic impact of the policy for NM. MCH Epidemiology, Maternal Health and Child Health staff will continue work in the Infant Mortality CoIINs and related Equity in Birth Outcomes coalition. Surveillance enhancements will continue with Healthy Start, Office of Border Health and both Tribal Epidemiology Centers. Understanding barriers to timely prenatal care, creating linkages between program and epidemiology staff, and

designing interventions with local and national support will help us determine next steps in the ongoing needs assessment and plans for the upcoming five-year cycle.

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 (F2F) program through Parents Reaching Out, EPICS (which focuses on Native American families who have children with special needs), and the strong family advocacy component of the Center for Development and Disabilities (CDD) at the University of New Mexico, among many others. Title V FHB staff meet regularly with our family support agencies and partner with them on several initiatives. Current collaborations include the CSHCN health finance ECHO project and a Mountain States Genetics initiative focused on Native American families. We continue to include family representatives on all program advisory boards as well.

III.A.2. How Title V Funds Support State MCH Efforts

Federal Title V MCH Block Grant funds are distributed through the Family Health Bureau (FHB) at NM DOH. We combine the Title V funding with other funding streams including the State Title V Match, other state general funds, program revenues, and other federal grants to enable us to expand services.

The programs in FHB have multiple funding streams, which complement each other to achieve objectives. For example, the Families FIRST perinatal case management program is funded with Medicaid billing revenue but makes referrals to WIC and Children's Medical Services (CMS). The Family Planning program has funds complemented by Title V, PREP grant, state general fund, private foundation funding and billing revenues to allow the program to reach a larger population. CMS, the NM Title V program for children with special healthcare needs, receives a third of the block grant and leverages these funds by combining them with state general funds, program revenues, and federal grants directed at newborn hearing screening. MCH Epidemiology receives Title V funds and state match as well as funding streams from the SSDI grant, PRAMS, Medicaid revenue and the Kellogg Foundation.

Additionally, funds provide support to projects in partnership with other stakeholders, such as with the NM Perinatal Collaborative for training hospital staff on diagnosis and treatment of neonatal opioid withdrawal syndrome and funding to increase public awareness of early signs of teen depression and suicide risk.

III.A.3. MCH Success Story

The Children's Medical Service (CMS) program has been providing care coordination to a child with a diagnosis of Transverse Myelitis, who was diagnosed at seven months and is now eight years old. The child received early intervention services and rehabilitation at Carrie Tingly Hospital (CTH) in NM. By age seven, the child was not walking but had regained limited use of her upper body and required use of a power wheelchair. Her specialist at CTH recommended that she be seen at the Kennedy Krieger Institute Spinal Cord program at Johns Hopkins (KKI) to potentially increase her mobility. At the time the child was on a care plan which presented severe challenges getting authorizations for essential medical care and equipment. The parents changed MCO's twice to continue getting services at CTH. CMS helped facilitate each MCO transfer and advocate for needed services. Due to difficulties with insurance, the family and provider were worried that the referral to KKI would be denied. A CMS social worker decided to present this story at a local Health Care Financing meeting where all MCO's, providers and care coordinators were present. From that meeting, the referral was approved and the family now receives care at KKI every four months. This patient is now walking with the help of robotics and it is believed that she will achieve the ability to walk independently. Her mother is becoming a family leader and is using her story to advocate for other CYSHCN who face barriers to care.

III.B. Overview of the State

POPULATION:

New Mexico (NM) is the fifth largest U.S. state, yet its population is only 2,088,070 (US Census, 2017), making hours of travel a common occurrence for NM residents. These wide-open plains provide breathtaking scenery, and New Mexico's vivid blue skies and stunning sunsets draw thousands of tourists each year; however, as we will discuss later, this vastness makes it challenging to provide access to services such as health care. While 62% of the population lives in the seven more urban counties -- including Bernalillo County, which is home to 33% of the state's population-- over 7% of the population resides in frontier or sub-frontier areas. Most counties, 25 out of 33, have population densities of less than 15 persons per square mile (US Census, 2010).

Minority groups continue to make up a majority of the population. According to the NM Indicator-Based Information System (NM-IBIS), in 2017, NM's total population consisted of 46.4% Hispanic, 41.4% non-Hispanic White, 8.8% American Indian, 2.0% African American, and 1.5% Asian and Pacific Islander (comparing, respectively, to the US percentages of 16.9% Hispanic, 63.9% non-Hispanic White, 0.8% American Indian/Alaska Native, 12.9% Black/African American, and 5.5% Asian/Pacific Islander, queried from the 2017 NM-IBIS). In 2015, 24.3% of the NM population was under the age of 18, compared to 23.3% nationally; by 2016, that percentage had decreased to 23.6% for NM and 22.8% nationally (US Census, American Community Survey, 2016).

NM is bordered by Arizona, Utah, Colorado, Oklahoma, Texas, and the Republic of Mexico. Our status as a border state with Mexico influences many areas of life in New Mexico, and national and local debate over immigration issues are more than just theoretical for those residing here. The Hispanic population of NM is a mix of deeply rooted families that have been in NM for generations and more recent immigrants. Many families are of mixed status, documented and undocumented, and several NM cities have passed policies supportive of immigrants.

POVERTY:

Poverty is a root cause of many other health issues and inequities, such as inability to access medical care, inadequate school readiness, food insecurity, and obesity. New Mexico continues to be one of the four poorest states in the nation, with a median household income of $45,674 compared to of US median of $57,617 in 2016. According to the most current American Community Survey estimates, 19.8%, or 404,463 individuals, of New Mexicans are now living in poverty (https://www.census.gov/quickfacts/fact/table/NM/PST045217). Children perhaps suffer the most from the high poverty rate, with almost a third of NM children currently living in poverty, and this rate is even higher for those in single parent homes. The "children in poverty" rate based on household income in 2016 ranked NM 48th in the nation, with 30% of children living in poverty (compared to 19% nationally); 20% of New Mexicans lived below the poverty level in 2016 (compared to 14% nationally). Twenty percent of all families and 45% of single-parent families had incomes below the poverty level (Annie E. Casey Foundation, 2016).

EDUCATION:

In recent years, the importance of the first 3-5 years of brain development, early literacy, and school readiness has received focused attention from legislators and private foundations. This has resulted in encouraging increases in home visiting, pre-K and high-quality childcare programs; however, we know that there are still more children in need of these services. The Thornburg Foundation is developing a Business Plan for Early Childhood that will make the business case for fully funding childcare, Pre-K and home visiting in NM. The NM Pediatric Society and Voices for Children have each released their own Agendas for NM's Children, both of which include recommendations around early learning. All of these groups will be presenting their recommendations to the Gubernatorial candidates and legislators in the coming election cycle.

High school graduation rates are another critical measurement. NM needs an educated workforce to meet the needs of businesses and attract technology and other new companies to the state. In the 2015-2016 school year, 71% of the NM population graduated from high school within four years (2017, NM-IBIS). In the same year, 7% of teens ages 16-19 were not in school and not high school graduates (national average is 4%), ranking NM as one of the worst in the nation in this indicator (2017, Annie E. Casey Foundation, Kids Count).

ACCESS TO HEALTHCARE:

There are many barriers to accessing health care in NM, including provider shortages, lack of affordable insurance, and having to travel long distances for specialty care. Travel is even more of an issue for pediatric subspecialty care, since most of the subspecialists, and the state's only Children's Hospital, reside in the state's largest metropolitan city, Albuquerque. Cultural barriers to care include language barriers and 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. Thirty-one of NM's 33 counties are "health professional shortage areas", demonstrating the need to address this critical access to care problem (HRSA, 2018).

New Mexico was one of the states that expanded Medicaid to include low-income adults under the Affordable Care Act (ACA), more New Mexicans are insured than ever before. This has helped improve access to some extent, although having insurance does not guarantee access to a healthcare provider. Immediately after ACA implementation, the state's uninsured rate was down to 12.8% (in 2015), compared to 20.2% in 2013. As of March 2018, New Mexico has enrolled 830,010 individuals in Medicaid and CHIP. The majority of new enrollees were in the Adult Expansion category.

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 and Project ECHO (which started in NM) 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.

For children in NM, Medicaid, CHIP, and the managed care organizations that contract with the Human Services Department are vital to healthcare access. NM Medicaid provides many health care services for children under a federal Medicaid policy which requires that children received Early Periodic Screening, Diagnostic, and Treatment (EPSDT). This policy includes preventive health services, maintenance health services and treatment of medical conditions. It also includes mental health or behavioral health services. Medicaid covers over 50% of children in NM and over 70% of births.

NMDOH PRIORITIES:

In May of 2014, NM Department of Health (NMDOH) published the State Health Improvement Plan (SHIP). The State Health Priorities identified in the plan 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. The SHIP is in the process of being reviewed and a revised five-year document will be published in 2019. We will also have a new administration coming in 2019, so priorities may shift at that time.

Obesity:

Although the DOH Office of Nutrition and Physical Activity resides in another Bureau, the Family Health Bureau WIC staff address childhood obesity every day in their work. 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. The Title V Director has also been working with WIC on a collaboration with NM State University (NMSU) to teach healthy eating and cooking habits to WIC clients in public health offices. NMSU staff provide cooking classes for clients who can get their WIC benefits at the same time. We have also been discussing adding produce from Roadrunner food bank as an added benefit for clients; when they attend the classes the participants also leave with produce provided by the food bank. In 2017, 13.9% of kindergarteners and 19.9% of 3rd graders were obese (2017, ONAPA). American Indian students are still significantly more likely to experience obesity than any other racial or ethnic group. By third grade, half (55.6%) of American Indian students are either overweight or obese, which has increased by 5.2% since 2015. This is followed by Hispanics who have 36.6% overweight or obese by third grade, but in contrast, has had a steady rate since 2014. The downward trend that has previously been observed in obesity prevalence among 3rd grade students is slowly increasing; after a five-year gradual decrease, rates have been increasing by approximately 0.5% per year for the last two years.

Smoking:

Cigarette smoking is the most modifiable health risk in the United States, and its contribution to infant mortality is well-documented. WIC screens every applicant for tobacco use and make referrals to the Quit line or medical providers as needed. Families FIRST also screens all their pregnant clients for tobacco use and makes appropriate referrals.

In New Mexico, we have estimated 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 21.7% (2011) to 16.8% (2016) (NM-IBIS), and from 20.5% to 14.8% among women of childbearing age (18-49 years) for the same period (NM BRFSS). Among women giving live birth who reported smoking in the three months before pregnancy in 2012-2015 (35.6%), almost three quarters (71.1%) quit during pregnancy. The prevalence of smoking during pregnancy decreased moderately from 9.7% in 2000 to 7.1% in 2015 (NM Pregnancy Risk Assessment Monitoring System). There has also been a decrease in the percentage of mothers who smoke postnatally. From 2000 to 2015, the percentage of moms who smoked decreased from 16.4% to 11.7% respectively. By maternal race-ethnicity, non-Hispanic White women (13.0%) were significantly more likely to smoke during pregnancy compared to Hispanic (5.9%) and Native American women (5.6%) giving birth in NM (2012-2015).

Drug and Alcohol Misuse:

The Family Health Bureau works on substance misuse and its effects in many ways. The PRAMS survey added supplemental questions in 2014 that have helped inform programs on drug use in pregnancy. The Title V Director and Maternal Health Program Manager have been on the Board of the NM Perinatal Collaborative (NMPC) for several years and have helped provide funding for one of the NMPC projects having to do with improving the diagnosis and treatment of babies born with NAS/NOWS (Neonatal Abstinence Syndrome/Neonatal Opioid Withdrawal Syndrome). The NMPC is also considering a project to work with hospitals to implement the Maternal Opioid AIM bundle. And recently, the Children Youth and Family Department engaged with us to help them respond to federal requirements that require them to report all babies born exposed to substances and develop safe care plans for each of these infants. This has been a wonderful opportunity for interagency collaboration.

In 2016, NM had the 12th highest drug overdose death rate in the nation. In the same year, NM's age-adjusted drug overdose death rate was 24.8 per 100,000 persons which translates to 497 New Mexicans. Drug overdose death

rankings have been improving for NM since 2014 when NM was the second highest in the nation. However, these changes are not due to an improvement in the death rate, but rather the worsening of the rates in other states. Between 1999 and 2015, the overdose death rated in NM increased by 62.0% and since 2014, rates have remained fairly stable. Prescription opioids have driven the increase in overdose death rates since 2006.

Legalization of marijuana has been brought up at the past three legislative sessions and it is gaining momentum now as all the Gubernatorial candidates have taken positions on it. NM legalized medical marijuana several years ago and the program continues to expand in the number of eligible conditions and in the number of certified growers and users. One of our upcoming challenges will be to make sure any changes in marijuana laws take into account the safety of children; we have already started to see incidents of children finding or accidentally ingesting marijuana and other substances.

In 2016, excessive alcohol use (i.e., binge drinking) remained one of the top leading preventable cause of death in the US. NM has the highest alcohol-related death rate in the US at 66 deaths per 100,000 population and which is nearly twice the US rate. Most of alcohol-related deaths involve working-age adults. Among women, drinking during pregnancy decreased from 5.2% in 2000 to 4.5% in 2015 (NM PRAMS). New Mexico, like many parts of the country experienced a sky-rocketing (about 9 times) increase in neonatal abstinence syndrome (NAS) diagnosis in infants born between 2000 and 2015. Just between 2011 and 2016, the statewide rate increased by two-fold from 6.1 to 12.2 per 1,000 live births.

NAS Diagnosis in Infants per 1000 live Births						
Year	2011	2012	2013	2014	2015	2016
Rate	6.1	7.6	8.8	9.4	10.3	12.2

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 (GDM). In 2016 American Indians in NM had the highest rate of deaths due to diabetes, about two times higher than that of Whites (2017, NM-IBIS). A partnership between the University of New Mexico and the Maternal Child Health program at DOH is currently working to address the issues faced by mothers diagnosed with GDM to help prevent the development of Type II diabetes later in life. 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; however, with loss of staffing the projects were discontinued. We are hopeful that these projects may be revived and expanded in the near future as there have been discussions with PHD Leadership about using public health nurses in different ways including possibly as diabetes educators, and the state funding outlook is brighter for 2019.

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 several factors including 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. Every county in New Mexico except one is a dental practice shortage area as well as a medical practice shortage area. The Legislative Finance Committee has estimated that the state needs an additional 153 dentists, the great majority of whom are needed in rural, underserved parts of the state.

NM Medicaid provides full dental services for children and limited for adults. In 2015, the PRAMS survey reported that 89% of mothers surveyed agreed that it is important to care for teeth and gums, however, only 46% of these mothers reported having their teeth cleaned in the year before they got pregnant (2015, PRAMS). In 2016, 37.7% of New Mexican residents reported not having a dental visit in the past year and 85.1% of residents over age 65 have had all their natural teeth extracted (2017, NM-IBIS). 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 2017, community water fluoridation was again supported and is in the process of reinstatement. In addition, Title V programs and the DOH Office of Oral Health are working together to resume an oral health surveillance system, including a survey of third graders receiving sealants on permanent molars. In May 2018, the NMDOH Office of Oral Health will apply for a grant that will provide five years of funding in order to establish a surveillance system in addition to other preventative dental activities. If approved, funding will begin October 2018.

Many dentists are not trained in how to provide services to children and youth with intellectual and cognitive disabilities, resulting in an even greater gap in services. The University of New Mexico School of Medicine's Department of Dental Medicine received some funds to create additional educational and clinical opportunities for UNM's special needs dental clinic. The five-year grant from the U.S. Health Resources and Services Administration will provide a special needs coordinator to oversee the academic program and direct patient care experiences for dental residents enrolled in UNM's dental residency program. Another program at UNM has a three-year HRSA grant to work with primary care providers to train and encourage them to include oral health screening in their patient visits. This will be described in more detail later in this grant as it directly affects the population of pregnant women in the state.

Teen Births:

The Title V Director (who is also the Family Health Bureau Medical Director) and the Family Planning Program staff have been working diligently on the issue of reducing teen and unintended births in NM and increasing access to long-acting reversible contraception (LARC). They work with UNM, Young Women United, Planned Parenthood, the ACLU and others as part of the LARC Statewide Working Group to train providers and promote awareness of LARC.

In 2016, there were 24,692 births to NM resident mothers. NM's age-specific fertility rate (typically called 'birth rate' for teens) has declined 45% between 2010-2016 but remains higher than the national rate. The 2016 NM rate for 15-19-year-old females was 29.4 per 1,000 live births compared to 34.2 in 2015 (2017, NM-IBIS).

Disparities persist for Hispanic and American Indian teens. In 2016 American Indian teens had the highest birth rates in NM (35.2/1000) followed by Hispanic teens (34.2/1000). Hispanics constitute more than half of NM's 15-19-year-old female population, and their share of teen births is higher, representing about 60% of the births in this age

group. Black/African American females ages 15 to 19 gave birth at a rate of 24.6 per 1,000; White females ages 15 to 19 gave birth at 17.8 per 1,000. Using the majority population (White) as the reference group, both Hispanic and American Indian teens have about 2 more births to every White birth (NM-Indicator Based Information System [IBIS], 2016 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 NM women not trying to get pregnant, 50.2% were using a contraceptive method to prevent pregnancy. The three most common reasons for *not* utilizing contraception were: not minding a pregnancy (57.2%), thinking a pregnancy could not occur when it did (28.6%), and having a husband, boyfriend or partner who did not want to use birth control (17.4%) (NM Pregnancy Risk Assessment Monitoring System [PRAMS], 2015 births).

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. A follow-up LFC report came out in fall of 2016. Recommendations of the original report included 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.

Since this report came out DOH/FHB has responded to the recommendations in several ways. We applied for and were given a two-year grant from the Brindle Foundation to fund a social media campaign; this campaign aims to educate NM teens about contraceptive options and how to access these options. Response rates so far have been higher than expected. In addition, as mentioned previously, FHB staff are participating in the LARC statewide working group, a coalition of stakeholders working on increasing access to LARCs through provider training and education. Three pilot sites have been trained, including Lea County, which has the state's highest teen birth rates, and anticipated funding from the Legislature will help fund expansion of the training to three additional sites, as well as a pilot using the DOH Pharmacy to stock clinics with LARC devices to encourage and promote same-day insertion for clients who want this.

The NMPC has also worked for three years on a project to increase Immediate Post-Partum LARC insertion in hospitals. This project has moved slowly due to several roadblocks having to do with data collection and billing problems, as well as resistance from hospital administrators. However, the work continues. During the 2018 Legislative Session the LFC appropriated $250,000 to the DOH for LARC training and stocking (i.e. stocking clinics/offices with LARC devices to promote ease of access and same day insertion). We are issuing an RFP for the training and are working with Medicaid on the stocking project. Medicaid included the LARC stocking in their 1115 waiver application. The goal is to increase access and reduce barriers while utilizing Medicaid federal matching funds as much as possible.

INPUT and NEEDS ASSESSMENT 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:

NM DOH/PHD received public health accreditation in 2015, and work on reaccreditation is beginning. The Public Health Division continues its work on “transformation of public health” but the PHD Leadership team has struggled somewhat to agree on what direction is best with regard to maintaining or decreasing clinical services in the health offices. There has been a slight trend towards decreasing clinical services and there is interest in making the public health offices hubs of community activities, but more discussion is needed. Recent changes in PHD Leadership with the retirement of two Regional Directors may have influence on this discussion but it is too early to know how this will affect the group dynamics. It is anticipated that the upcoming change in state government administration will also have effects on the future direction of public health in NM.

Data improvements:

Over the last couple of years, several programs in the FHB have been undergoing major changes in their IT and client data collection systems. Children’s Medical Services (CMS) has a new IT system, CACTUS, which was originally scheduled to be rolled out in 2015-2016 but has had several delays. It is currently in the final stages of the implementation and training. Additionally, WIC is partnering with Texas and Louisiana in a three-state IT solution; this system is currently in pilot phase and will be fully rolled out statewide by September 2018. Families FIRST, a perinatal case management program, will be utilizing the same system as CMS. Additionally, the Human Services Department (Medicaid agency) is developing a new Management Information System that they anticipate rolling out in the next 2-3 years. The plan is for this system to serve as a “hub” for data from all state agencies, both receiving this data and acting as a source for data review and analysis.

CHALLENGES:

Many of the same challenges continue, including the constant challenges of high poverty rates, health care provider shortages, inadequate funding, and the challenges of addressing health inequities in a multi-cultural state. The state budget has stabilized compared to a couple of years ago; however, hiring remains a challenge due to changes in the hiring process and loss of staff. 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. 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). 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.

All NM public health programs are currently seeing a decrease in caseload, partially due to immigrants being afraid to come to the health offices or access services. We are trying to get the word out that public health programs are still available for everyone in NM. Children's Medical Services and WIC staff in particular report that families are very fearful about possibly being deported, and parents are making contingency plans for their citizen children in case the undocumented parents disappear suddenly.

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

The Family Health Bureau programs regularly convene councils and committees to obtain feedback and recommendations on maternal child health priorities and strategies. Consumer/Client feedback is solicited through client satisfaction surveys among the WIC population, CMS clinics, and Families FIRST. These surveys are reviewed and the results are used to improve the services that we provide in the Family Health Bureau. They are also used to identify possible gaps in population participation or opportunities for cross-referral and program service coordination.

The Maternal Child Health Epidemiology Program leads the statewide five-year needs assessment and works with programs to identify ongoing opportunities to seek input on needs and priorities throughout the state. They also interface with community needs assessment staff and processes in the Public Health Regions with tribes and with hospital systems conducting ACA-required assessments. To assure ongoing communication, MCH Epidemiology holds regular Steering committee meetings for the Pregnancy Risk Assessment Monitoring System (PRAMS) and Toddler Survey surveillance activities.

Data Sources and Tools Used in Assessment

NM-IBIS-The NM Indicator-Based Information System (NM-IBIS) is a source for data and information on NM's priority public health issues. It includes all NMDOH datasets including birth and death data, population estimates, hospitalization discharge data and survey data for BRFSS, PRAMS and YRRS (state equivalent to YRBS).

The Guttmacher Institute- The Guttmacher Institute (AGI) is a leading research and policy organization committed to advancing sexual and reproductive health and rights in the US and globally. Data from AGI is used by NM FPP and MCH Epidemiology to track changes in the teen birth rate by state and to provide comparisons with other states and national trends.

Kids Count Data Center- The Kids Count Data Center is a project of the Annie E Casey Foundation, which annually compiles a robust list of indicators on economic, health, education and community well-being at the state level.

National Survey of Children's Health- This survey provides a comprehensive query system to produce both national and state-level estimates on child well-being, including risks and protective factors.

RWJF County Health Rankings- RWJF provides a source of county and sub-county wellness data and provides rankings of health outcomes for each jurisdiction.

Environmental Tracking System- This is a CDC-sponsored birth defects tracking tool which also measures environmental exposures for the birth through early childhood population.

Child Health

There are multiple advisory councils and early childhood committees that provide input and information, including: the Early Learning Advisory Council (ELAC), the state advisory council mandated by the federal Improving Health Start for School Readiness Act of 2007; the J. Paul Taylor Early Childhood Task Force, a legislative convened task force to establish policy that would expand screening of children and families for risk factors; and the Early Childhood Comprehensive Systems-Act Early (ECCS-AE) State Team that focuses on developmental screening, social-

emotional development and screening, and family involvement.

Adolescent Health

NM FPP interacts with community members in various ways, including:

- Representation to local/county Health Councils at state-wide meetings;
- Information on NM Title X goals and work plan shared with NM FPP Information & Education Committee Members;
- Information for non-profits or government agencies interested in decreasing unintended teen pregnancy and increasing access to family planning services;
- Participation with community members at community and/or school health fairs;
- Sharing an overview of NM Title X goals and clinical services to participants in NM FPP Education Programs;
- Input on community engagement from Title X clinical providers;
- Administration of client surveys, to inform local PHO and State Office staff of the availability, access, and appropriateness of family planning clinical services through client self-report.

Client Survey-Since 2007 the Family Planning Clinic Client Survey has been asked of a random sample of all DOH Title X clients. In addition to satisfaction questions, clients are also asked how they heard about services offered at the public health office and if there were any barriers to receiving services. Responses to this survey are used to measure effectiveness and plan changes to Title X services throughout the state.

Training Needs Assessment-The Training Needs Assessment is a survey conducted by the NM Family Planning Program with Title X clinicians and nurses to ensure that the trainings received are pertinent and provided in a timely manner.

LARC Workgroup-The Long-Acting Reversible Contraception (LARC) Workgroup is a public/private partnership that is focused on increasing client and provider awareness of and access to contraception to prevent unintended pregnancy, such as IUDs and implants.

I&E Committee-The Information & Education (I&E) Committee is a public/private partnership that focuses on disseminating information on evidence-based teen pregnancy prevention strategies and clinical protocols.

Maternal Health

The Maternal Health Program gathers information from customers and constituents in three ways:
1) As the program overseeing midwifery licensing, we conduct quarterly midwifery advisory board meetings for the certified nurse-midwives and the licensed midwives group(s).
2) The program periodically conducts site visits with the group of contracted provider sites. Each site is queried on aspects of the funding administration as well as on the services that are offered at the provider clinics and the experiences of the clients who are eligible for the funding.
3) In other program projects, we are designing and testing interventions to inform preconception/inter-conception and early pregnant clients of available services and to engage consumers in early prenatal care. A recent panel was conducted to gather information from clients/consumers of La Clinica's services to improve the approaches we incorporate into the project's design.

CYSHCN

Children's Medical Service (CMS) continues its established partnership with the MCH Collaborative, which meets quarterly and provides input to CMS on the unmet needs of the CYSHCN population. The MCH Collaborative is comprised of CMS, Family Voices, Parents Reaching Out (PRO), the Pediatric Pulmonary program at UNM, the

UNM Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program, the Developmental Disability Planning Council (DDPC), and the organization Education of Parents of Indian Children with Special Needs (EPICS). The collaborative is a good mechanism for CMS to receive feedback from other MCH funded programs and parent organizations representing diverse backgrounds.

CMS also receives feedback 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. Family satisfaction surveys are completed at the cleft palate clinics and an exit interview is done with each family to clarify their unique needs. CMS staff attend health fairs, outreach events and have staffed a table at both family leadership conferences held by PRO and EPICS. The NM team for the Mountain States Regional Genetics Collaborative is in the process of conducting a needs assessment of families who have a child with a genetic condition, focusing primarily on feedback from Native American families in rural areas.

Noted changes in the health status and needs of the state's MCH population, as compared to the identified priority needs for the MCH Block Grant

With all the information gathered from these various sources noted above, and considering the FHB and DOH capacity to address the needs, the Title V FHB team made the decision to narrow down our priorities this year so that we could focus our work and energy on the high priority areas where we feel we can have the biggest impact.

Noted changes in the state's Title V program capacity or its MCH systems of care, particularly for CSHCN, and the impact of these changes on MCH services delivery

Since 2016, capacity to address maternal mortality has increased substantially as has its focus as an emerging issue in New Mexico. While it did not emerge as a focus during the 5-year needs assessment, it has steadily risen in public health and across the United States as a concerning problem.

The system of care for CYSHCN in New Mexico is increasingly dependent on NM Medicaid policies and practices. New Mexico has benefited by the ACA as a Medicaid expansion state. This has helped close the gaps in health care access for youth age 18 and older who historically had trouble finding affordable insurance coverage after aging out of Medicaid/CHIP. Medicaid is in the process of renewing the 1115 Waiver and key components include care coordination enhancements, patient centered medical homes and integrative behavioral/physical health homes. The Title V program has developed key partnerships with the MCO's and this provides the perfect opportunity to provide input into policy development around key elements such as care coordination, medical home and transition. Another key opportunity directed at financing is the Health Care Financing ECHO project lead by Parents Reaching Out our F2F, Title V, Medicaid, the MCO's and other key partners. This has provided a platform to address financing issues for CYSHCN and could be used to address systemic change.

The breadth of the state's Title V partnerships and collaborations with other federal, tribal, state and local entities that serve the MCH population

New Mexico Title V staff have led initiatives in infant mortality prevention through collaborative and innovation networks (CoIIN) since 2012. The multi-sector participation began with a scan and blueprint of infant mortality prevention touch points and prioritization through national strategy areas. The NM Hospital Association has been a key partner working to address the reduction of non-medically indicated deliveries, and they continue to support Title V efforts in perinatal regionalization, maternal mortality review and breastfeeding policy assessment.

NMDOH MCH Epidemiology works closely with both area (AASTEC and Navajo Epidemiology Center (NEC) TECs-

We participate with NM Tribal PRAMS, Navajo area MCH workgroup, and cross-jurisdiction needs assessment approach w AZ, UT, Navajo and Albuquerque Area. From 2012-2015 NM PRAMS and Navajo PRAMS staff worked with AASTEC to oversample Native American participation in the state surveillance. This had a significant impact on our ability to provide data specific to AI/AN women in NM but not at the tribe level for most communities. Through ongoing communication and development of multi-jurisdictional data sharing agreements, NMDOH MCH

DOH MCH Epidemiology, NEC and AASTEC designed trainings, protocols and operations materials to assure continuity in the original state and Navajo surveillance for NM and transfer of knowledge to the new all-tribes surveillance starting in 2018. A NM Tribal PRAMS surveillance database was completed by AASTEC and staff were trained in data collection procedures from December 2017-February 2018. Live data collection began in May 2018. The three agencies are in the process of planning a Maternal Child Health Tribal data symposium for October 2018. This will be an opportunity to obtain feedback from community members, healthcare providers and health systems analysts.

Changes in organizational structure and leadership

The Department of Health leadership remained fairly stable in 2017. The only position that turned over was the Deputy Secretary for Programs: James Ross left the Department and Dawn Hunter from the Office of Policy and Accountability was appointed as the new Deputy Secretary. The Pubic Health Division and Family Health Bureau leadership teams remained in place, providing consistency and stability for the Title V programs. Many changes in public health leadership are expected in 2018 and 2019 as several staff members are planning to retire. In 2019 the state will have a new Governor and likely an entirely new Cabinet, including the Secretary of Health and the Deputy Secretaries, so planning is already ongoing regarding proposals that might be suggested to a new administration.

Zika Virus Update in New Mexico

Since 2016, the Zika outbreak that was of much concern here in New Mexico due to the potential impact and risk of adverse maternal outcomes has become less of a risk. Provisional data reported by the CDC as of June 6, 2018 reports that there have been 20 Zika virus disease cases reported in the United States and no reported cases in New Mexico. However, the with the New Mexico Department of Health, Infectious Disease reports 10 travel-associated cases in 2016, no cases in 2017 and no cases so far in 2018. The Family Health Bureau worked with others in PHD and DOH regarding a state plan for Zika. The plan included a collaboration between the Infectious Disease Epidemiology Bureau and Environmental Health Epidemiology Bureau to ensure that Zika testing is done for pregnant women and infants if it is warranted. The collaboration resulted in increased capacity overall. New Mexico does travel screenings on all microcephaly and CNS birth defects to rule out travel to a Zika affected area.

As part of a long overdue process to move from a passive birth defects surveillance system to an active birth defects surveillance system Children's Medical Services (CMS) is moving to address unmet needs for families with congenital conditions. Data collection and active surveillance started in January of 2017. Ms. Susan Merrill was hired as the Birth Defects Coordinator in the CMS program last March, and developed a system that identified babies born with a diagnosis that may be related to the Zika Virus. For 2017, which was the first year of the Birth Defects Active Surveillance, there were 3,464 babies reported to the state with a BD diagnosis, from that it was determined by ICD 10 coding that about 80% may need and/or qualify for services. While Zika is no longer an emerging threat in New Mexico, it is systems like this active surveillance that have been put into place that assure that NM remains prepared to deal with new health threats.

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 know the Affordable Care Act has decreased the number of uninsured New Mexicans, 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 impacts inter-conception spacing, teen birth rates, and birth outcomes such as pregnancy intention, preterm delivery, and low birthweight.

The New Mexico Department of Health continues its partnership and leadership with the New Mexico Perinatal Collaborative (NMPC). The Title V Director currently serves as Vice President of the NMPC. The collaborative has prioritized improving access to long-acting reversible contraceptives for women immediately after delivery (IPP LARC). 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 NMPC on addressing Neonatal Abstinence Syndrome (NAS). The NMPC is working to develop and disseminate NAS diagnosis and treatment protocols for birthing facilities across the state and train hospital providers and staff. 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. NM 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. In addition, the Maternal Health Program leads a maternal mortality review process, which is currently working with NM Vital Records, University of New Mexico Obstetrics and MCH Epidemiology staff to review several years of maternal deaths before asking a larger committee to review aggregate case findings for 2016 deaths.

Infant Health

New Mexico’s infant mortality rate decreased from 6.9 infant deaths per thousand live births in 2012 to 5.1 in 2015. The decrease between 2012 and 2015 rates was initially attributed to fewer infant deaths among Hispanic mothers within the neonatal period (0-28 days), but there were also 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. For the past five years, perinatal conditions, including low birth weight and preterm birth, accounted 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 2015, New

Mexico's opiate overdose death rate remained one of the highest in the nation (8th overall) with a rate of 25.3 per 100,000 population. 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 program staff, first responders, and individuals at risk of experiencing or witnessing an opioid-related overdose.

The Title V program works in partnership with the NMPC 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 Pregnancy Risk Assessment Monitoring System (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 indicated there that about 6% of women with live birth use marijuana and 4% use prescription painkillers in the month before pregnancy. New Mexico MCH Epidemiology Program applied to participate in a 12-question supplement to PRAMS to assess further behaviors and attitudes about marijuana and pregnancy, as well as breastfeeding. The program was funded and planned to implement the data collection with 2017 births.

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 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/2016KC_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 ended 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 rate of substantiated victims of child abuse has steadily increased from 9.9 per 1,000 children in 2013 to 21.3 in 2015. Title V is working with the Office of Injury Prevention and the Children Youth and Families Department to address these issues of abuse, neglect, and maltreatment, as feasible.

CSHCN

Children's Medical Services (CMS) continued its established partnership with the MCH Collaborative, convening 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 Leadership Education in Neurodevelopmental and Related Disabilities (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 Society, CMS social workers, and 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, including women and infants. Adverse Childhood Experiences and stressful 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 adverse 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 who experience the most challenging conditions. Our recent analysis geocoding births by quartiles of disadvantage showed that among the NM birth population

Teen birth rates are three times higher in geographies of high social disadvantage compared to those in the lowest quartiles of concentrated disadvantage. Preterm birth prevalence is significantly higher among high cd quartiles, and late prenatal care is also significantly higher in those communities. This indicates there is a structural, not just individual, aspect to early child-bearing rather than or in addition to an individual behavior.

The needs assessment indicated that access to insurance, insurance navigation and healthcare utilization were top priorities. Title V team members collaborated with Dona Ana County Health Services, federal Healthy Start sites, NM Alliance of Health Councils, and the Robert Wood Johnson Foundation (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

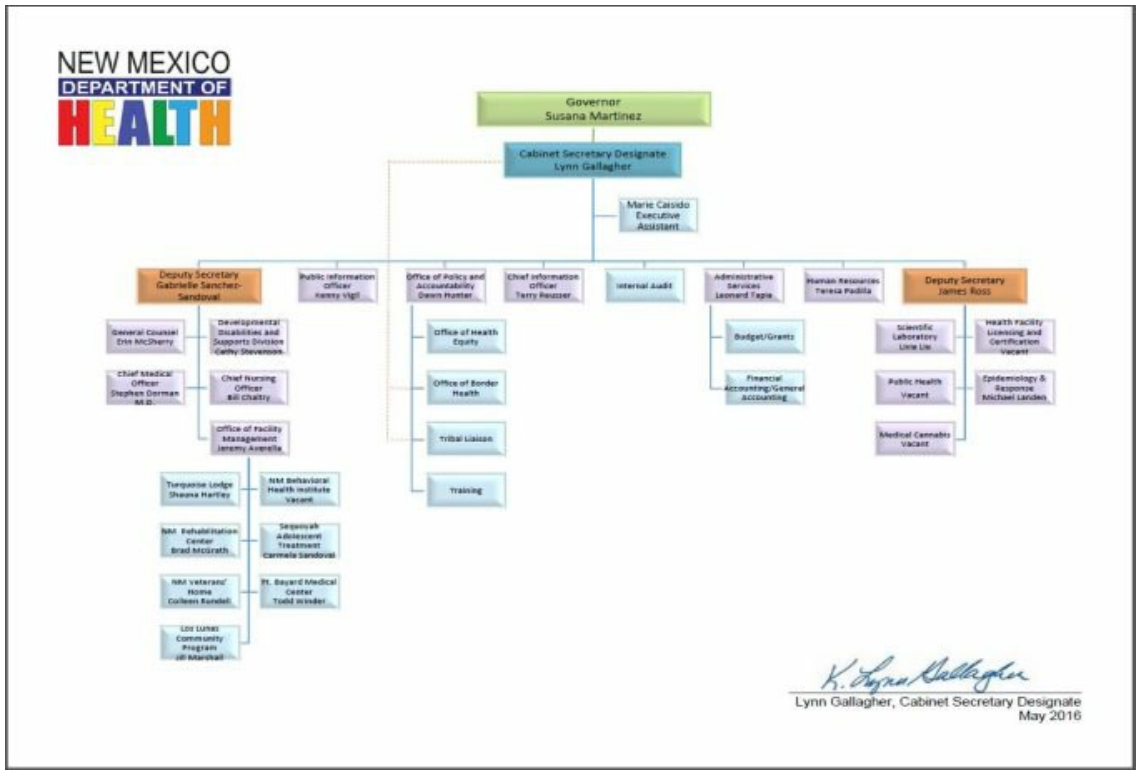
In 2015 there was an increase in the capacity to impact oral health in the child and maternal populations due to a higher level or partnership and collaboration around oral health. Oral health has been a priority in the previous five-year cycle (FFY 2010-FFY 2015). Children of poorer families have 2.5 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 (the Healthy People 2020 goal is 42%), and 37% had untreated decay (the Healthy People 2020 goal is 20%). A 2014 pregnancy risk assessment monitoring system (PRAMS) survey found that 48.1% of women had their teeth cleaned during pregnancy. 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 focus on systems building and theory-based clinical change to build a MCH primary care oral health care delivery model with statewide reach.

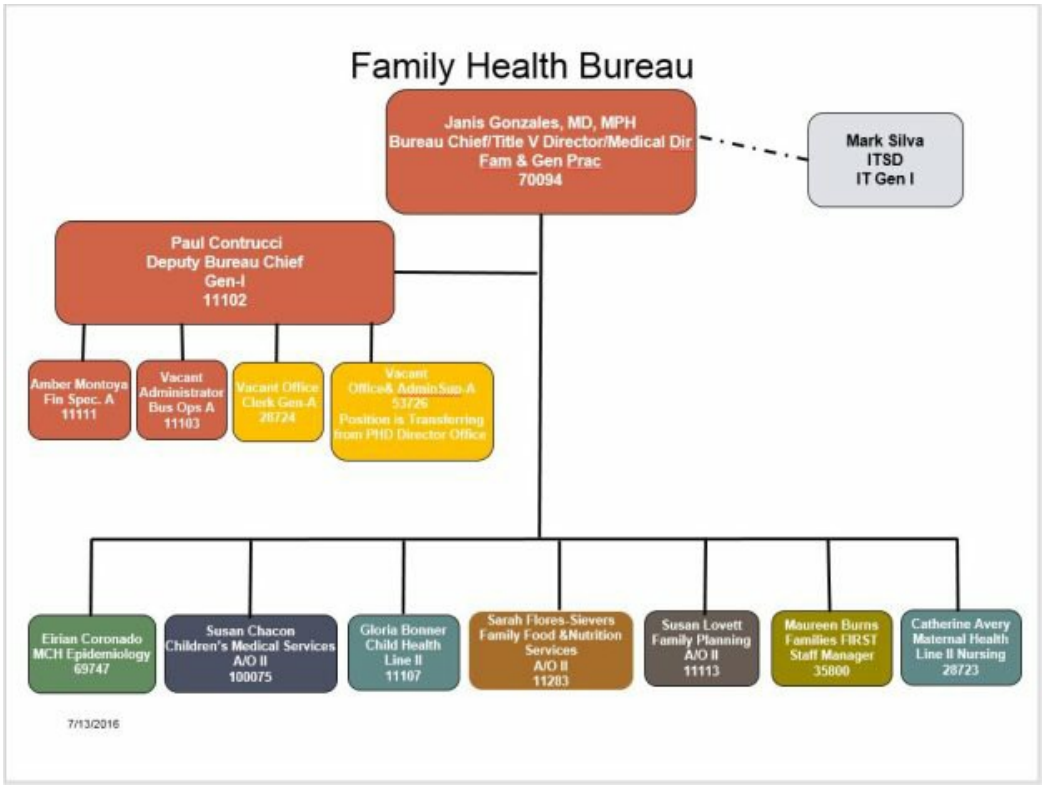
Adolescent Health

Bullying remains a priority in adolescent health and in the Office of School and Adolescent Health, with efforts directed at the impact of bullying on adolescents.

Adolescent well-visits remain a priority. After the Title V Needs Assessment indicated a need to address adolescent well-visits, New Mexico applied and was accepted to the Adolescent and Young-Adult (AYAH) CoIIN where the primary focus was 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. The AYAH CoIIN has ended; however, the work continues with the partners in NM and collaboration with other AYAH CoIIN states.

Organizational Structure


NEW MEXICO
DEPARTMENT OF
HEALTH
Governor
Susana Martinez
Cabinet Secretary Designate
Lynn Gallagher
Marie Casido
Executive
Assistant
Deputy Secretary
Gabrielle Sanchez-
Sandoval
Public Information
Officer
Kenny Vigil
Office of Policy and
Accountability
Dawn Hunter
Chief Information
Officer
Terry Reuzer
Internal Audit
Administrative
Services
Leonard Tapia
Human Resources
Teresa Padilla
Deputy Secretary
James Ross
General Counsel
Erin McSherry
Developmental
Disabilities and
Supports Division
Cathy Stevenson
Chief Medical
Officer
Stephen Dorman
M.D.
Chief Nursing
Officer
Bill Chaltry
Office of Facility
Management
Jeremy Avenelle
Turquoise Lodge
Shauna Hartley
NM Behavioral
Health Institute
Vacant
NM Rehabilitation
Center
Brad McGrath
Sequoyah
Adolescent
Treatment
Carmela Sandoval
NM Veterans'
Home
Colleen Randall
Ft. Bayard Medical
Center
Todd Winder
Los Lunas
Community
Program
Jill Marshall
Office of Health
Equity
Office of Border
Health
Tribal Liaison
Training
Budget/Grants
Financial
Accounting/General
Accounting
Scientific
Laboratory
Lina Lin
Public Health
Vacant
Medical Cannabis
Vacant
Health Facility
Licensing and
Certification
Vacant
Epidemiology &
Response
Michael Landeis
K. Lynn Gallagher
Lynn Gallagher, Cabinet Secretary Designate
May 2016


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

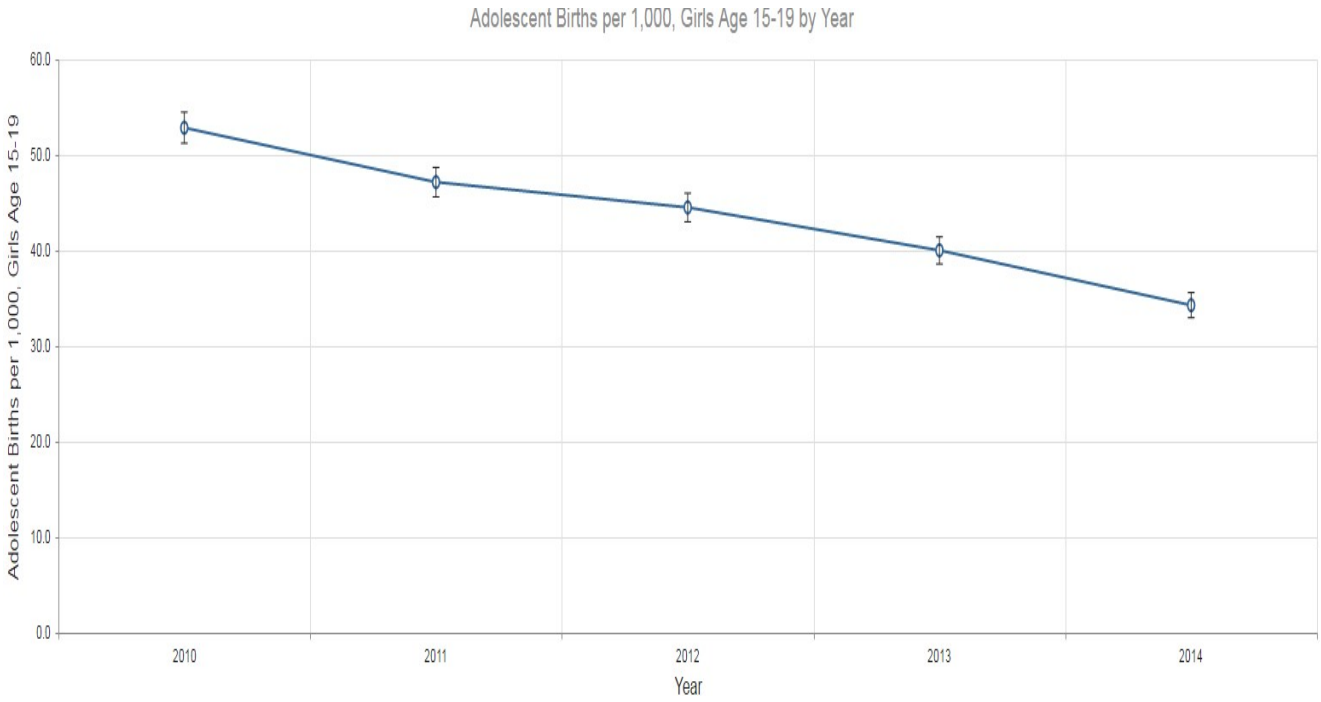
Needs Assessment Annual Update

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

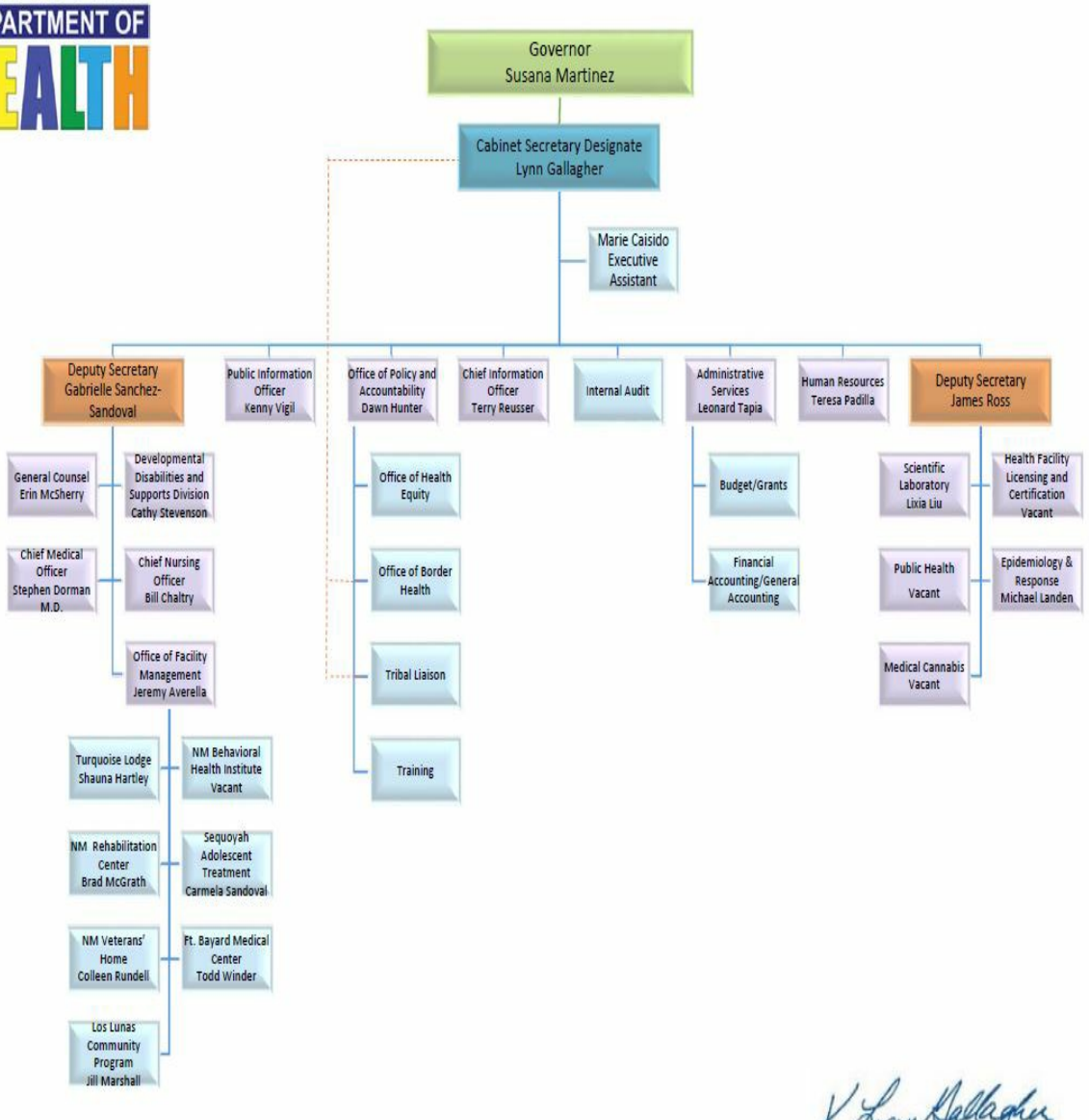
Bullying remains a priority in adolescent health and in the Office of School and Adolescent Health; therefore, there will still be some effort to reduce impact of bullying on adolescents because the programs will continue the efforts that have already been put in place.

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

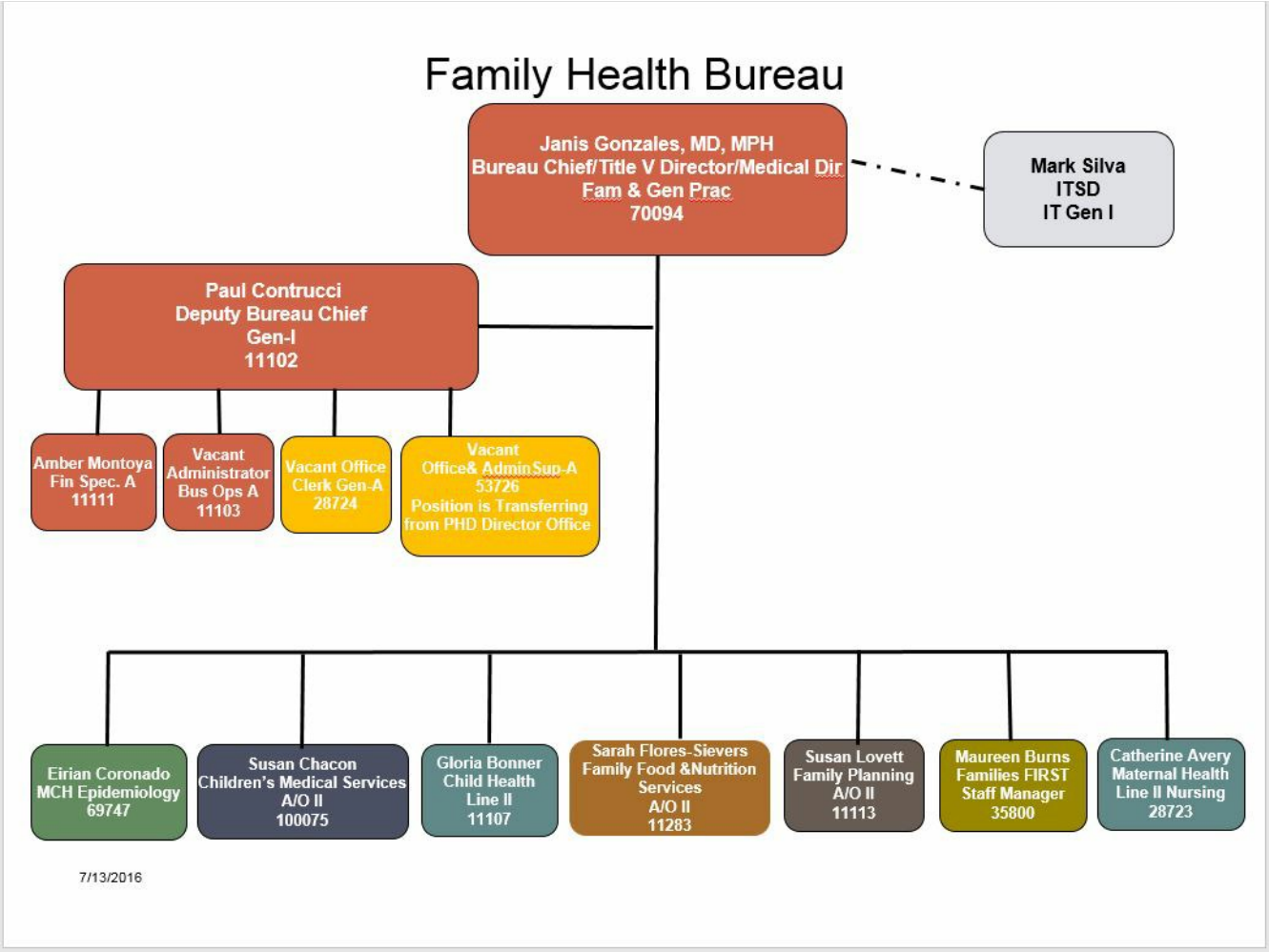
The New Mexico Department of Health experienced a significant change in organizational structure over the past year. The following organization charts are current.

NEW MEXICO DEPARTMENT OF HEALTH



K. Lynn Gallagher

Lynn Gallagher, Cabinet Secretary Designate
May 2016


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.

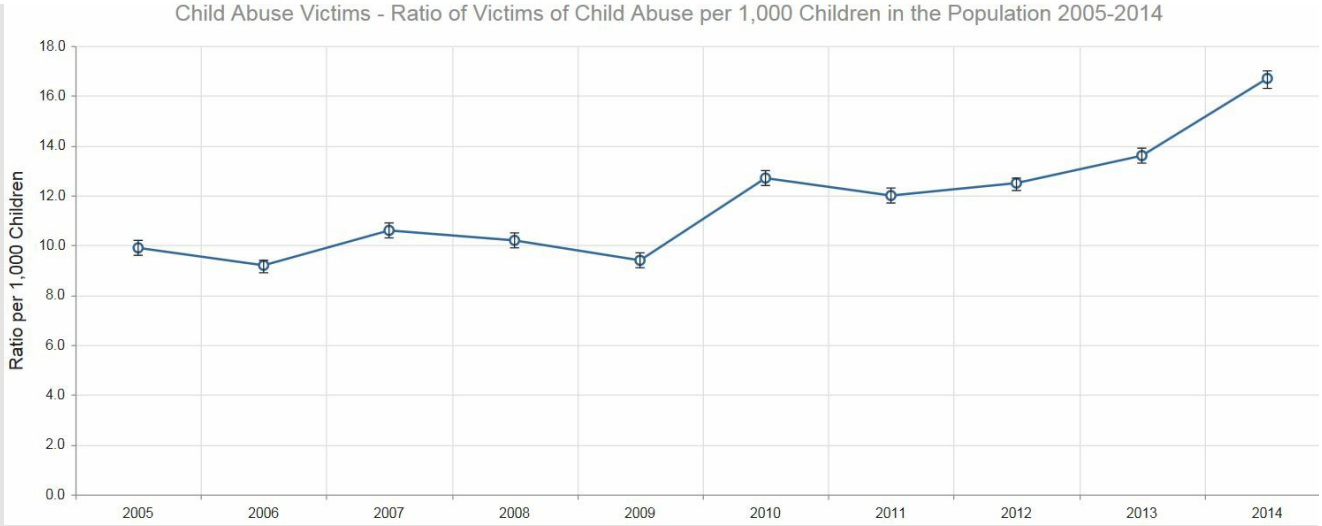
Relating to maternal and women’s health, participants surveyed were asked to rate relative importance of several health needs; the highest need is prenatal care (63%); the lowest, elective C-section (25%). Relating to infant health, the highest need was treatment referrals for infant drug exposure (56%); 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 local health off

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.

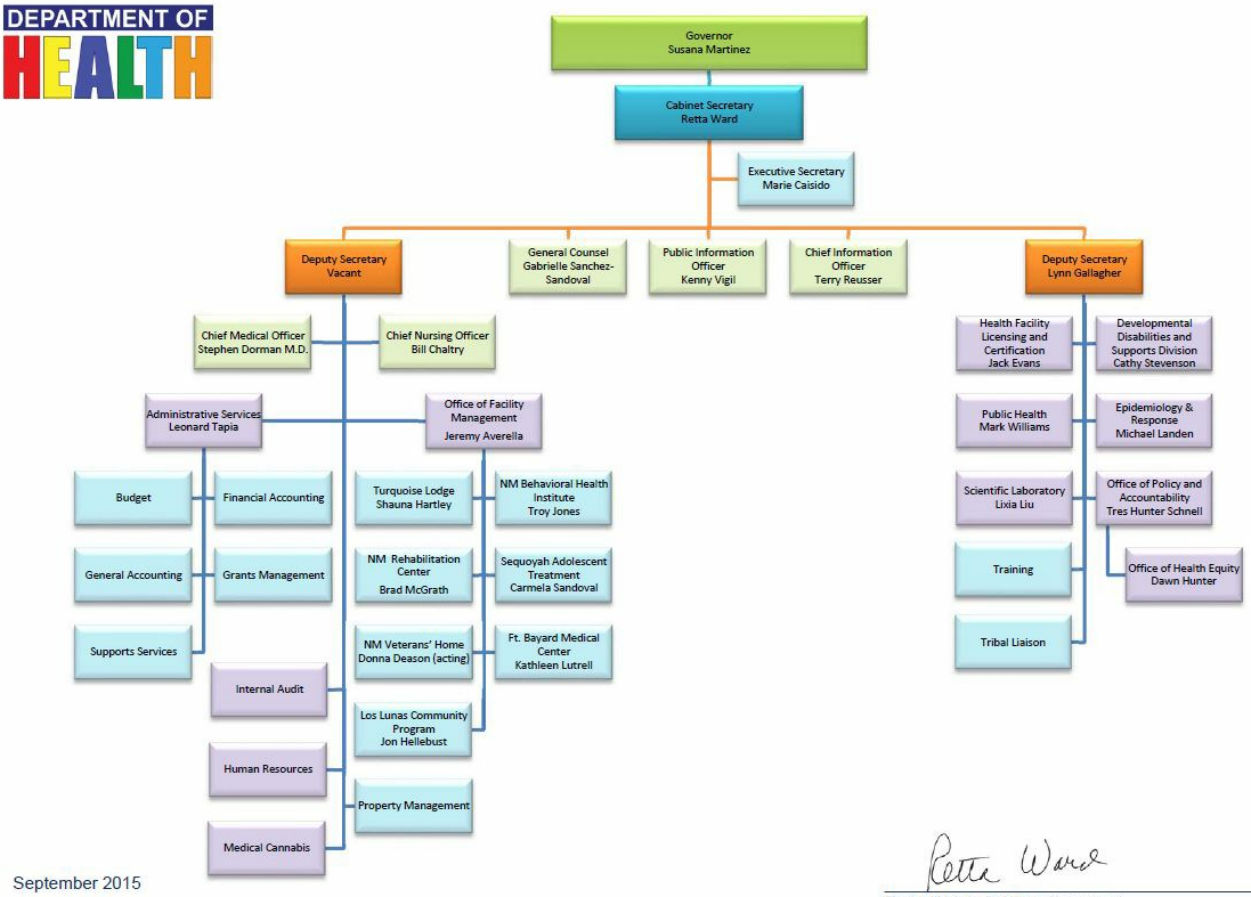
The MCH Epidemiology Program serves the data and information needs of the FHB and its many partners. It has incorporated tl genetic
sreening, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group. The MCH staff, including a position funded by SSDI, aid 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.

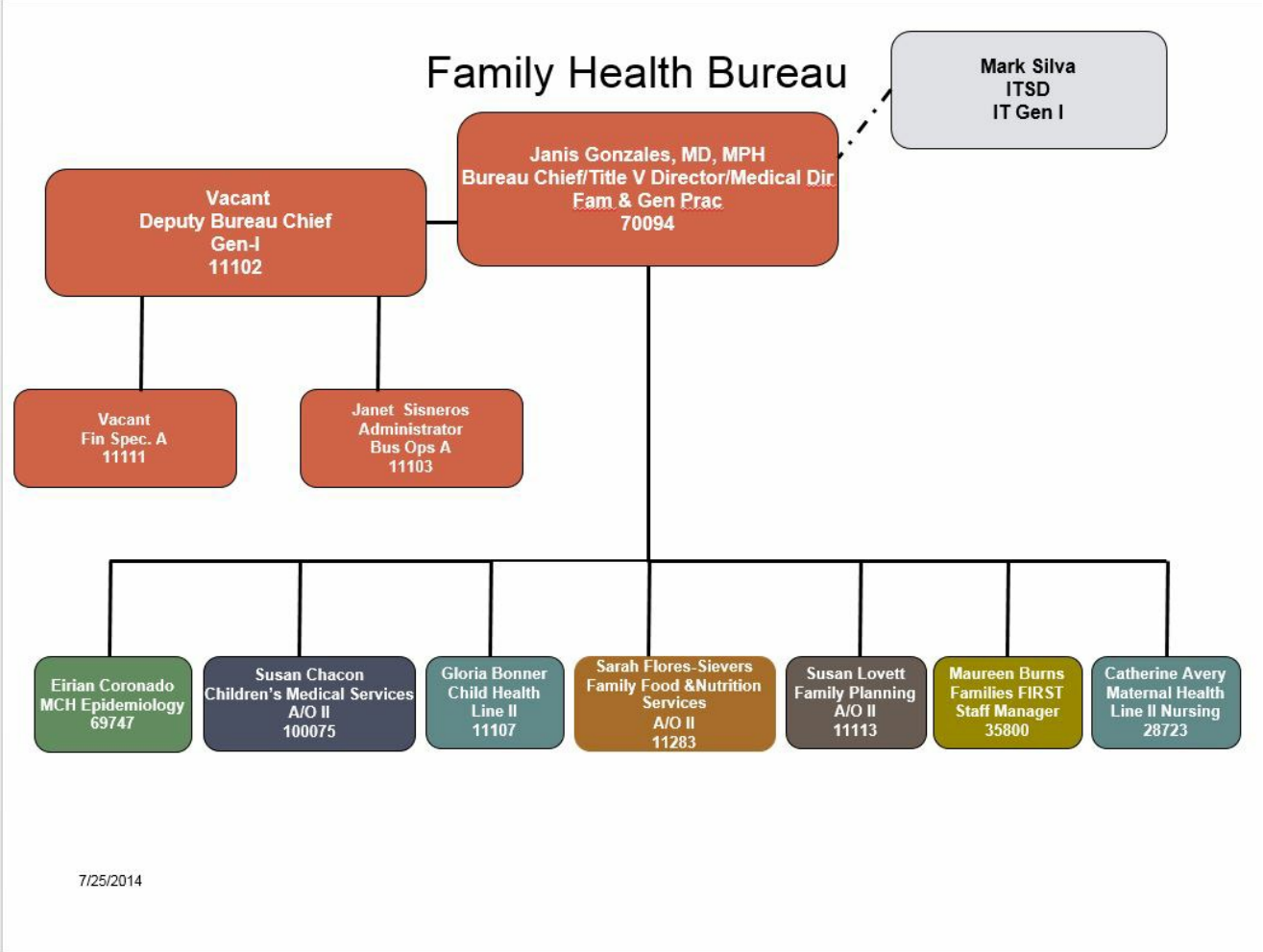
The FHB is organized into five programs: 1. MCH Epidemiology, 2. Family Planning/Title X, 3. Children's Medical Services, 4. WIC Food and Nutrition and, 5. Maternal and Child Health, and 6.Families FIRST perinatal case management. The FHB is responsible for carrying out the majority of Title V programs. 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





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).

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,006,215	$3,783,840	$4,048,292	$4,376,866
State Funds	$7,264,811	$6,669,159	$6,675,779	$6,984,517
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$6,501,745	$7,314,571	$10,487,490
SubTotal	$11,271,026	$16,954,744	$18,038,642	$21,848,873
Other Federal Funds	$68,379,602	$42,768,655	$53,072,414	$42,501,710
Total	$79,650,628	$59,723,399	$71,111,056	$64,350,583

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,075,191	$3,505,374	$4,063,782	
State Funds	$6,963,800	$9,686,381	$6,019,300	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$6,501,745	$13,650,046	$9,377,300	
SubTotal	$17,540,736	$26,841,801	$19,460,382	
Other Federal Funds	$45,775,263	$39,695,243	$49,335,723	
Total	$63,315,999	$66,537,044	$68,796,105	

	2019	
	Budgeted	Expended
Federal Allocation	$4,067,381	
State Funds	$8,430,253	
Local Funds	$0	
Other Funds	$0	
Program Funds	$8,818,600	
SubTotal	$21,316,234	
Other Federal Funds	$52,117,307	
Total	$73,433,541	

III.D.1. Expenditures

For FY17 New Mexico spent $3,985,891 of federal funds from the Title V Grant during this project period. The state spent 40% 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. A little over 40% 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 6.5% of the grant expenditures went to Administrative costs, which included a small indirect portion paid to the Department of Health Administrative Services Division and a portion of the salary of the Title V Director and Medical Director for the Family Health Bureau (FHB), an administrative position that oversees and assists all the MCH programs within the Bureau. The remaining funds (approximately 10%) were spent by the maternal health program to provide high risk prenatal services for pregnant women with no other source of coverage and cover the salary of the maternal health program manager and administrative staff.

The FHB spent $358,071 of Title V funds on direct services; this is a slight decrease from 2016 and again went mostly for high risk prenatal services. The vast majority of the Title V funding for CSHCN 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. For 2016 just over $1 million was used to support 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 neonatal abstinence project of the Perinatal Collaborative, midwife licensure, work on youth transition and teen pregnancy issues, and coalition building to address developmental screening, safe sleep, and child maltreatment.

The FHB programs continue to struggle to meet the needs of our MCH population within funding limitations. 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. FHB programs have worked diligently to increase their program revenues to supplement the federal and state funds to better meet the needs of the populations they serve.

Salaries for critical positions such as nurses and social workers remain well below market value, even though the CMS social workers did get reclassified a couple of years ago and nurses are currently in the process of being reclassified as well. Low salaries directly impact the ability of the programs to recruit and retain staff, and hiring has also been slow due to understaffing in human resources. This results in the variance between budgeted funds and expended as funds allocated to salaries cannot easily be used for other purposes.

III.D.2. Budget

3D1. Expenditures

The Title V federal block grant is a critical source of funds for New Mexico, and the only federal grant that is dedicated to improving the health of the maternal and child population. New Mexico is careful to spend down all our Title V federal funds, as we want to assure we are meeting the needs of our population to the fullest extent possible. Our expenditures reflect the fact that we blend multiple funding streams to support our programs.

The budget forms (2, 3a and 3b) were prepared by the FHB Admin staff and Title V Director, using information from the budget allocations and expenditures as reported in the state accounting system, SHARE. Field notes have been added to provide additional information on expenditures as needed. Over the past several years the state has shifted focus towards more population-based programs and support of public health systems and less direct services.

For FY17 New Mexico spent $3,505,374 of federal funds from the Title V Grant during this project period to date. We are continuing to spend down with the expectation that the grant will be fully expended by Sept. 30, 2018. Some programs have budgets that are set up to utilize Title V funds in the second year of the project period; however, the plan is to try to shift this over the next 1-2 years so that the majority of the grant funds are expended within the first 12-15 months. This will enable more accurate reporting on the full expenditures of the grant.

The Title V program strives to comply with the rules for allocation of funds, including spending at least 30% on services for preventive and primary care for children and at least 30% on children with special healthcare needs, and no more than 10% on administrative costs. The state spent 31.9% of the Title V funds on preventive and primary care for children (and infants), 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. A little over 45% 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 8.1% of the grant expenditures went to Administrative costs, which included a small indirect portion paid to the Department of Health Administrative Services Division and a portion of the salary of the Title V Director and Medical Director for the Family Health Bureau (FHB), an administrative position that oversees and assists all the MCH programs within the Bureau. The remaining funds ($496,010) were spent by the maternal health program to provide high-risk prenatal services for pregnant women with no other source of coverage and cover the salary of the maternal health program manager and administrative staff.

These high-risk prenatal services account for the vast majority of direct services that are funded by Title V. Most of the Title V funding for CSHCN provides enabling services rather than direct services, paying salaries for CMS social workers to provide care coordination to families and children with special healthcare needs and chronic medical conditions. For 2017 just over $800,000 was used to support public health services and systems, mostly by paying partial salaries for staff who support the Title V work in a variety of ways. Examples include data surveillance and analysis, assisting with the neonatal abstinence project of the Perinatal Collaborative, midwife licensure, work on youth transition and teen pregnancy issues, and coalition building to address developmental screening, safe sleep, and child maltreatment.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: New Mexico

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

The Title V program's partnership and leadership roles in accomplishing the MCH Block Grant's goals and mission

In New Mexico, Title V does not exist as a single program, but rather a network of professionals and organizations across the state that focus on Maternal and Child Health. Partnerships both within the Department of Health and outside of it are essential to be able to extend the reach of Title V to the largest number of populations that we serve. The Family Health Bureau (FHB), Maternal Child Health Division of the NM Department of Health (DOH) is the home of the Title V block grant, and the Bureau is constantly seeking partners to help us accomplish the MCH Block Grant goals. Title V leadership strives to create accountable programs that achieve optimal health status for the MCH population.

The explicit role that FHB has for Title V in New Mexico is that of preparing and submitting the Title V Block Grant yearly application and report, as well as the Five-Year Needs Assessment. The Title V MCH Director and Title V CSHCN Director both are housed in FHB, and the MCH Director oversees the entire Bureau which consists of 70 staff in central office and over 400 staff in the regions statewide. The MCH Epi program H is responsible for the coordination of the grant submission and the ongoing work, but relies heavily on the numerous programs around the state that contribute to Title V strategies. The mission of Title V is well-aligned with the NM state DOH mission to promote health and wellness, improve health outcomes, and assure safety net services for all people in New Mexico.

Collaboration is a key component of the Title V CYSHCN program to address and improve the system of care for children in our State. We rely on our many partners and the relationships we have built to develop and implement strategies that drive performance measures and outcomes. This collaboration includes other state agencies, the private sector, family organizations, businesses and other advocacy programs. We are always working to develop new partnerships as well. There are many challenges in our state and we continue to work together to improve the lives of mothers, children, children with special health care needs and families.

The Title V program's framework and strategic approach to addressing the identified MCH priorities

The NM DOH annually publishes a Three Year Strategic Plan which serves as a guide for public health practice by providing a state vision, mission, values and priorities. Among these values is a focus on health equity, which serves as a unifying approach to all of DOH. Outside of DOH, health equity has organically developed as an approach to public health initiatives and creates unity in the numerous partnerships that create the Title V network. Health equity is especially important as an approach in NM because greater than 50% of the population identifies as an ethnic minority and health disparities are common in these minority populations. To maximize our impact, the Title V leadership made a conscious decision to focus on a limited number of the priorities identified in the Five Year Needs Assessment, as well as newer, urgent priorities that have become critically important in the past couple of years, such as maternal mortality and Neonatal Opioid Withdrawal Syndrome.

The purpose and commitment of the Title V program in providing a foundation for family and community health across the state and in assuring access to the delivery of quality health care services for mothers, infants and children, including CSHCN.

The Title V block grant is part of the base funding of the Family Health Bureau (FHB) in the NM Department of Health. The Bureau's purpose is to assess and respond to needs in the maternal and child health population of the state, and we are committed to improving health outcomes for those populations. To do this, FHB staff realize the need to connect and collaborate with many other individuals, groups and agencies all around the state whose work and interests overlap with our goals. The Title V MCH Director (who is also the Bureau Chief/Medical Director for FHB) has made collaboration across programs, divisions and agencies one of her main goals for the Bureau. Being

part of this broad network of stakeholders not only enables us to leverage resources but also provides a foundation and a focus for the maternal child health work. The Title V CSHCN program, Children's Medical Services, works with medical providers, disability advocates, Medicaid and Managed Care Organizations, family organizations and many others to ensure that the special needs of children are addressed on various levels. The Title V CSHCN program has staff in all the public health offices across NM, so the program has a broad overview of what is currently happening in the state with regard to children with special needs and access to care. CMS social workers live and work in the communities across the state and connect intimately with the families they serve. Other FHB programs such as WIC, Families FIRST, and Family Planning have similar reach, which is important when working in a large rural and multi-cultural state. The Maternal Health and Child Health Programs do not have staff around the state, but they work on the systems level to improve the health of their respective populations, continually collaborating with a variety of stakeholders. The Title V MCH Director and Family Health Bureau Chief is constantly looking for connections between our MCH work and the work being done by others. FHB staff are dedicated to the importance of this work and committed to moving it forward in a patient/family-centered way.

Supporting coordinated, comprehensive and family-centered systems of care at state and local levels

The Title V CSHCN Program in NM provides professional, family-centered care coordination based on a best practice model and works to assure access to specialty care and to develop a coordinated system for CYSHCN, transition for youth, and statewide policy that reflects the Title V vision of coordinated, compassionate, family-centered care. The program works with key stakeholders including Medicaid and the MCO's to help them recognize that they have a duty to listen to family voices. There are established partnerships in place between Title V, Medicaid, the four Managed Care Organizations, Family Organizations and the NM Child Health Improvement Program Envision, which is part of the NIPN network. Several initiatives are in place with these partners addressing issues such as developmental screening, newborn hearing screening, medical home, Neonatal Abstinence Syndrome, adolescent health and pediatric specialty care. The Maternal Child Health Collaborative, which includes programs/agencies that are working with the MCH/CYSHCN population, meets quarterly to promote awareness of MCH/CYSHCN issues and seeks opportunities to address systemic issues that affect access to quality care.

New Mexico has a developing familiarity with the National Standards for Systems of Care for CYSHCN as part of an Action Learning Collaborative (ALC). The ALC team was successful in submitting comments to Medicaid regarding youth transition as part of the 1115 Medicaid waiver renewal, requesting Medicaid to include best practices based on the National Standards framework for youth transition. Our project goals include:

- To develop comprehensive policies and strategies to address specific standard domain areas such as Medical Home, Family Professional Partnership, Transition to Adulthood and others that may be identified as areas of weakness to improve the overall system of care for CYSHCN in New Mexico.
- Implement strategies to strengthen Medical Homes with a focus on identification of CYSHCN, care coordination, and family centered care with an emphasis on cultural and linguistic access needs.
- Implement strategies to improve and standardize the transition to adulthood for YSHCN.
- Enhance strategies to develop and mentor families with CYSHCN reflective of the diverse cultures, languages and ethnicities to become family leaders and partners and represent the voices of families in a leadership capacity across state agencies and other systems of care.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

Title V Funded Staff:

Title V Director's Office

The Family Health Bureau houses seven separate programs. The Bureau Chief/Medical Director/Title V Director, Dr. Janis Gonzales, oversees all programs and works with each of the program managers for direct oversight of each program. Dr. Gonzales is Board Certified in Pediatrics and has a Master's Degree in Public Health. She previously spent nine years in private practice followed by work in hospice and in Early Childhood Developmental Screening before joining CMS/Family Health Bureau. She also had a daughter with special needs. For the past ten years she has served as Medical Director for the Title V CYSHCN program in New Mexico. She served as the CMS Medical Director for five years and as the Family Health Bureau Medical Director for the past four years. She was promoted to Bureau Chief and Title V Director in Feb. 2015 and is currently Vice President/President-Elect of the NM Chapter of the AAP. She has a Deputy Bureau Chief, a Bus-Ops specialist and a financial specialist on her Administrative Team.

Maternal & Child Health

Catherine (Katie) Avery, MS, CNFP is the Maternal Health Program Manager, responsible for the High-Risk Prenatal Care Fund program, Midwifery Licensure & Regulation & the Maternal Health program. This Program is also the NMDOH coordinating lead for the NM Maternal Mortality Review Committee proceedings. The Child Health Manager, Gloria Bonner, is responsible for child health program activities with a focus on improving developmental screening in NM. The program also has a community health educator, Sabrina Curry, MPH, who was hired in June 2017. Jessi Sanchez has been the Administrative Assistant for the Maternal Child Health Section which encompasses the Maternal Health Program and the Child Health Program since September 2016.

CYSHCN: Children's Medical Services

Ms. Susan Chacon, LISW is the Title V CYSHCN Director. Ms. Chacon has 12 years of program management within the Children's Medical Services Program. The Title V CYSHCN Director position is the Statewide Program Manager for Children's Medical Services (CMS), under which fall the CYSHCN Program, the Multidisciplinary Specialty Outreach Clinic Program, the Newborn Genetic Screening program and the Newborn Hearing Screening program and Birth Defects program. Dr. Janis Gonzales has been the CMS Medical Director since 2008.

The CMS state office staff consists of the Title V Statewide CYSHCN Program Manager, two nurse consultants who work with Newborn Genetic Screening, the Newborn Hearing Screening Coordinator whose position is funded by a HRSA/MCHB grant, a birth defects program coordinator, a clinic coordinator/Executive Secretary, a financial specialist, a training and development specialist, a Finance Manager and two general clerks and a data manager for newborn screening. The CMS management team includes the statewide Title V CYSHCN program manager, the medical director, the field supervisors, regional program managers and key state office staff. The management team meets monthly to review policy issues related to the implementation of the CMS programs.

Brenda Romero, RN is the State Genetics Coordinator and Carla Ortiz, RN is the nurse consultant for screening; both have been with the program for over 12 years. Robert Morrison was hired as the Newborn Hearing Screening Coordinator in February 2017. He has a Master's in Public Administration and many years of experience coordinating Public Health programs. Kaye Martin is the clerk specialist and provides administrative support to the Newborn Screening Programs. Michelle Quintana who has also been with the program for over 10 years is the Training and Development Specialist. Mary Lewis is the Financial Specialist and Paul Frey oversees the budget and

all grant funding. Adrienne Miera-Branch was hired as the Clinic Coordinator in 2016 and she comes to the program from WIC where she worked for over 15 years. A new position was created through the Zika preparedness funding to support birth defects surveillance and linkage to support services, Susan Merrill was hired into this position early 2017. Ms. Merrill was a CMS Social Work Supervisor in the Northeast Region for over 10 years and has extensive knowledge of community resources and care coordination. Reanna Garcia was also hired in 2017 into a newly created data manager position. Ms. Garcia manages the data bases for the newborn screening programs. The CMS staff in the Public Health offices consist of regional program managers, social work supervisors, social workers, clerks and nutritionists. Fully staffed, CMS has about 90 personnel statewide. The program has had success recently in filling vacant positions and even creating new social work positions in high need areas, which has boosted morale and productivity. There are also several contractors in place that help to support the program, including an additional nurse who assists with follow-up on unsatisfactory bloodspots and several contractors who assist with follow-up on newborn hearing screens and evaluation of the newborn screening data base.

Working within the program are several parents who have children with special health care needs and others who were children/youth with special health care needs or had sisters or brothers with special needs. In addition, the Title V CYSHCN program contracts with Parents Reaching Out (the State F2F), EPICS (Educating Parents of Indian Children with Special Needs and Hands & Voices to provide support and training to diverse parents in the State who have CYSHCN and these agencies provide feedback and partnership to the program on family centered care and family professional partnership. In this way, the program has internal and external family expertise to guide its policies.

Maternal & Child Health Epidemiology

Currently, there are five epidemiologists, a data manager, two data collection staff and a program clerk. Eirian Coronado, MA, MPH candidate, is the Section Manager. Christina Brigance, MPH coordinates the Title V grant & Needs Assessment and was hired in January 2018. Up until June 30, 2018, Garry Kelley, MPH provided advanced analytic support for the CMS and WIC programs. He also coordinated and led New Mexico in the Collaborative Improvement and Innovation Network to prevent infant mortality. 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. Sarah Schrock, MPH coordinates the PRAMS and NM Toddler Study and was hired in March 2018. Dorin Sisneros is a data manager and provides fiscal oversight to the program. Nicole Hernandez provides survey data collection, data entry and general clerical program support to MCH Epidemiology and 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 for CMS and the newborn screening program.

The Family Planning Program (FPP)

Susan Lovett, the Title X Director/Program Manager in the State Office, manages the statewide Family Planning Program including oversight of budget, personnel, and Federal Grant requirements. The Clinical Team includes the Medical Director Max Torres, MD, MPH and Peg Ickes, Nurse Practitioner Consultant. The two vacant Nurse Consultant positions are currently posted. The Education Team includes Kate Daniel, an Epidemiologist, and Julie Maes and Mercedes Gonzales-Clay, Educational Project Officers. The Administrative Team includes Genevieve Lujan, the Fiscal Manager, who supervises two Contract Specialists, Cindy Martinez and Joseph Arguello. The Purchasing Agent position is in the process of being filled.

Adolescent Health

Tessa Medina-Lucero is the Adolescent Health Coordinator working in the Office of School and Adolescent Health (OSAH) which is housed in the Population and Community Health Bureau. She works in the Natural Helper Program

which promotes Positive Youth Development Approach and Prevention, and the NM Adolescent and Young Adult CollN.

Injury Prevention

John McPhee is the Childhood Injury Prevention Coordinator for the NM DOH. He works to implement and coordinate prevention programs for unintentional and intentional childhood injury. This position is part of the Office of Injury Prevention and reports to the Program Section supervisor. The scope of work includes providing a range of safety trainings to service providers and parents, assembling and distributing safety information statewide, as well as providing media interviews, press releases and articles specific to child safety as requested. The job also entails maintaining membership on and active support for the state Safe Kids Coalition, as well as seeking long term sponsors for new regional Safe Kids coalitions. This position also requires continuing affiliation with Consumer Product Safety Commission as their NM State Designee, membership on two Child Fatality Review Panels, as well as membership on advisory committees for EMS For Children, the Child Ready Program, the NM Poison and Drug Information Center and the NM Injury Prevention Coalition.

III.E.2.b.ii. Family 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. These partnerships help the programs understand and address the priority needs of families and consumers in the State.

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 that are 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), and the Early Hearing Detection and Intervention (EHDI) stakeholder committee. CMS recruited a parent representative to join the Newborn Genetic Screening Advisory Council, which includes participation in the Mountain States Regional Advisory Collaborative. The Newborn Genetic Screening Advisory Council team - which includes the CMS NBG program, Family Voices, a parent from the Navajo Nation, the UNMH Genetics program, the UNMH Office of telehealth and several other parents who have children with genetic conditions - is working with Mountain States as part of their project to improve genetic services to families in rural and underserved areas. The New Mexico team is undertaking a needs assessment of parents on the Navajo Nation and other Native communities to better understand the needs and gaps in services.

Family Organizations are invited to provide input into the CYSHCN Program activities and the Title V Block Grant during scheduled MCH Collaborative meetings and the other named stakeholder 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. Each agency holds their own family leadership conference and a diverse contingency of parents attend.

A family consultant was hired to review and critique the newborn hearing screening education material and the annual newborn genetics screening program annual report. 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. This project with Family Voices and PRO was yearlong and consisted of quarterly calls with the project advisor from Family Voices. The goal was to identify opportunities in the state for family leaders to sit on advisory boards or provide input. These leadership opportunities were brought to the PRO annual conference and a roster of family leaders is in the process of being compiled. A contract was also maintained with Hands & Voices to support the work they do with families who have a child that is deaf or hard of hearing. Hands & Voices is working towards the creation of the Guide by Your Side program in the state and is also developing a family handbook for newly diagnosed infants who are deaf or hard of hearing. The contract also funds two parents to attend the annual EHDI meeting. EPICS also receives funding to send two parents representing the voice of Native American families to the annual EHDI meeting. The partnership with PRO who houses the Family to Family Health Information Center has intensified over the past year due to the success of the Project Echo Financing Clinic that is held bimonthly. These clinics continued to be held once a month. Family participation in the Medical Home project with Envision was key to obtaining feedback as to the challenges receiving coordinated care in rural areas of the state and in the development of recommendations to improve systems.

The Early Childhood Comprehensive Systems-Act Early (ECCS-AE) State Team includes members from parent advocacy organizations as well as parents of our target population. The ECCS/AE State Systems Team is addressing family engagement, and specifically family engagement in the developmental monitoring of their children, through a human-centered design (HCD) framework. With the help of a subject matter expert in HCD, the team is implementing the steps of identifying the skills of empathizing with families, synthesizing the information learned, rapid experimenting of new concepts, and deciding on tools that will allow providers in the state to understand the conditions for successful family engagement.

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 OYE summit included the Public Allies, NM; Youth Alliance; and Forum Network.

The Maternal Health Program (MHP) is partnering with two stakeholder entities: a maternity and family planning clinic at UNM and the NMDOH Diabetes Prevention and Control Program (DPCP) to address the appropriate follow-up for post-partum women diagnosed with gestational diabetes mellitus (GDM) in the pregnancy. One of the first steps of this project is to work with a contractor to gain feedback from potential or actual clients regarding the barriers to appropriate care and the manner in which they would like to receive this care. We are considering a component of the programming that would collect timely feedback from some of these same clients over a 1-3 year period as a measurement of effectiveness and acceptance.

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 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 four years to formalize health promotion, knowledge sharing and collaboration among most 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.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

New Mexico has a robust Maternal Child Health Epidemiology Program with five full-time epidemiologists, including the program manager. The PRAMS surveillance team has over 30 years combined staff experience and is a premiere example among the states. The surveillance team developed a follow-up component to survey mothers of two-year-old children starting in 2016 and will make estimates available prior to 2019, for a variety of measures, including Adverse Child Experiences (for mother and child), developmental screening, and behavioral health experiences for mother and child. In addition, the PRAMS2-Toddler Survey provides the state's first population-level estimates on breastfeeding beyond the immediate postpartum period. For developmental screening we have bolstered the PRAMS2 survey tool with the complete Survey of Wellbeing of young Children (SWYC) to better support our early childhood wellness constituents.

Objectives in the State Systems Development Initiative (SSDI) include a linkage between birth certificate records and New Mexico's hospitalization and Inpatient Dataset (HIDD). In NM only non-federal facilities are required to report for syndromic surveillance and for HIDD, but most IHS facilities are voluntarily reporting on an annual basis. The state MCH Epidemiology and Title V programs have routine access to ED and inpatient data for specific conditions, and upon request there is access to annual analysis files. Specific linkage plans contributing to Title V program efforts include: a full birth certificate cohort linkage to hospitalization data to assess the prevalence of severe maternal morbidity (SMM), a multi-set linkage between the birth certificate, HIDD and the Prescription Monitoring System (PMP) for Neonatal Abstinence Syndrome analysis, and a linkage between syndromic records for an evaluation of statewide pediatric asthma referrals to the Children's Medical Services case coordination. A Family Planning evaluation team has worked across state agencies and UNM pediatric staff to plan linkages between Medicaid claims and birth certificate data. To project the unmet need for long-acting reversible contraceptives in NM, this team is pulling data from a variety of local and national datasets including PRAMS, Medicaid, Title X and birth certificate files.

For breastfeeding outcome monitoring, the MCH Epidemiology Program and UNM evaluators work together to link hospital-specific data to population surveillance data, but due to restrictions in NM Vital Records identification of facility-level data, those linkages cannot be publicized and the direct sharing with hospitals has also been cautious. To address this barrier, NM PRAMS added state-specific questions for women to voluntarily report their delivery hospital.

Already completed linkages include a WIC nutrition client- Medicaid client match completed in 2017 to plan a brief follow-back survey with Medicaid eligible families not accessing WIC, and two separate Medicaid claims linkages with Family Health Bureau programs, Families FIRST perinatal case management, and Children's Medical Services. Analysis of select health and health service utilization indicators revealed better maternal and infant outcomes among Families FIRST recipients compared to the general non-Families FIRST Medicaid population. These results are currently being culled to design a post-partum support program called 'Welcome Home Baby'. This program would optimize public health nursing staff to provide universal post-delivery visits with NM women and provide referral options to more intensive home visiting and case management options when needed.

III.E.2.b.iv. Health Care Delivery System

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. The Exchange open enrollment period in Dec. 2017 was cut in half from 12 weeks to 6; therefore, only 49,792 people enrolled in individual market plans through the New Mexico exchange during the open enrollment period for 2018 coverage, which was almost 9 percent lower than the 54,653 people who had signed up the year before.

The NM insurance market in 2017 experienced uncertainty due to proposed federal changes to try to dismantle some of the ACA provisions. Insurers in New Mexico were allowed to file two sets of 2018 rates, due to concerns over the long-term funding for the ACA's cost-sharing reductions (CSR). The Trump Administration ultimately did terminate CSR funding on October 12. Rate increases for 2018 varied from 26.1 (BCBS) to 69.6 (Molina). However, as in prior years a majority of HIX enrollees (73%) were receiving premium subsidies in 2017, so they are somewhat protected from these large premium increases.

New Mexico Health Connections (NMHC), one of the four carriers offering plans for 2018 in the New Mexico exchange, is a CO-OP (consumer oriented and operated plan) established with funding provided by the ACA. Of the 23 CO-OPs that began selling plans in the fall of 2013, only four are still operational as of 2018 — New Mexico Health Connections is among them. But the CO-OP has struggled financially, with reported losses of $17.9 million in 2017, in large part due to unexpectedly high risk adjustment payments that they were required to make. New Mexico Health Connections is one of several health insurers that have filed lawsuits against the federal government over the risk adjustment program In January 2018 NMHC finalized a partnership with Virginia-based Evolent Health, resulting in the formation of True Health NM, a new for-profit subsidiary of Evolent. True Health New Mexico is covering the roughly 20,000 enrollees who previously had coverage under NMHC's employer-sponsored plans. NMHC continues to be a non-profit, and is now focused entirely on the individual market, where they had about 18,000 enrollees in 2017.

The NM Medical Insurance Pool (NMMIP) 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. Because the state provides the carriers with tax credits to offset their losses from the Pool, the NMMIP has at times been targeted for possible closure; however, it remains one of the strongest of the remaining state high risk pools. Membership has decreased from a high of over 8000 to approximately 2500 now. The DOH continues to rely on the Pool to insure CYSHCN and those with HIV who are not eligible for Medicaid or any other insurance programs.

NM Medicaid re-issued its RFP for managed care in 2017. New contracts will begin January 1, 2019 and will replace the current four Managed Care Organizations that have been contracted since 2014. All four of the insurers that lost the bidding process — Molina, UnitedHealthcare, WellCare of New Mexico, and AmeriHealth Caritas New Mexico — have appealed the state's decision to deny them Medicaid managed care contracts. Two of the four current MCOs, Molina and United, were not awarded contracts for 2019, and Molina has threatened to leave NM altogether after 2018. This would mean the loss of Molina's Exchange plans as well.

The NM Legislature passed two legislative memorials in February 2018 (SM3 and HM9) that call for a cost analysis of a Medicaid buy-in program in New Mexico. There will be a task force created to study the pros and cons of this option; this program would allow New Mexico residents who aren't eligible for Medicaid to purchase Medicaid if they choose to do so.

All told, the uninsured population in NM has dropped by 50% since inception of the ACA, largely due to the Medicaid

Expansion. It is unclear if the number of uninsured New Mexicans can be reduced much further as there will always be those who do not qualify for assistance, the undocumented, and those who choose not to purchase insurance. If predicted cuts to Medicaid occur on the federal level, the uninsured rates in NM are expected to increase again, especially for the newly insured “expansion” population of low-income adults.

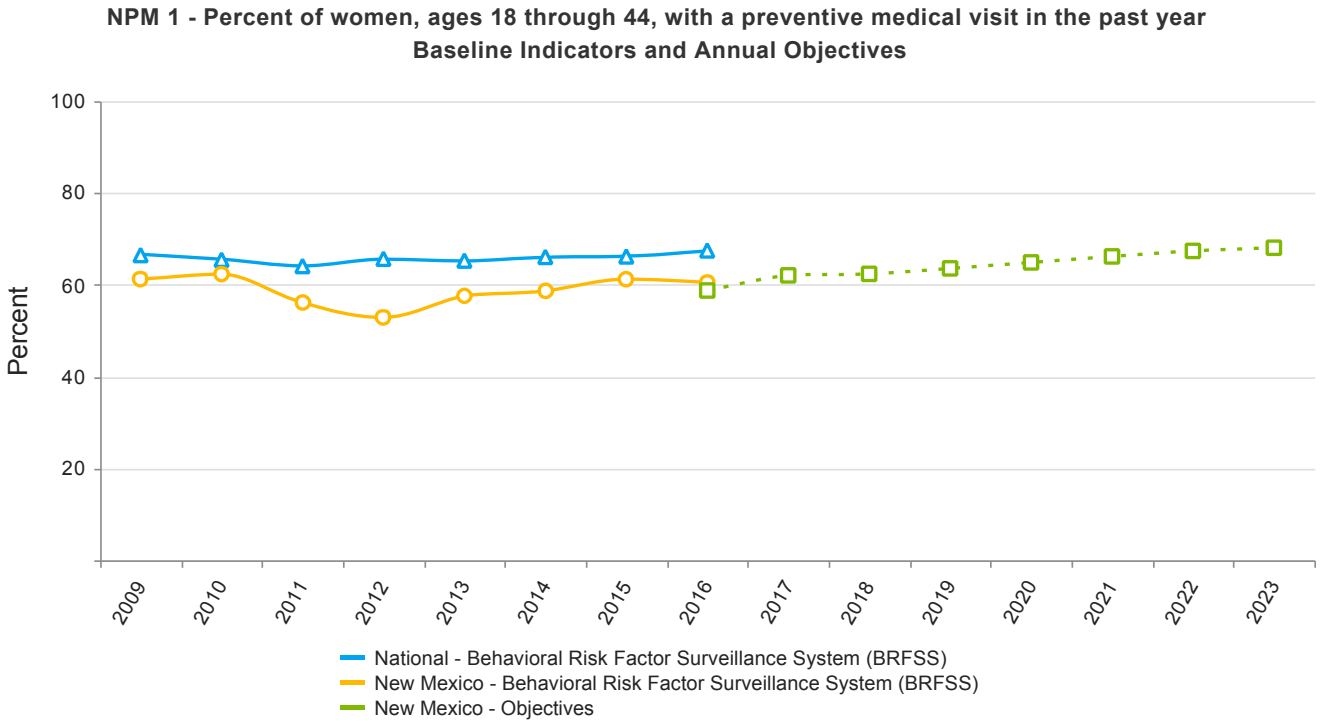
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	163.5	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	21.5	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	9.0 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.0 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	27.6 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	4.3	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	5.1	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	3.1	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.0	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	108.5	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	4.5 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	9.4	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	29.8	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	11.4 %	NPM 1

National Performance Measures



Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	58.7	62
Annual Indicator	61.1	60.6
Numerator	213,517	212,186
Denominator	349,603	349,927
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	62.3	63.5	64.8	66.1	67.3	68.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of completed postpartum visits by maternal clients followed at the Title V Maternity and Family Planning Clinic in metro Albuquerque.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	100	100
Data Source	UNM Cerner Hosptial Medical Records	UNM Cerner Hosptial Medical Records
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	75.0	80.0	83.0	85.0	87.0	89.0

ESM 1.2 - Number of training opportunities to midwives in the areas of appropriate coding and billing

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Maternal Health Program	Maternal Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

ESM 1.3 - Out of those who tested positive for pregnancy at the three pilot sites (Teen Resource Center, NMDOH Public Health Office and La Clinica de Familia), the percentage of women who received and completed a first trimester prenatal visit.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	70.0	80.0	90.0	93.0	95.0

ESM 1.4 - Percentage of primary providers that have received training and/or consultation in assessing and treating behavioral health needs.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	10.0	25.0	50.0	75.0	90.0

State Performance Measures

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Inactive - Ongoing work will be reported in annual updates but recording progress over one year with short term goals will limit our state in showing changes.

State Provided Data		
	2016	2017
Annual Objective		83
Annual Indicator	81.3	81.3
Numerator	209	209
Denominator	257	257
Data Source	NM Vital Records	NM Vital Records
Data Source Year	2015	2015
Provisional or Final ?	Final	Provisional

SPM 4 - Teen Birth Rate, Girls ages 15 to 19 years

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		31.6
Annual Indicator	34.2	29.4
Numerator	2,307	2,000
Denominator	67,519	68,117
Data Source	NM Vital Records	NM Vital Records
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	28.8	26.1	23.4	20.7	18.2	17.6

SPM 5 - Adequate Insurance Across the Lifespan

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	90.0	92.0	94.0	96.0	98.0

State Action Plan Table

State Action Plan Table (New Mexico) - 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

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

Increase early prenatal care utilization by 10% among women in the targeted impact area(s) (Border Region of the state) through the development of place-based improvement strategies that address the social determinants of health by October 2020.

To prevent the onset of Type II diabetes for women with a history of GDM. The aim is to increase the percentage of women in the University of New Mexico Hospital's Maternal and Family Planning (M&FP) Clinics completing a post-partum visit and appropriate testing to 80% by 6/30/19.

To increase the percentage of primary care providers who receive education and support for assessing and treating clients with perinatal mental health disorders. By June of 2020, the aim is that 25% of primary care providers within the reach of the dedicated programs are reached.

Strategies

Design and implement a prenatal care resource app that will be used with women who have a positive pregnancy test at three community-based sites in the border area.

Work in a collaborative partnership to address the prevention of Type II DM by addressing barriers to postpartum visit completion.

Provide training opportunities on the assessment, referral and/or treatment of women with perinatal mental health disorders to primary care providers in rural areas of the state.

ESMs	Status
ESM 1.1 - Percent of completed postpartum visits by maternal clients followed at the Title V Maternity and Family Planning Clinic in metro Albuquerque.	Active
ESM 1.2 - Number of training opportunities to midwives in the areas of appropriate coding and billing	Inactive
ESM 1.3 - Out of those who tested positive for pregnancy at the three pilot sites (Teen Resource Center, NMDOH Public Health Office and La Clinica de Familia), the percentage of women who received and completed a first trimester prenatal visit.	Active
ESM 1.4 - Percentage of primary providers that have received training and/or consultation in assessing and treating behavioral health needs.	Active

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 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 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
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

State Action Plan Table (New Mexico) - Women/Maternal Health - Entry 2

Priority Need

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

SPM

SPM 5 - Adequate Insurance Across the Lifespan

Objectives

Reduce the infant mortality disparity ratio between Black/African-American and White Infants by 25% in 2019

Improve health insurance coverage among NM women of reproductive age by 5% by 2020

Increase prenatal care utilization in the first trimester (and by adequacy of care index) statewide by 5% by 2020

Complete an economic impact study and community needs assessment of Paid Family Leave in NM by 2020

Strategies

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 postpartum and inter-conception periods.

Leverage participation in the Infant Mortality CoIINs to improve equity in birthing options and in healthcare utilization before during and after pregnancy.

Coordinate multi-sector, State (DOH, HSD, CYFD) and tribal health entities, including Albuquerque Area Indian Health Board (AAIHB), Tribal Epidemiology Centers, and Medicaid Managed Care tribal liaisons to improve surveillance and health assessments.

NPM: Percent of women, ages 18-44, with a preventive medical visit in the past year.

Objectives

- Increase early prenatal care utilization by 10% among women in the targeted impact area(s) (Border Region of the state) through the development of place-based improvement strategies that address the social determinants of health by October 2020.
- To prevent the onset of Type II diabetes for women with a history of GDM. The aim is to increase the percentage of women in the University of New Mexico Hospital's Maternal and Family Planning (M&FP) Clinics completing a post-partum visit and appropriate testing to 80% by 6/30/19.
- To increase the percentage of primary care providers who receive education and support for assessing and treating clients with perinatal mental health disorders. By June of 2020, the aim is that 25% of primary care providers within the reach of the dedicated programs are reached.

Strategies:

- Design and implement a prenatal care resource app that will be used with women who have a positive pregnancy test at three community-based sites in the border area.
- Work in a collaborative partnership to address the prevention of Type II DM by addressing barriers to postpartum visit completion.
- Provide training opportunities on the assessment, referral and/or treatment of women with perinatal mental health disorders to primary care providers in rural areas of the state.

Midwifery and Birth Worker Workforce Development

The following activities served to address the former FFY16-18 objective, *the adequacy and the accessibility of the delivery of care for pregnant women will be increased in five years*. New and established programming described are intended to increase the adequacy and accessibility of care by:

a) improving components of the midwifery workforce licensure processes

b) securing reimbursement for midwife services to allow birth setting options

c) expanding the quality and breadth of care to perinatal populations in perinatal mood disorders, gestational diabetes/post-partum care, and oral health.

In FFY17-18, the Maternal Health Program (MHP) finished revising the certified nurse-midwives (CNMs) Practice Rule (NM Admin Code or NMAC 16.11.2) with the assistance of a CNM contractor and with the legal guidance provided by the New Mexico Department of Health (NMDOH). The Practice Rule was overhauled to improve licensing processes, to clarify the disciplinary proceedings to follow when license action is warranted and to add specific wording and guidance on opioid and controlled substances prescribing as mandated by new law, NMSA 26-1-16.1 (2017), entitled "Opioids; requiring practitioners to obtain and review reports from the prescription monitoring program", which went into effect on January 1st, 2017.

The MHP also continued work on introducing an on-line licensing application process to streamline licensure. Staff worked with a contractor assigned specifically to this project management/IT staff in our Public Health Division, and to engage with staff of the state's Regulation and Licensing Department which will host the on-line application. An inter-government agreement (IGA) was drafted to address the start-up activities as well as the maintenance of the on-line system.

To address the strategy of training midwives in appropriate billing procedures to enhance Medicaid reimbursement

success, a training was conducted in conjunction with the Annual Conference of the New Mexico Midwives Association (the professional association for LMs in the state) in February 2018. The training was done by a certified nurse-midwife who runs a licensed birthing center in the Albuquerque metro area. Feedback from the training was positive, and its purpose was to provide the licensed midwives a basic introduction to Medicaid claims billing and how to avoid mistakes that would cause claims rejections. MHP is planning to have a CNM contractor convert the training module into a format that can be viewed from the MHP website to increase viewing access for all LMs. This step of the training is expected to be completed by December 2018.

Maternal Mortality Review

Throughout FY2017, plans were made to solidify a formal Maternal Mortality Review Committee (MMRC). The MMRC hosted a training visit from CDC technical experts who worked with the MMRC to develop procedures and protocols to assist in forming the MMRC. DOH Title V staff attended a CDC Maternal Mortality Review Information Application (MMRIA) database training in Atlanta. The Maternal Mortality Review (MMR) staff attended trainings and collaborated with CDC technical experts to plan for the re-launch of the state MMRC. Legislation was introduced in the 2017 legislative session to strengthen the confidentiality protections of the Committee's proceedings, specifically in the areas of handling medical records and protecting committee members from outside legal interference. The bill also intended to institutionalize and codify MMRC proceedings so that they would be sustained through state government changes in leadership and resources over the years. The bill made it successfully through both legislative chambers but was vetoed by the governor. The MMRC continued its planning work through these events, and in calendar year 2017 they selected a membership roster and hosted a training visit from the Centers for Disease Control (CDC) Foundation whose staff is assisting states with forming MMRC's and managing chart abstraction and database recording using the MMRIA. On May 11, 2018, the first MMRC meeting was held in conjunction with the Annual Meeting of the NM Perinatal Care Collaborative. The Committee reviewed four cases and developed draft recommendations associated with the review. They also reviewed the draft policy and procedure document for the MMRC. The MMRC will meet two more times in calendar year 2018. The Core Planning Group (composed of the MHP Manager, the two MMRC Clinical Chairs, a visiting UNM professor-MMRC medical epidemiologist, a NMDOH MCH epidemiologist and a lead chart abstractor/CNM) will also meet in interim time frames to continue the work of aggregating MMRC meeting findings and decisions for eventual dissemination to stakeholders.

Maternal and Child Oral Health

Title V Bureau Chief/Director, epidemiology and maternal health staff collaborated with the University of New Mexico on the New Mexico Maternal and Infant Oral Health Project. The project began with a grant in 2015 to train physicians, non-clinical community health workers and home visiting staff in early intervention skills for pregnant moms and infants. Implementation phases developed throughout 2016-2017. Activities were developed with four home visiting sites, four federally qualified health centers, and six school-based health centers. This project is described more in the perinatal-infant domain report.

Advancing multi-sector partnerships to address equitable birthing options and access to care

The New Mexico Department of Health (NMDOH) makes health equity a priority in its strategic planning and state health improvement plan (SHIP). 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 approach the multi-factorial nature of healthcare access by addressing heath inequities related 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 community level and within a health and policy systems framework. The Title V team brings together individuals from

the NMDOH (MCH Epidemiology, case management, Children's Medical Services, Injury Prevention, Family Planning/Title X, and WIC, Office of Oral Health, Adolescent Health), community-based organizations, and community members with experience in maternal and child health. The diverse team skills include policy development, community engagement, program evaluation, data analysis and epidemiology. This team still leads the infant mortality Collaborative Improvement and Innovation Networks (CoIIN) for NM which includes participation from the NM March of Dimes, the NM Health Equity Partnership, NM Breastfeeding Task Force, Young Women United, Healthy Start programs, the Dona Ana County Maternal Child Health Coalition, the Southwest Women's Law Center and the Office of African American Affairs.

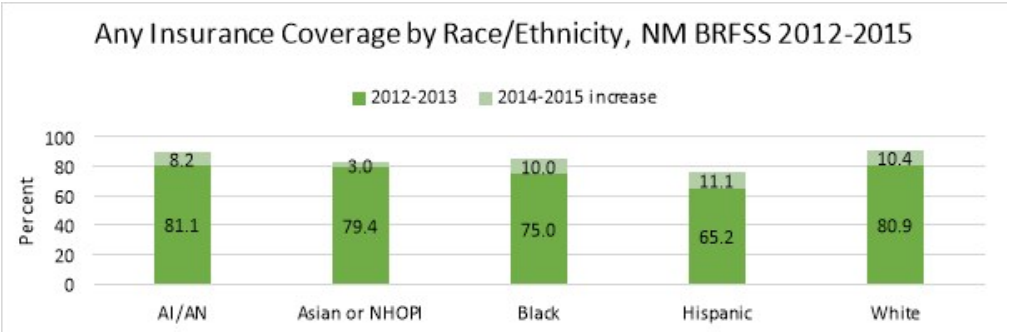
Centering Black Women in New Mexico

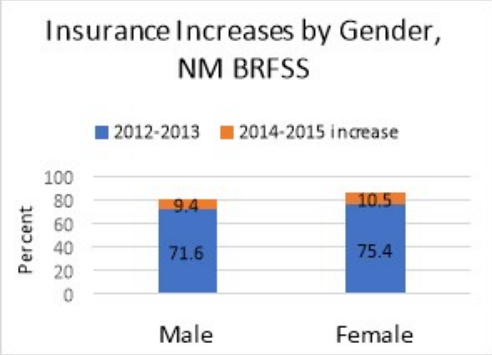
Through work on concentrated disadvantage and other life-course metrics, MCH Epidemiology staff convened an equity in birth outcomes cohort (CityMatch) with Young Women United, University of New Mexico, and partners including the SW Women's Law Center, Office of African American Affairs, Tewa Women United, doulas, midwives, and DOH Office of Health Equity, NM Tribal Epidemiologist, and Navajo Nation. The initial focus on concentrated disadvantage and perinatal outcomes (Low birthweight, preterm birth, late prenatal care) brought to focus the need for better facilitation around hard community conversations. While the partners were committed to improving access to birthing support and home births, there was discomfort and difficulty around the obvious disparities for women of color, and solutions were not readily offered through the equity in birth outcomes work. After a year of NM core leader conferencing on these complex and historically rooted disparities, an opportunity for the Office of American Affairs and the NM March of Dimes to lead the work led to a solid and committed coalition of partners committed to changing the course of poor maternal and infant outcomes for women of color. And, specifically, because African American/Black women bear the highest burden of these health challenges, we came to a consensus that the work should focus on that population, and the concept of Centering Black Women was adopted. Indigenous women and other women of color are working to support this focus, bringing a range of community and medical expertise to the effort.

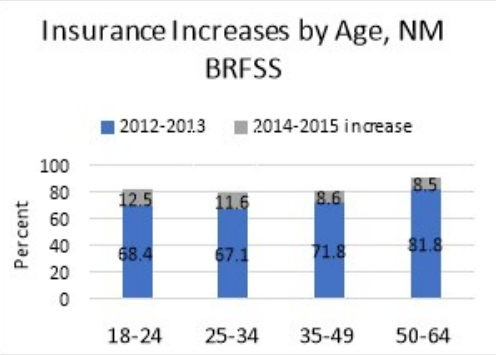
Parallel work continues to broaden the access and professional development of doulas and midwives of color throughout New Mexico. In 2017 we continued to build the evidence through economic impact study and literature review for the benefits of doula support at delivery and postpartum, if expanded to serve a larger proportion of our birth population.

Access to healthcare and adequate insurance

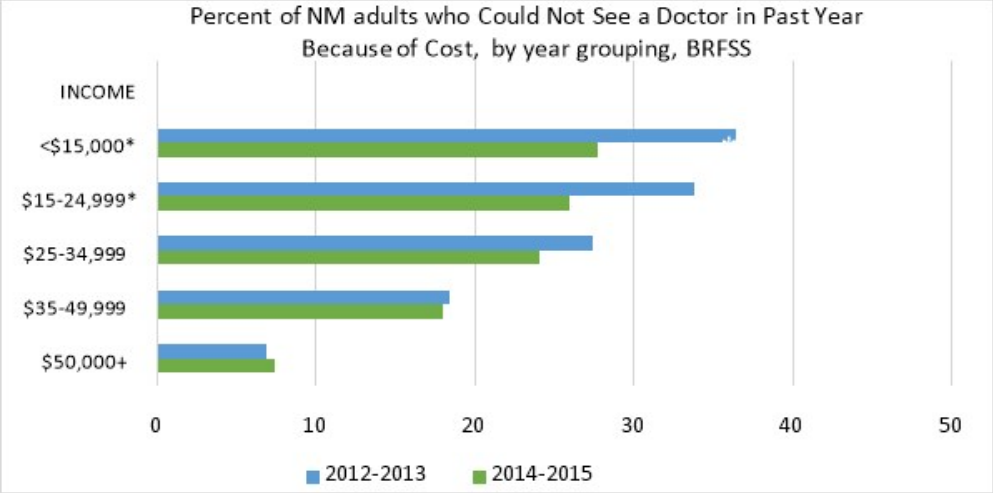
New Mexico struggles with insurance coverage and access to care across all populations, which impacts pregnancy timing, family planning, and birth outcomes. The prevalence of insured adults in NM changed positively with Affordable Care Act (ACA) expansion. Statistically significant changes in insurance coverage occurred among all adult women (10.5% increase) and among Hispanic adults (11.1%). The greatest increase by age was for those under 34 years (NM Behavioral Risk Factor Surveillance System).







Despite overall improvement the disparities persisted in barriers to care. For adults with income below $50k per year, over 23% still could not get needed healthcare. In anticipation of potential changes or reversal of ACA insurance expansion, the expectation is Title V may be tasked with covering gaps in perinatal and adult insurance coverage. The existing barriers to insurance coverage for women of child-bearing age carry over to prenatal care where lack of pregnancy recognition, distance to care, and health professional shortage areas all contribute to delayed entry. This could have a dramatic impact in border counties or in rural/frontier areas of our state.



The NMDOH MCH Epidemiology and Maternal Health Programs co-lead the activities associated with cross-cutting strategies with the following activities initially identified through the 2015 needs assessment process:

Border health and prenatal care utilization

Initial activities defined through the 5-year needs assessments were continued:

1. Improve access to and navigation of health insurance coverage and resulting services and learn how ACA has impacted access and how navigation can be implemented;
2. Increase prenatal utilization in the first trimester (and by adequacy of care 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 partner with US-Mexico border region health organizations to understand and respond to barriers in access to healthcare, health insurance coverage, timely prenatal care and linkages between primary and behavioral/mental health care. There are unique challenges associated with border residence. Although Mexico has nearly universal healthcare, families must have at least one officially employed member to qualify for healthcare

coverage. For those families who migrate between the US and Mexico this may not be the case, or they may not have access to care year-round.

In addition, some families are fearful of or unfamiliar with accessing care in the United States even if they have legal citizenship. Barriers to provider reimbursement complicate the solutions to opening these access points for women qualifying for Medicaid. New Mexico's Medicaid Division and the Maternal Health Program created a Birthing Options Plan (BOP) in 2008 via legislation. This Plan is integrated into the Centennial Care model (NM's state-based Medicaid model) that was introduced with the introduction of ACA. Reimbursement challenges and general lack of knowledge and compliance with the tenets of the BOP continue to plague the claims and reimbursements across the three groups involved: licensed midwives attending at home births, the MCOs claims staff and the staff of the state Medicaid Division. Therefore, we continue to address training and negotiations with Medicaid to facilitate improvements through the MHP and Title V leadership.

NM Title V programs help communicate insurance options through the Public Health Office of Border Health, and by working with partners in Dona Ana County such as the federally qualified health centers, La Clinica de Familia and First Step Clinic, hospital systems including Mountainview and Memorial Medical Center, La Clinica de Familia Healthy Start, Ben Archer Healthy Start and the Dona Ana County Health and Human Services Health Promotions programs. NM has partnered with these organizations for over two decades through the NMDOH Office of Border Health and through the Title V programs with staff in public health clinics through WIC, Children's Medical Services and Family Planning. These collaborations and stakeholder input received in the NM Title V state needs assessment led to the following recommendations for the current five-year period:

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; we will 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.

In 2017 we detailed strategies and objectives for three broad recommendations to advance regional and population-specific solutions for the remainder of the 5-year period. The recommendations were originally derived from an assessment of US-Mexico border region health systems and stakeholders, but there are many crossovers applicable to other regions and sub-populations. To understand more about statewide barriers to health service utilization, we conducted a statewide data linkage between WIC clients and Medicaid recipients. This analysis will help us to understand why the caseload has fallen in WIC and asks families to comment on why they do not utilize WIC even though they qualify. Once the data are collected they will be shared with WIC management to develop outreach and quality improvement strategies in the delivery of existing caseload. And to evaluate the unmet need for Families FIRST perinatal case management, we conducted a PRAMS analysis of birth and healthcare utilization outcomes comparing recipients of Families FIRST participants and other Medicaid recipients not participating in Families FIRST. Families FIRST is a model of care very similar to Healthy Start but with more saturation.

In the Fall of 2017 Maternal Child Health Epidemiology and Maternal Health staff joined an infant mortality Collaborative Improvement Innovation Network (CoIIN) to improve prenatal care utilization among women residing in US-Mexico border counties. Project Concern International (PCI) received a grant through the Association of Maternal Child Health Programs (AMCHP) to work with CA, AZ, NM, and TX Healthy Start sites and provide technical

assistance to Title V program staff across those states. By December we had established plans to focus efforts in Dona Ana County where there are two Healthy Start sites but where many families do not access timely perinatal healthcare. Due to the identification of this issue, a focus of this CoIIN work revolves around getting more women in to prenatal care in the first trimester. The Department of Health is working in a pilot testing mode for the first year. The pilot sites are all located in Anthony, New Mexico and are the Teen Resource Center, NM Department of Health Public Health Office and La Clinica de Familia. This infant mortality CoIIN work is led by Title V and Healthy Start staff in Dona County.

Also in FFY2017, the MHP collaborated with the NMDOH Diabetes Prevention and Control Program (DPCP) and with the staff of an Albuquerque metro maternity and family planning clinic run by the University of New Mexico Hospital (UNMH) to develop a project to address the appropriate assessment and follow-up of women diagnosed with gestational diabetes (GDM), focusing on the post-partum visit as the time to address this. This project was submitted to the MCH Workforce Center and accepted as a participating project for their 2018 Learning Institute Cohort. Staff from NMDOH MCH and staff from the UNMH Clinic attended the Learning Institute sessions in Chapel Hill, NC in March 2018. The working group for this initiative has broken the project into several phases to move towards completion. The first phase is currently in progress and aims to improve clinic scheduling processes. The overall aim of the project is to increase, to 80%, the percentage of women with GDM in our pilot clinics who complete a post post-partum visit and receive the correct follow up blood tests.

To improve coordination on perinatal mood disorders and maternal depression screening and treatment, the MHP program manager attended the launch of a New Mexico Perinatal Mental Health (PMH) Collaborative funded through the University of New Mexico (UNM) School of Nursing. The aims of this Collaborative are: to improve perinatal mental health (PMH) services to NM's diverse maternal and infant populations; to provide other stakeholders with subject matter expertise around PMH disorders; and to work with prenatal and pediatric providers to support the assessment, care and referral of moms and/or babies with PMH concerns. Members come from the birth provider community, the UNM School of Nursing and the UNM Psychiatry department (a child psychiatrist and a perinatal mood disorders psychiatrist).

Currently no trainings have been provided and are set to begin in spring 2019 through ECHO, the telehealth service through the University of New Mexico. Further plans to expand the reach of the trainings will happen in subsequent years, with ECHO serving as the entity to help identify the providers that will receiving the training. The NM PMH Collaborative also has a smaller workgroup addressing funding to sustain activities and will seek to be integrated into the NM Perinatal Quality Care Collaborative as a recognized work group.

IM CoIIN- Paid Family Leave and Health Equity/Provider Bias

We started a parallel Social Determinants of Health CoIIN partnering with the Southwest Women's Law Center, Navajo Nation, Office of African American Affairs, and the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) to identify potential policy and practice changes that could diminish the gender pay gap and/or decrease provider bias in healthcare. The NM team decided that our goals for this Social Determinants of Health CoIIN are to increase family-friendly workplace leave policies and improve health provider education in implicit bias and differential treatment based on perceived race.

Maternal-Infant surveillance enhancements

State-Tribal health surveillance and assessment collaboration

As part of our years two and three Title V plans, we 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), which was approved by the Institutional Review Board at New Mexico State University and originally planned to begin in 2017 but was deferred to start with 2018 birth data collection.

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 elements of community participatory research. Because Navajo Nation and NM state PRAMS staff already share PI-Project Directorship of NM PRAMS, and building from previous surveillance expansion with the AASTEC communities, this was a natural progression to data sovereignty.

Perinatal Mood Disorders and Mental or Behavioral Health

New Mexico has been addressing opioid and prescription misuse in several ways. The MCH Epidemiology program implemented a supplemental questionnaire (developed by the Council of State and Territorial Epidemiologists) in the 2017 state PRAMS to include questions about marijuana and prescription drug use during and after pregnancy. The questionnaire supplement also asked about interactions with health providers and women's attitudes about breastfeeding and substance use. Because New Mexico was the first state to pilot a set of questions regarding immediate preconception drug use, New Mexico PRAMS was selected among a handful of states to pilot the more in-depth set of questions through the Council of State and Territorial Epidemiologists (CSTE). The funding from CSTE helped Title V staff convene work groups and subject matter experts through collaboration with the Substance Abuse Epidemiology Unit and with members of the NM Perinatal Collaborative. Goals to share data across stakeholder planning groups and to conduct data linkages were met in 2017. Final data from the CSTE supplement will be available in 2019 for analysis, but existing data was used to guide conversations and planning. A data linkage of birth certificate data, prescription monitoring data, and hospitalization records indicated that about 1/3 of infants diagnosed with neonatal abstinence withdrawals did not have a corresponding diagnosis or history of prenatal substance use for the mother. This indicates significant challenges in engaging treatment options during pregnancy.

In March 2017, a clinical team from UNM presented at the Annual Meeting of the New Mexico Perinatal Collaborative (NMPC) on a project addressing neonatal abstinence syndrome (NAS) protocols and training for clinical staff in birth hospitals across the state. The project was a 2016-17 effort funded by an AMCHP Birth Outcomes Grant. The goals of the project were: to improve care of infants with NAS around the state; to empower birth hospital sites to keep and treat babies when capable; and to improve the hospital transfer process when necessary. Through a three-phase process, the work team seeks to target a hospital site's needs in the assessment and care of NAS infants and tailor a training program suited to those needs, Phase I: assessing needs, is complete; Phase II, training and protocol development is set for summer 2018 and Phase III: sustainable programming and evaluation will be completed in the next year.

The relationship between substance abuse and family violence and child abuse-neglect is unfortunately an area we must include in our assessments and planning. New Federal requirements to address family assessments for child abuse during prenatal and delivery healthcare require that we coordinate efforts to screen and provide referrals to multi-sector resources. Because we have engaged in this work through the perinatal -infant health domain, the report and plans are discussed in those sections. Ultimately, we are actively shifting the prevention work and screening to the prenatal period because that is where many families are experiencing the stress of economic disadvantage and stressful relationships.

Infant Mortality CoIIN- Collaborative Improvement and Innovation Networks

Two infant mortality improvement and innovation collaboratives will continue leveraging partnerships to increase equitable access to care. We will build on existing work with the Social Determinants CoIIN and the PCI Border CoIIN to improve equity in healthcare utilization in New Mexico. There are two work groups that will interact on a quarterly basis but will remain distinct their scope of work and composition for the Social Determinants of Health CoIIN: 1. The Paid Family Leave work group will continue to explore avenues to improve family leave options across the state and to tie the impact to maternal-infant health outcomes demonstrated in that expansion in other states. 2. The Health Equity/Provider Bias work group will focus more directly on health outcomes and health practice expected to improve healthcare utilization in NM. Using qualitative and surveillance data to understand disparities in early prenatal care and inter-conception care, we will coordinate with partners to plan interventions and innovative approaches in healthcare delivery.

Prenatal Care Utilization- Border States IM CoIIN

The PCI Border Infant Mortality collaborative will expand on its current target of a 10% increase in prenatal care utilization in the border counties through a tiered approach of preconception and prenatal intervention designs. Design sprints are in progress to determine actual course of action, but a general outline for 2018-2019 includes the following field testing components:

Utilize a Universal Referral Form used across all agencies to identify target population when conducting initial enrollment or intake.

1. The Universal Referral is an electronic platform from which a participant will be linked to specific needs for women struggling to obtain first trimester prenatal care (this will be open to all Dona Ana County residents).

2. Once that participant is linked to the agency a tracking mechanism will be used via electronic platform for follow-up.

Deploy an online app to provide resources and address known barriers to prenatal care entry – (insurance coverage, fear to interact with the health care system, not knowing about or recognizing symptoms of pregnancy, inability to schedule an appointment when needed)

1. Design Impact – (contingent on participation of 'target' population, follow up, tracking)
2. Allow for self-identification in the app to facilitate follow-up by clinical staff
3. Provide generalized de-identified, but specific, support for women not wishing to be identified for self-referral (determined through an algorithm of online answers to basic questions like geography, age group and need)
4. Provide a toll-free warmline for women to speak with a *promotora*/ health service navigator and to field more urgent situations for clients needing more help

Develop a protocol and tools to measure impact of online app and clinical follow up for women with a positive pregnancy test

1. Introduction to the online app will be made in at least three clinical sites (La *Clinica de Familia*, at least one NM Department of Health Public Health office, and the Teen Resource Center (TX)
2. Initial (immediate) follow up to self-identified women will occur based on their association with a selected site
3. *Promotoras* from LCDF will provide follow up with self-identified women to assure they have gotten the

appointment and resources they desire

4. Utilize media and online resources to address common barriers identified by women using the online app and with input from the selected site staff

In the evaluation of these steps, NM Title V staff, Healthy Start leadership and clinical stakeholders will recommend broad scale replication of redirection to more clinical sites. They will work together to measure the impact of the online app on prenatal care utilization by analyzing clinic and population data to assess approximation of the 10% increase. In collaboration with the Dona Ana County MCH Coalition and a broader selection of stakeholders, Title V and Healthy Start personnel will advance the best form of the intervention in the next 5-year period.

Gestational Diabetes Project – MCH Workforce Learning Institute

Over the next year, project work will continue with the HRSA Maternal Child Health Workforce Development Center's staff as well as with the NM-based work team on the "GDM Project" to improve post-partum follow-up to and for women diagnosed with gestational diabetes mellitus (GDM) in the pregnancy. A short-term objective is to assess, from clients in the population of interest (diverse clients who are eligible and served by the Title V direct care funding for prenatal and post-partum clinical services), what are the barriers to post-partum visit completion as well as to healthy and recommended lifestyle changes to address pre-diabetes risk. This information will be gathered in fall 2018 and integrated into the planning of the longer-term goal of introducing clinic flow changes at the Title V clinic to improve post-partum follow-up, and to improve the providers' assessment and management of pre-diabetes risk in the client population. Phases of this project have been developed to make successful implementation a workable goal:

Phase I: Improve the scheduling of the postpartum visit, visit completion and appropriate follow-up diabetes testing for women with a GDM history.

Phase II: Starting at the postpartum visit, introduce an evidence-based, tailored counseling and education and referral approach for managing diabetes risk for women with history of GDM.

Phase III: Disseminate the interventions described above to a larger group of health service sites that see women with Title V and/or Medicaid coverage

Phase IV: Work with interested DM service-related stakeholders across the state to institute incentive-based programming to providers to ensure the above interventions are implemented in a variety of settings across the state.

Perinatal Mood Disorders and Mental or Behavioral Health of Mothers and Infants

From spring to summer of 2018, there were developments in creating the infrastructure to provide training to primary care providers in the state. An effort was made to apply for a HRSA grant that would fund the network through the University of New Mexico's Project ECHO. The grant proposal was not able to be readied in the given time frame but the staff of Project Echo committed to work on the next grant opportunity. That is pending for October 2018. Also, a collaboration has formed between the NM Department of Health, the NM Human Services Department and the NM Children's, Youth and Families Department and stakeholders in the areas of infant mental health and perinatal mental health to promote more reliable and accessible mental health services to the pregnant, postpartum mother and newborn. This effort is receiving technical support from the national Zero to Three organization. The goals of this project are to:

1. To develop a continuum of behavioral and emotional health services in NM which are connected through referrals and patient information incorporating all existing services and new service opportunities from prenatal through 5 years old;
2. To incorporate the DC 0 – 5 classification system into the continuum at all service locations, ages 0 – 5

Midwifery and Birth Worker Workforce Development

Programming for 2019 will include presenting the revised NMAC 16.11.2 (the certified nurse-midwife or CNM Practice Rule) at a public hearing. Once enacted, the Maternal Health Program (MHP) will offer a webinar on the changes to informed licensed CNMs via website access. MHP is considering building in continuing education components to the training to incentivize webinar participation.

To advance improvements to midwifery licensing activities, MHP will pursue an on-line application midwifery licensing project. Application designing is expected to commence in early 2019. Other planned improvements in the work of midwifery licensing are: engaging with MANA or the Midwifery Alliance of North America to improve the client services data reporting that is mandated by NMAC 16.11.3 (the Licensed Midwife [LM] Practice Rule) to be done on a quarterly basis; finalizing the revisions to the NM Midwives Association Practice Guidelines (for the LMs) and publishing an updated Guidelines document by mid-year 2018; revising Student Midwife materials to bring them up to date and organized for the apprentice midwifery population; and re-introducing legislation in 2019 to secure the acquisition and use of needed emergency medications by LMs in the homebirth setting. This legislation is part of a broad effort to improve access to home birth in New Mexico.

The MHP will also be starting a separate project to bring continuing education (CE) monitoring on-line using a reliable vendor. This service will allow renewing midwives to record and store their CE work on-line, and the vendor will authenticate the stored files to confirm that they meet CE requirements as mandated by the midwifery practice laws. This service will make a slow and tedious step in the multi-steps of midwifery licensing processing much more efficient and streamlined.

In FY18-19, the midwifery billing training described above will be developed into a continuing education webinar and offered on the NMDOH Midwifery website found at: https://nmhealth.org/about/phd/fhb/mwp/ for all newly licensed and renewing licensed midwives (LMs) to view. The MHP's CNM contractor will be the lead on the project and work with the MHP's administrative assistant to develop the training in a virtual format. A new 5-year contract will be starting in January 2019 with 3 managed care organizations (MCO) and State Medicaid. There are trainings on this contract with the MCO staff in summer and fall 2018, and the MHP is working with Medicaid staff to include the MHP as well as 1-2 experienced licensed midwives in the training so that the three entities (MCO, Medicaid and licensed midwife attendees) can exchange information that will enhance the new contract compliance with New Mexico's Birthing Option Plan (BOP). The BOP allows Medicaid recipients to opt for out-of-hospital birth settings for delivery.

Advancing multi-sector partnerships to address equitable birthing options and access to care

Centering Black Women in New Mexico

Plans to advance maternal and infant health for black women focus in on the following strategy matrix (Table 1.). Because maternal mortality and infant mortality have been so adverse for Black women compared to all women, the coalition of Equity in Birth outcomes has committed efforts to improve health in that population as the highest priority. Women of color, and most notably Black women in NM are disproportionately burdened with severe maternal morbidity and mortality. And there is a close association with low or late healthcare access to those outcomes. We will address that relationship and develop recommendations for prevention through the continued work of the recently-vetted Maternal Mortality Review Committee. We will finish reviewing the cases from 2015 for analysis and reporting by early 2019. The plan to complete 2016 and 2017 case reviews through quarterly meetings. Another matter to address is developing a methodology to work with the American College of Obstetricians or ACOG on combining state data with regional data to find trends unique to the region of western and largely rural states.

In the Equity in Birth Outcomes coalition, the Office of African American Affairs, NM March of Dimes, and Title V staff will flesh out the following work group goals and continue the work of both assessment and intervention with community and academic partners. The table shown at the foot of the document is a draft work plan by task domain

(see Table 1).

Paid Family Leave and Provider Bias

NM Title V staff and partners will continue the work to evaluate the potential impact of paid family leave by studying its economic return in other states and by gathering community impact on the positive or negative views for employees and employers. Working with the SW Women's Law Center and

State-Tribal health surveillance and assessment collaboration

Building on the last 5-year needs assessment we will continue partnerships to improve measures of well-being in alignment with validated or perceived protective factors unique to American Indian communities. Our plans to pilot these measures in our perinatal surveillance systems were initiated through a two-day planning retreat among NMDOH, TECs, and tribal community members in 2018.

1. Improve Title V knowledge about insurance barriers among Native American families and how they have changed with ACA and post-ACA provisions;

2. Improve State agency (DOH, HSD) surveillance and assessment 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.

3. Develop and test community and personal resiliency factors to balance risk-based metrics in public health surveillance.

4. Share Tribal PRAMS surveillance data in a Maternal Child Health Symposium offered by AASTEC, NEC and NMDOH.

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 the PRAMS surveillance we added questions in consultation with the Albuquerque Area Indian Health Board and Tribal Epidemiology Center to reframe questions about late prenatal care utilization. The reasons women across all demographics struggle to maintain adequate levels of insurance are diverse in geography, age and education levels. For women living in rural areas the primary drivers tend to be transportation and distance to care but include factors associated with health professional shortage areas. Therefore, the activities in the following year will retain a life-course framework. Because population data available specific to tribal communities are limited, we worked with both Tribal Epidemiology Centers to establish maternal-infant population surveillance for NM tribes to begin in 2018. The 2019 plans will incorporate initial results and be used to inform the NM state needs assessment process.

Black Women's Story Collection Project	Provider Curriculum
• Partner with Mental Health Providers • Provide Incentives for participant recruitment • Healing Circle • Work with Organizations that have story collection mechanisms • Video or other means of recording stories of black women/families in NM	• Obtain Provider "Buy-In" • OHE Online Class Format • Use stories to inform curriculum • CHWS • Work with UNM Med School and Health Sciences Center: Provider Lecture Series • Free CME's available • Work with Highland's NMPHA, to add our program
Pilot Stress Reduction Sister Circles for Black Women	**Increase Female Providers of Color (in NM)**
• Work with Community Health practitioners to present to groups • Work with HEP on community needs assessment • Pull and focus qualitative data output • Work with evaluators (ERD, FHB, DOH) • Work with Black Mamas Matter Alliance • Work with Health Clinics to Host Sessions	• Work with UNM to design + fund programs geared towards this population • Work with NM NEC to reach across the state to RN training programs • Use evidence based midwifery models to inform and co-lead design • Work with DOH (OHE, etc) to train and certify CHW's
Youth Engagement & Movement Building	
• School-Based Health Clinics and public school champions • Increase Visibility of Providers of Color to Youth and Education stakeholders-Create partnership in schools to educate and learn from young black women /women of color	

Table 1. Matrix of Activities for the Centering Black Women Birth Equity Collaborative

Perinatal/Infant Health

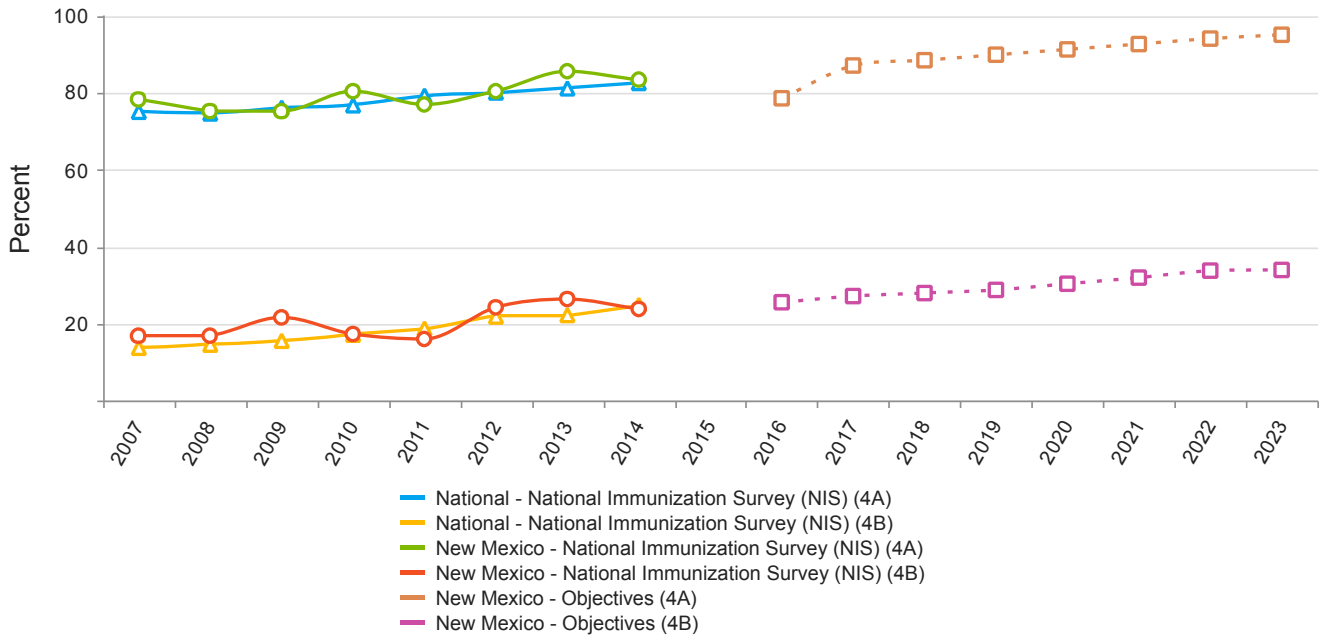
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	5.1	NPM 4
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.0	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	116.2	NPM 4

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Baseline Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	78.5	87
Annual Indicator	85.5	83.2
Numerator	21,270	20,438
Denominator	24,890	24,563
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	88.4	89.8	91.2	92.6	94.0	95.0

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	25.6	27.2
Annual Indicator	26.6	24.0
Numerator	6,319	5,708
Denominator	23,784	23,807
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	28.0	28.8	30.4	32.0	33.8	34.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		29
Annual Indicator	27.2	28.2
Numerator	5,679	5,574
Denominator	20,855	19,734
Data Source	NM PRAMS	NM PRAMS
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	31.3	33.0	35.0	37.0	39.0

State Performance Measures

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Measure Status:	Inactive - Ongoing work will be reported in annual updates but recording progress over one year with short term goals will limit our state in showing changes.

State Provided Data		
	2016	2017
Annual Objective		83
Annual Indicator	81.3	81.3
Numerator	209	209
Denominator	257	257
Data Source	NM Vital Records	NM Vital Records
Data Source Year	2015	2015
Provisional or Final ?	Final	Provisional

SPM 2 - Percent of infants placed to sleep on their backs

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		80.3
Annual Indicator	75.4	78
Numerator	17,707	17,558
Denominator	23,487	22,517
Data Source	NM PRAMS	NM PRAMS
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.9	81.5	83.1	85.7	86.5	87.2

State Outcome Measures

SOM 1 - Percent of Infants who were usually placed to sleep in a crib or bassinet

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	82.0	84.0	86.0	88.0	90.0

State Action Plan Table

State Action Plan Table (New Mexico) - Perinatal/Infant Health - Entry 1

Priority Need

To maintain and increase breastfeeding initiation and duration

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

Increase the proportion of birthing facilities with Baby-friendly designation and corresponding self-reported experience in PRAMS by 50% by 2020

Increase the degree of cultural specificity and awareness in the breast feeding education/training with at least two home visiting programs by 2019

Increase the proportion of NM health providers reporting confidence in their capacity to address at least three predictors of breastfeeding duration by 2020

Strategies

Utilize PRAMS and the NM Toddler Study to measure the correspondence between self-reported experience and the facility identification as Baby-Friendly

Collaborate with the March of Dimes, Office of the Medical Investigator, Indigenous Women Rising or Young Women United to create or adapt culturally resonant language for breastfeeding-friendly, safe sleep education and messaging

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 the UNM Pediatrics and Envision Community Advisory Board (CAB), the NM Breastfeeding Taskforce and NMDOH to document the quality improvement of breastfeeding support and breastfeeding-friendly workplace policies in NM

Execute agreements with at least two home visiting or doula program sites to integrate linguistically and culturally functional evidence-based, safe sleep and breastfeeding concepts in their education protocols in 2019.

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

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
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 (New Mexico) - Perinatal/Infant Health - Entry 2

Priority Need

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

SPM

SPM 2 - Percent of infants placed to sleep on their backs

Objectives

Increase the number of NM birthing facilities trained by the NMDOH in safe sleep education protocols from 3 to 15 by 2020

Transition at least five NM birthing facilities to report standardized statistics for Shaken Baby Education to the NMDOH in 2019

Leverage existing program partners to increase the number of home visitation and perinatal case management programs trained in Safe Sleep and Shaken Baby education from 5 to 15, statewide by 2020.

Strategies

Create an incentive program to award hospitals with Safe Sleep certification

Develop and track a data collection protocol for Shaken Baby Education at NMDOH; tie use of protocol to certification to incentivize hospitals

Participate in an evaluation of Shaken Baby and Safe Sleep Education delivered by NMDOH

Draft and present a statewide, multi-sector Safe Sleep Strategy by 2019

State Action Plan Table (New Mexico) - Perinatal/Infant Health - Entry 3

Priority Need

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

SOM

SOM 1 - Percent of Infants who were usually placed to sleep in a crib or bassinet

Objectives

Increase crib or bassinet sleeping environments for infants

Strategies

Provide evidence from the NM Sudden Unexpected Infant Death Registry and PRAMS to inform prevention strategies / encourage crib and bassinet use

NPM: A) Percent of infants who are ever breastfed
B) Percent of infants breastfed exclusively through six months

Objectives:

- Increase the proportion of birthing facilities with Baby-friendly designation and corresponding self-reported experience in PRAMS by 50% by 2020
- Increase the degree of cultural specificity and awareness in the breast feeding education/training with at least two home visiting programs by 2019
- Increase the proportion of NM health providers reporting confidence in their capacity to address at least three predictors of breastfeeding duration by 2020

Strategies:

- Utilize PRAMS and the NM Toddler Study to measure the correspondence between self-reported experience and the facility identification as Baby-Friendly
- Collaborate with the March of Dimes, Office of the Medical Investigator, Indigenous Women Rising or Young Women United to create or adapt culturally resonant language for breastfeeding-friendly, safe sleep education and messaging
- 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 the UNM Pediatrics and Envision Community Advisory Board (CAB), the NM Breastfeeding Taskforce and NMDOH to document the quality improvement of breastfeeding support and breastfeeding-friendly workplace policies in NM
- Execute agreements with at least two home visiting or doula program sites to integrate linguistically and culturally functional evidence-based, safe sleep and breastfeeding concepts in their education protocols in 2019.

Title V and WIC staff collaborated to set data and analysis goals for activities related to WIC client data and breastfeeding outcomes measured in PRAMS, the National Survey of Children's Health and NM Vital Records. They also collaborated to evaluate the CDC Breastfeeding Peer Counselor Program and to develop new metrics in the NM Toddler Survey. Over the reporting period we interacted to monitor objectives and strategies to increase breastfeeding duration and encourage safe infant sleep practices with community partners.

NM WIC Breastfeeding promotion activities

New Mexico's Women Infant and Children program (NM WIC) trained all new staff within the first year of employment on breastfeeding promotion and education through a full 2-day workshop entitled Using Loving Support to Grow and Glow in WIC. This training is required by the United States Department of Agriculture (USDA) in all states receiving WIC funding, and was presented in both in the northern and southern areas of the state. NM WIC also participates in an advanced 4-day Lactation Training Program, presented by the Childbirth and Postpartum Professional Association (CAPPA), which is available for all WIC Nutritionists after one year of employment. In addition, WIC continued use of the Hug Your Baby Training, a series of web-based trainings on normal baby behavior related to feeding and sleep issues, which was required and completed by all WIC Nutritionists and Breastfeeding Peer Counselors.

In 2017, NM WIC staff participated in the ongoing design and development of new data collection system alongside the Texas and Louisiana WIC Programs. The new data collection system is changing to improve efficiency and

quality of nutrition and breastfeeding services to WIC participants, and to improve data reporting capability. The new system includes increased availability of prenatal and breastfeeding data, improved and expanded reporting measures, as well as maintenance of an electronic breast pump/supply inventory system. It is scheduled for roll-out to NM WIC clinics in the summer of 2018.

All WIC clinics engaged in various activities during World Breastfeeding Week, August 1-7, or during the entire month of August, to bring awareness to the importance of supporting breastfeeding families. Activities included clinic parties, spa days and ceremonies honoring their WIC breastfeeding families, and community-based activities such as barbeques in the park, fun-walks/runs, events at the local zoo, and celebratory events at the Farmers' Markets. Most events included refreshments, raffle prizes, gifts and other fun activities for WIC families.

WIC expanded the Breastfeeding Peer Counselor (BPC) program from 65 to 75 active BPCs. BPCs provided one-on-one counseling support via telephone calls, home and hospital visits, even after WIC clinic hours, to WIC participants within 65 WIC sites/communities and 11 hospitals in New Mexico. Additional activities and initiatives completed by the BPC Program included the following:

- Hospital BPC Project (11 of the 29 maternity care hospitals statewide participating)– Focused expansion on SE & SW regions of the state whose breastfeeding initiation rates are the lowest and whose lactation resource are scarce or non-existent. Added one hospital in the SE region and three hospitals in the SW region, and assisted Tribal organizations in the NW region to expand support in their hospitals.

- Community Support Groups (20+ statewide) – adhered to 2011 US Surgeon General's Call to Action to Support Breastfeeding through the establishment of community lactation support groups statewide and served as a resource for hospitals seeking Baby Friendly designation to help them meet the Step 10 requirement of fostering the establishment of breastfeeding support groups and referring mothers to them upon discharge. Expanded three breastfeeding support groups by equipping community partners and community health workers trained in basic lactation to transition from a BPC-led breastfeeding support group to a community-led breastfeeding support for sustainability.

- Breastfeeding on the Border Project– a binational effort to increase breastfeeding rates in US/Mexico border communities. Each state (NM, TX, Chihuahua, MX) applied for a three-year, Community-Based Health Initiative Project Grant through the Office of Border Health in New Mexico, effective for the state fiscal years 2018, 2019 and 2020. Each state will coordinate its own project as well as partner and support each other's efforts by sharing resources, trainings, workshops and funding where possible. Goals of the New Mexico project include increasing breastfeeding rates in three border communities in New Mexico through addressing three objectives to meet Healthy People 2020 breastfeeding goals:
    1. Build on the Hospital Baby-Friendly Initiative by providing a resource for referral for lactation support after hospital discharge (step 10);
    2. Adhere to the 2011 US Surgeon General's Call to Action to Support Breastfeeding;
    3. Bridge health and racial disparities along the US/Mexico border through the formation of binational partnerships and by equipping partners and health promoters in basic lactation to increase accessibility to bilingual health services and resources.

- Collaboration with Tribal WIC Programs by training Tribal BPCs and staff and by sharing resources.

Title V, WIC and the NM Breastfeeding Taskforce

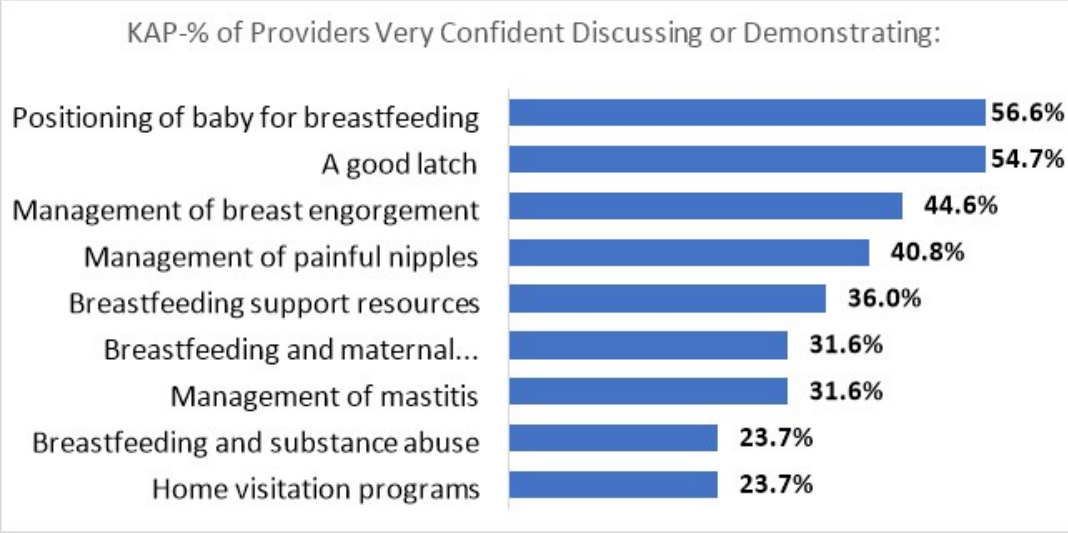
NM WIC and the New Mexico Breastfeeding Taskforce (NMBTF) collaborated on the NM Breastfeeding Behind Bars Pilot Project at the Bernalillo County Metropolitan Detention Center (MDC). This project involved educating the correctional system on the important role breastfeeding plays in the health and well-being of inmates and their

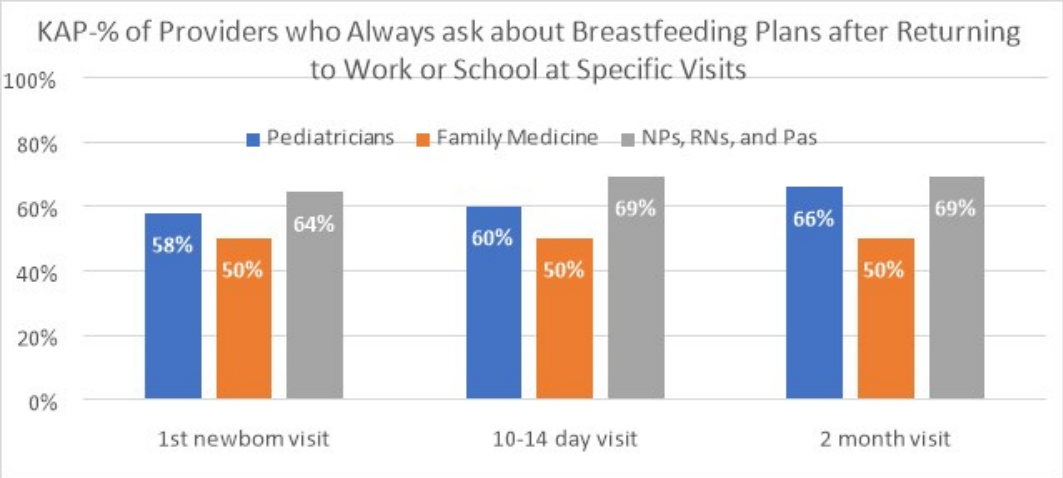
families. It resulted in the Bernalillo County MDC establishing a Breastfeeding Support Program to provide encouragement and support for incarcerated mothers to express and store breastmilk at the facility. Plans included that WIC will work to provide a breast pump and peer counseling to an incarcerated mother whose infant is certified on WIC.

In March 2017, the NMBTF and NM WIC Program partnered again, along with local Albuquerque hospitals, to sponsor the 23rd Annual Breastfeeding Conference. The conference focused on the biophysics of breastfeeding, human milk banking, marijuana research and breast cancer research regarding breastfeeding. Over 350 health care professionals attended, with about 77% from NM (including all WIC Nutrition staff) and 23% from other states nationwide.

The NMBTF Workplace Program, initially funded through ASTHO in partnership with NMDOH in 2016, increased outreach efforts to businesses in major municipalities and higher education programs around NM, providing best practices to promote support for breastfeeding employees through evidence-based information, technical assistance and standardized resources. Outreach included major employers such as city, county and school employers in the target areas of Taos County, San Juan County, McKinley County, Dona Ana County, Bernalillo, Rio Arriba County and Sandoval County. This was an expansion of the originally intended major metropolitan areas of Bernalillo and Dona Ana counties. The workplace team also made a significant effort to engage Native American populations with outreach and collaborations with leaders in the Zuni, Santa Ana, San Felipe Pueblos. The New Mexico Department of Health Title V-MCH Epidemiology team and the NM Breastfeeding Task Force applied for continued ASTHO funding in 2017. The application was not funded, but the agencies continued to work together and have joined efforts to address paid family leave policies for the 2019 Title V Plan.

The NM Breastfeeding 'Community Advisory Board' (CAB) included Title V, NMBFTF and UNM evaluation and pediatric staff who worked to assess provider knowledge on breastfeeding laws and collaborated with the NMBFTF to increase breastfeeding duration in NM communities and businesses. The CAB developed a survey of health providers designed to measure the knowledge, attitudes, and practices (KAP) of outpatient providers around breastfeeding promotion and support. The questionnaire was designed to both parallel the provider survey being used in our hospital quality improvement efforts, which is based on Baby Friendly Hospital measures, while also being responsive to the outpatient practice setting. For example, while the inpatient provider survey focuses largely on promoting breastfeeding initiation after birth, the outpatient provider survey focuses on the opportunities for supporting continuing breastfeeding at well-child visits. The resulting dataset includes responses from 77 providers. Over half (61.8%) were pediatricians; the rest were either nurse practitioners, registered nurses, or physician's assistants (22.3%) or family medicine or other physicians (15.8%) (see Table 1 below). The majority (65%) were outpatient only providers, but about 35% provided care in both inpatient and outpatient settings and most were practicing in the metropolitan public health region. Some KAP survey results are summarized here.





Data collection and analysis

a) Longitudinal data collection and data linkage improvement

Data collection for the longitudinal follow-up to PRAMS began in November 2016. The study is a prospective survey of PRAMS (sample of women with live birth) participants when their child reaches the age of two. The collaboration to develop the survey included expertise from the University of New Mexico, Bureau of Business and Economic Research (BBER), independent epidemiology research consultants and early childhood service and breastfeeding program staff. Data analysis of 2015 births (with two-year old results) was completed and will be summarized for the Steering Committee by October 2018. PRAMS staff analyzed infant survey data (2012-2015 births), created short reports and presented results for several audiences in 2017. The Toddler Survey data had not been linked to the PRAMS dataset, so that information has not been shared. Maternal Child Health Epidemiology selected a PRAMS and Toddler Study Coordinator to address these objectives along with the toddler component results, which will be used to measure the impact of baby-friendly experiences to early breastfeeding duration and their relationship to ongoing (after 10 weeks) breastfeeding duration. In 2017 we focused on improving data collection methodologies and response rates which were initially at ~42% for 2014 births and had increased to over 53% by the end of the calendar year. Steering committee members were convened in May 2017 and provided constructive input for the logo, letterhead and survey design used in the

toddler surveillance.

We (Title V stakeholders and MCH Epidemiology) had also planned work with UNM Economic Research (BBER) to model simulated breastfeeding outcomes using PRAMS data with work leave indicators. The analysis plan had a target completion date of December 2016 and a reporting target of May 2017. These targets were not met, and we are revisiting that analysis plan as a Title V deliverable for FY18. During the FY17 period we did release PRAMS datasets for analysis to the University of New Mexico Envision program and to the NM Breastfeeding Task Force epidemiologist, Heidi Fredine. In addition, the NM PRAMS PI/PD Eirian Coronado and analyst Glenda Hubbard completed several analyses, reports and presentations to inform NM progress toward achieving breastfeeding duration goals. The focus of these products was primarily on the prevalence and impact of Baby-Friendly indicators/experiences on breastfeeding duration at 9 weeks. A separate publication focused on breastfeeding initiation and duration gains among Native American women in New Mexico. Because I.H.S facilities in New Mexico were the first to achieve baby-friendly designation, we expected to see improvements in breastfeeding initiation and duration with available data in PRAMS over the period 2000-2015. Those improvements were notable, and although we did not have access to facility level indicators from Vital Records, we did conduct sub-population analysis, indicating Native American women did have a higher prevalence of several lactation support indicators compared to other women. Despite these gains, the providers practicing across New Mexico may not be up to speed on their actual practice to support breastfeeding mothers, as demonstrated in the KAP survey. In particular, family medicine providers may need more help to support women in the post-partum period. These gaps are addressed in the FY19 plans.

The NMBTF amplified efforts to increase the number of New Mexico hospitals births in Baby-Friendly USA designated facilities and saw measurable increases in 2017. The team of three consultant contractors engaged with 29 maternity care hospitals including two in Arizona. Nine hospitals were designated Baby-Friendly and the organization is working with eight additional hospitals that are on the pathway to this designation. Envision NM, in collaboration with NMBTF, University of NM, Nuestra Salud and other breastfeeding stakeholders, organized the 4th Statewide Hospital & Clinics Maternity and Infant Care Summit. There were 83 attendees in fields ranging from IBCLCs, RNs, BPCs, MDs, Midwives and other hospital staff. The PRAMS data were presented showing comparisons by ethnicity and region regarding provision of Baby-Friendly practices, self-reported in PRAMS.

NMBTF assisted with capacity building to develop 11 of active chapters across the state and assist in identifying measurable goals to continue to support breastfeeding within their communities. All 11 chapters engaged in different activities during World Breastfeeding Week to bring awareness to the importance of supporting our breastfeeding families and the importance of breastfeeding. The NMBTF Advocacy and Policy Committee worked with legislators and community breastfeeding advocates to support legislation during the 2017 NM Legislative session, resulting in the passage of the NM Lactation Care Provider Practice Act, which allows lactation care providers to be licensed under the State of NM.

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

The NM Breastfeeding Taskforce epidemiologist utilized the Newborn Genetic Screening breastfeeding data to produce facility-specific report cards for all NM birthing hospitals. These report cards were used in conversation with facilities regarding the progress they are making with breastfeeding rates at discharge. While the facility-level 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. The MCH Epidemiology program did not have access to the data but did communicate with the epidemiologist charged with analyzing the data to plan a data linkage or comparison analysis with NM PRAMS. The PRAMS data would add validation to the data on the NBGS card and may improve the interpretation of the PRAMS data. It would also allow for hospital identification on PRAMS indicators, and since we do not receive that information on the birth certificate data, we have also added that question to the

PRAMS questionnaire (for 2017 births). The data will be ready to analyze early in 2019.

c) Comparison of baby-friendly designated hospitals or regions with prevalence of baby-friendly indicators in PRAMS.

We used PRAMS to compare prevalence of baby-friendly indicators with facility designation. However, we were limited to 2015 births and earlier because NM Vital Records restricted hospital information from the PRAMS dataset starting with 2016 births. Without specific facility data, we obtained the following information from PRAMS: the percentage of NM resident moms indicating they had the primary predictive factors associated with breastfeeding duration increased from 16% in 2012 to 34% in 2016. The data do not include the full spectrum of Baby-Friendly practice indicators but do include breastfeeding in the first hour after birth, only feeding infant breastmilk, receiving help from staff to breastfeed, and not receiving a pacifier or infant formula gift pack. As previously mentioned, the NM PRAMS PI/PD Eirian Coronado completed several analyses, reports and presentations to inform NM progress toward achieving breastfeeding duration goals. The focus of these products was primarily on the prevalence and impact of Baby-Friendly indicators/experiences on breastfeeding duration at 9 weeks. A separate manuscript focused on breastfeeding initiation and duration gains among Native American women in New Mexico. Because I.H.S facilities in New Mexico were the first to achieve baby-friendly designation we expected improvements in breastfeeding initiation and duration with available data in PRAMS through 2015, and the program did not receive a 2016 weighted data set from the CDC during this reporting period. However, the baby-friendly indicators were added to the survey with 2012 birth data, so baseline measurement starts with that year, and there are enough years to assess some trend and to aggregate indicators for County or sub-County analysis. We also supported NM Breastfeeding Task Force Goals to improve breastfeeding support women whose infants are hospitalized in the Neonatal Intensive Care Unit (NICU). PRAMS data indicated that only 58% of women with infants in the NICU breastfed more than two months compared to 65% of all other women.

Safe Sleep/SUID prevention

SPM: Percent of infants placed to sleep on their backs

Objectives:

- Increase the number of NM birthing facilities trained by the NMDOH in safe sleep education protocols from 3 to 15 by 2020
- Transition at least five NM birthing facilities to report standardized statistics for Shaken Baby Education to the NMDOH in 2019
- Leverage existing program partners to increase the number of home visitation and perinatal case management programs trained in Safe Sleep and Shaken Baby education from 5 to 15, statewide by 2020.

Strategies:

- Create an incentive program to award hospitals with Safe Sleep certification
- Develop and track a data collection protocol for Shaken Baby Education at NMDOH; tie use of protocol to certification to incentivize hospitals
- Participate in an evaluation of Shaken Baby and Safe Sleep Education delivered by NMDOH
- Draft and present a statewide, multi-sector Safe Sleep Strategy by 2019

Early in 2017 the New Mexico Department of Health (NMDOH), Office of Injury Prevention (OIP) and Family Health Bureau (FHB) programs met with the Children Youth and Families Department (CYFD) Home Visiting Program staff

to plan and design a broadly-defined, safe sleep plan to be used across both agencies. The ideal curriculum would promote breastfeeding as a recommended SUID/SIDS prevention practice while still promoting all safe sleep practices (room-sharing, not surface sharing without a protective container, avoiding tobacco smoke, keeping sleep environment free of toys, blankets, sheets, pillows and plush objects). The Maternal Child Health (MCH) Epidemiology program, OIP, FHB Child Health Program, and the CYFD Home Visiting Program had previously planned to formalize an agreement, in 2016, to partner with Cribs for Kids to make cribs and safe sleep training materials available to home visiting clients, statewide. However, changes in leadership and transitions in early childhood priorities for CYFD altered the course of the collaboration. We broadened the scope of a potential safe sleep education curriculum to include poverty, economic and social risk factors associated with adverse early childhood outcomes, as well as unsafe sleep practices. After one meeting, we were not able to convene cross-agency partners, and the staff turn-over/re-direction of duties in the Office of Injury Prevention at DOH made it very challenging to respond or plan around this strategy.

FHB staff invited the CYFD Home Visiting staff to work on the collaborative safe sleep strategy of the NM Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). However, this invitation to collaborate and attend a national meeting for team building and orientation was declined. The FHB made multiple attempts between February and August 2017 to share PRAMS analysis on home visiting and to obtain updates on the Baby Boxes or Bassinets being distributed to CYFD home visiting site clients. There was no response by CYFD program staff to our ongoing requests for communication in person, by email or phone. At the request of DOH and CYFD Cabinet Secretaries, staff from the two departments convened once in March 2018. Although the Home Visiting program in CYFD was not responsive, the Child Protective Services Division (CPS), also in CYFD, was eager to collaborate with NMDOH staff. Early in 2017 the CYFD staff approached the NMDOH OIP to develop a Train-the-Trainer education model for safe sleep and general home safety for families interacting with Child Protective Services. The trainings were tested in workshops statewide, resulting in the training of approximately 600 staff members. The workshops led to plans for electronic web-based trainings to be used in 2018. Health Educator Sabrina Curry was hired in 2017 to support the FHB early childhood screening and education efforts. Ms. Curry and John McPhee (OIP) have joined efforts to provide safe sleep and shaken baby syndrome trainings to CPS and perinatal case management staff throughout the state.

MCH Epidemiology and OMI staff shared SUID and PRAMS data at the NM Injury Prevention Coalition statewide meeting held in August 2017. In December 2017, MCH Epidemiology staff received inquiries from Indian Health Services (IHS) health promotion staff regarding the rate of SUID in the Navajo Service Area. IHS had planned to initiate national distribution of Baby Boxes with clients who receive prenatal or delivery services at their facilities. However, concerns were raised over the cultural dissonance boxes create with Navajo families. Traditional Navajo families do not discuss death, as it is taboo. Additionally, there are specific cultural teachings regarding prenatal and maternity care that make the box less desirable to many people. Boxes reminded some clinicians of death and they felt families may have the same reaction. While the boxes may be distributed or offered at delivery, it is unclear if families will accept them or how they may be used. MCH Epidemiology and Navajo Nation Epidemiology Center staff are working together to assess the outcomes of these discussions and decisions proposed through IHS. The Tewa Women United *Yiya Vi Kagingdi* doula program (based in Espanola) and Many Mothers in Santa Fe have been using Baby Boxes with their clients, and Title V staff have reached out to understand how well they were accepted and used by families. Meanwhile, John McPhee of OIP-NMDOH is advocating, both statewide and nationwide, for replacing the “baby box” concept with the use of a simple plastic tub. This allows the mother ready access to the baby for breastfeeding and constant visual contact with the baby because the tub is shallower than a box, and the tub, unlike the box, can also be easily washed.

The 2017 legislation for Shaken Baby Syndrome (SBS) education mandated a protocol on SBS education for every family discharged from a NM birthing hospital. A provisional curriculum on shaken baby education was developed in

2017-2018 based on a pilot study conducted at the University of New Mexico Hospital Birthing Center. The new SBS education law now mandates DOH-led education for staff and families delivering at every birthing facility, starting in 2018. The initial findings from the UNM pilot study indicated education had a major impact on new parents - there were no injury deaths or injuries reported at a six-week follow up call. The New Mexico Injury Prevention Coalition had previously convened statewide stakeholders to share early findings and discuss the ramifications for proposed legislation, and DOH is working to implement training and tracking.

The NMDOH OIP staff reviewed the literature and discussed evidence around the Dr. Harvey Karp's Happiest Baby on the Block curriculum for both safe sleep and shaken baby prevention trainings. The DVD's and streaming videos are available and were discussed as a possible product to be used by perinatal case management in DOH case management and in clinical or public health sites https://www.happiestbaby.com/blogs/blog/the-5-s-s-for-soothing-babies
The 5S's (side/stomach, soothing, swaddling, swing, suck) were reviewed by the Office of Injury Prevention for potential use in Public Health case management programs, and there was direct consultation with Dr. Karp. While we are not promoting commercial products or the side/stomach sleep position, the other components are readily utilized by parents, and we would like to evaluate its impact on stress and coping for new parents.

The panel for the NM Sudden Unexpected Infant Deaths (SUIDS) Registry was active and included ongoing representation from OIP and NMDOH throughout 2017. Dr. Lori Proe, Office of the Medical Investigator (OMI) pathologist, led the death review panel with participation from lead field investigator, Rebecca Tarin, starting in June 2017. The team was rounded out by NMDOH staff to develop recommendations for the annual child fatality review. Christina Brigance, Title V MCH Epidemiologist joined the SUID review team at OMI and OIP. OIP and OMI staff attended the 2017 CDC SUID national meeting followed by a state site visit with DOH MCH Epidemiology/PRAMS, Tobacco Use and Prevention and Control staff, St. Joseph's Home Visiting Program and other Public Health partners.

Follow- up Report to the 2018 Work Plan

1. Creation of a Senate Memorial to form a multi-sectorial SUID Task Force statewide:

    The legislation was not introduced again in 2017. March of Dimes and FHB staff agreed that we could pursue strategies detailed in the memorial regardless of its passing. OIP and MCH Epidemiology convened monthly meetings to develop incremental plans and outcomes to address details originally written for the memorial. Pediatric Society endorsement was garnered for the Senate Memorial calling for a SUID Multi-Agency Task Force, and the incoming President of the Society is engaged in the safe sleep work.

2. Hospital engagement and follow up to 2014 birthing facility trainings:

    NMDOH OIP contracted with Dr. Theresa Cruz at the UNM Prevention Research Center in 2017 to implement one-on-one obstetrician and delivery staff trainings with two major birthing facilities in Albuquerque, NM. Plans to expand the trainings with more facilities are in progress.

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

    We were not able to meet this goal since WIC was in a statewide transition of their entire client data system.

4. Assess 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:

The NM 1,000 Grandmothers contact, Dave Baldrich, presented the curriculum to the Infant Mortality CoIIN partners in 2017 and there was quite a bit of interest, however the CoIIN team for safe sleep was in transition, then discontinued as an infant mortality focus, so follow-up has not occurred. Safe sleep trainings with hospitals, foster parent programs and perinatal programs are still active.

Perinatal/Infant Health - Application Year

Breastfeeding

Planned activities/initiatives for the NM WIC Program in 2019 include:

- Expand partnerships and collaboration with community health programs/organizations to improve health outcomes of NM families.
- Complete roll-out of new WIC data collection system during July-September of 2018, which includes extensive training of staff in use of the new computer system, along with training in new and revised policies and procedures required by this system.
- Continue all required staff training: Using Loving Support to Grow and Glow for all new staff by one year of employment; CAPPA advanced lactation education training for WIC Nutritionists after one year of employment: Hug Your Baby on-line modules for all WIC Nutritionists.
- Expand the Hug Your Baby on-line module education to community partners statewide.
- Host statewide clinic celebrations of World Breastfeeding Week and Month in August.
- Expand WIC community- led lactation/health support groups to the SE region of NM.
- Expand Breastfeeding Peer Counselor (BPC) program from 75 to 80 active BPCs. BPCs provide one-on-one counseling support to WIC participants within 67 WIC sites/communities and 13 hospitals in New Mexico.
- Continue implementation of the Breastfeeding on the Border Project and partnerships with the various binational groups/committees working along US/Mexico border through:
    - Expanding the Breastfeeding on the Border Project into the community of Sunland Park, NM;
    - Applying for an increase in funding for the Breastfeeding on the Border Project to implement the initiative statewide;
    - Hosting a Binational Lactation Conference and Quarterly Binational Lactation Lecture series in Southern NM; and
    - Presenting PRAMS data and Vital Records data to the communities in the Breastfeeding on the Border Project and working in collaboration with the Collaborative Improvement and Innovation Network (CollN) on prenatal care utilization in rural Dona Ana County to improve breastfeeding support.
- Incorporate mental health first aid as a required training for BPCs.
- Partner with NM Public Education Department and Graduation Reality and Dual-Roll Skills (GRADS) program to provide basic lactation education to students and staff. This will facilitate the incorporation of lactation into the classroom core curriculum and enable the formation of teen-led breastfeeding support groups.

Planned activities/initiatives for the NM BFTF:

- Continue efforts to increase the number of New Mexico hospitals births in Baby-Friendly USA designated facilities.
- Continue development of and support to local chapters.
- Co-sponsor, along with WIC and NM hospitals, the 25th Annual Breastfeeding Conference in March 2019.
- Host a 5th Statewide Hospital & Clinics Maternity and Infant Care Summit, along with other community health providers.
- Continue outreach of the NMBTF Workplace Program to an increased and significant percentage of employer throughout NM.
- Continue and expand where feasible, the Behind the Bars Project to provide encouragement and technical assistance to the NM detention centers in developing breastfeeding support programs and policies; continue collaboration with WIC to provide breastfeeding support, through breast pumps and peer counseling, to incarcerated mothers whose infants are certified on the WIC Program.
- Make paid Family Leave a priority for NMBTF advocacy in the NM 2019 Legislative Session.
- Local chapters will host World Breastfeeding Week/Month activities in their communities and encourage collaboration of their events with WIC and other community partners.
- Increase collaborative partnerships in all NMBTF initiatives.

Data Collection and Analysis Plans

a. Longitudinal data collection and data linkage improvement

The New Mexico Toddler Study Coordinator and PI will convene the Toddler Advisory Committee at least 3 times in FFY19. The committee is working to redesign the logo and survey materials to measure the impact on response rates. Because there is some overlap between this committee and the PRAMS Steering committee, they may merge the committees or alternate between survey content in the meetings. The MCH Epidemiology team will follow up with Dr. Andy Rowland and several other Population Health colleagues at the University of NM to develop an initial analysis of breastfeeding duration for the first time. For the FFY19 we will release three reports on breastfeeding in PRAMS and the Toddler Study results.

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

We plan to use the record-level breastfeeding field on the NBGS card along with additional fields for maternal ethnicity and age, (but excluding all genetic screening information) in a data linkage with Vital Records and PRAMS. This will help us meet objectives of analyzing facility-level outcomes with self-reported information in PRAMS. Because the data available from the NBGS has been so limited and general, it was hard for evaluators to assess breastfeeding initiation by facility or even facility type. The proposed linkage with PRAMS will improve data quality in completeness and in identification of gaps in facility performance.

c. Comparison of baby-friendly designated hospitals or regions with prevalence of baby-friendly indicators in PRAMS

New Mexico MCH Epidemiology will continue to work with the Community Advisory Board (CAB) which involves the RWJF Center for Health Equity, NM Breastfeeding Task Force, Young Women United, and Nuestra Salud. The first planned analysis with PRAMS and Toddler survey follow up is a more focused analysis of Baby Friendly indicators by birthing facility type (federal and non-federal, Baby-Friendly v. non-Baby-Friendly) to assess characteristics of women reporting Baby-Friendly experiences. As shown in Table 3, about 91% of medical providers responding to the KAP survey were familiar with baby-friendly practices, and only about half (53%) knew all 10 steps. If the providers don't know them all it is likely they do not practice all of them, and it is likely that the facilities are not conducting quality improvement or evaluation of related competencies.

Table 3: Familiarity with BFHI, the 10 Steps, and Recommendations for Breastfeeding Duration, Overall and by Provider Type, 2016 Outpatient Provider KAP Survey, N=77

	All Respondents	By Provider Type		
		Pediatrician - General or Sub-specialist	Family Medicine or other Physician	Nurse Practitioner, RN, or Physician Assistant
Familiar with BFHI	90.9%	87.2%	100.0%	94.1%
Familiar with 10 Steps to Successful Breastfeeding	53.3%	54.3%	50.0%	56.3%
Recommendation for Exclusive Breastfeeding for 6 Months	77.0%	80.4%	75.0%	73.3%
Recommendation for Continued Breastfeeding for 12 Months	86.5%	87.0%	75.0%	93.3%

Complementary Strategies with providers

Based on the assessment of provider knowledge in KAP and facility efforts around BFHI, Envision New Mexico is developing a free telehealth series on Motivational Interviewing and Breastfeeding, including an opportunity to discuss specific cases, led by Jeanne Dalen, Ph. D., Research Assistant Professor in the UNM Department of Pediatrics and expert in Health Psychology. Her knowledge is informed by over 13 years' experience conducting both research and clinical work.

Through this Motivational Interviewing and Breastfeeding series participants will:

- Learn/review the **basics of motivational interviewing** and how it can assist with having conversations about breastfeeding;
- Learn **4 specific strategies** to apply when having conversations about breastfeeding in a short timeframe; and
- Have the opportunity for a **case consultation**, and receive guidance and feedback (privacy will be maintained and case consultations will not be recorded).

Paid Family Leave

The New Mexico Department of Health began work on a Paid Family Leave project through the Social Determinants of Health Infant Mortality CollN. The charter started late in 2017 and will be developed through the end of 2019 to address two areas identified by the work group: 1.) Provider bias and differential patient treatment/diagnosis and 2.) Paid Family Leave policies to support and encourage family friendly workplaces. Since breastfeeding is impacted by family leave, the paid leave group will be reporting back to Title V staff to share results and brainstorm for future strategies and objectives.

Cultural Competency

Rachael Lorenzo with Young Women United and Indigenous Women Rising provided cultural competence training to NM Breastfeeding Task Force Members and led efforts to make breastfeeding align with traditional knowledge and practice for NM moms. Her leadership led to national recognition for New Mexico Breastfeeding innovations in 2018.

The NMBTF participated in the 2018 “Make the Breast Pump not Suck Hackathon: Community Innovation Program,” which took place April 2018 at the MIT Media Lab, a partnership between NMBTF and Indigenous Women Rising. The team worked with an Apache seamstress to develop breastfeeding-friendly traditional clothing that will meet the breastfeeding needs of parents and babies while remaining true to the traditional styles and design. The team, led by Rachel Lorenzo, was awarded the WK Kellogg foundation Healthy Communities Award for their innovative approach to re-designing traditional dress to facilitate breastfeeding. Rachael Lorenzo will provide training and support to local breastfeeding coalitions and Tribal WIC programs to help indigenous women and traditional communities support breastfeeding duration while also continuing their participation in tribal ceremonies and community events important to their well-being. https://breastfeedingnm.org/hacking-traditional-native-regalia-for-easier-breastfeeding.

Safe Sleep and Sudden Unexpected Infant Death (SUID) prevention

In 2019, we will continue to engage new members to the SUID child fatality review committee and SUID registry. So far in 2018, MCH Epidemiology has reached out to several organizations including WIC, Families FIRST and several other home visiting programs, but have not been successful at bringing them to the table. Plans are in place to collaborate in following areas:

1. Integrate safe sleep and breastfeeding promotion efforts.

We will continue to work with partners at the OMI/CDC SUID registry, Tewa Women United, NM birthing facilities,

Navajo Nation and several home visiting programs to promote breastfeeding while including safe sleep education for NM families. We will strive to:

- Conduct an environmental scan of program practice and policy across New Mexico. We plan to use this to develop a strategic plan and evaluation of statewide capacity around safe sleep education. From there, we plan to share the resulting logic model and plan to address process measurements and tasks for preliminary team review.

- Convene existing stakeholders from the Child Fatality Review (central Office of Medical Investigator OMI); University of NM; NMDOH; NM Children, Youth and Families Department (CYFD); native tribal entities; home visiting programs; NM Breastfeeding Task Force; Voices for Children; and the March of Dimes to begin strategic planning process. Utilize quarterly inter-agency meetings (CYFD-DOH)

- Hold quarterly interagency strategy and communication meetings between NMDOH and CYFD programs (to include CYFD Home Visiting staff).

- Contribute to the analysis of NM SUID registry data and publication. Staff a full-time position in MCH Epidemiology to support injury prevention, including SBS and SUID analysis.

  With support of a Graduate Student Epidemiology Program intern, Esther Gotlieb, and National Institute for Child Health and Human Development (NICHD) safe sleep champion, Dr. Mary Overpeck, MCH Epidemiology staff completed an in-depth analysis of the Child Death Registry (SUID) data for New Mexico via 2015 death data. The MCH epidemiology program is now fully staffed and committed to updating the analysis pending access to the registry. We are prepared and have technical capacity to produce reports and scientific presentations with the SUID data. However, we have not received permission to analyze data from the registry.

2. Increase the number of programs and facilities with both SBS and Safe Sleep trained staff. Our efforts will include:

- Exploring regional and local efforts (Child Protective Service (CPS) trainings and hospital protocols) to expand e-learning modules in development with CPS.

- Reviewing current National campaign materials (NICHD) to increase safe sleep awareness and media messaging

- Developing regional messaging and cultural adaptability with consultants in Albuquerque and rural communities

- Employing environmental scan, logic model and engagement strategy plans:
- Expanding DOH and state agency Child Fatality Review participation and stakeholders to develop recommendations

- NM Safe sleep campaign/webinars

- Infant mortality CoIIN safe sleep strategy transition to early childhood/infant health and safety collaborative

- March of Dimes program service committee engagement of multi-sector participation in safe sleep strategy and communication plans to initiate invitations to representatives from state agencies, NM hospital

association, NM Voices for Children and Federal MIECHV home visiting sites.

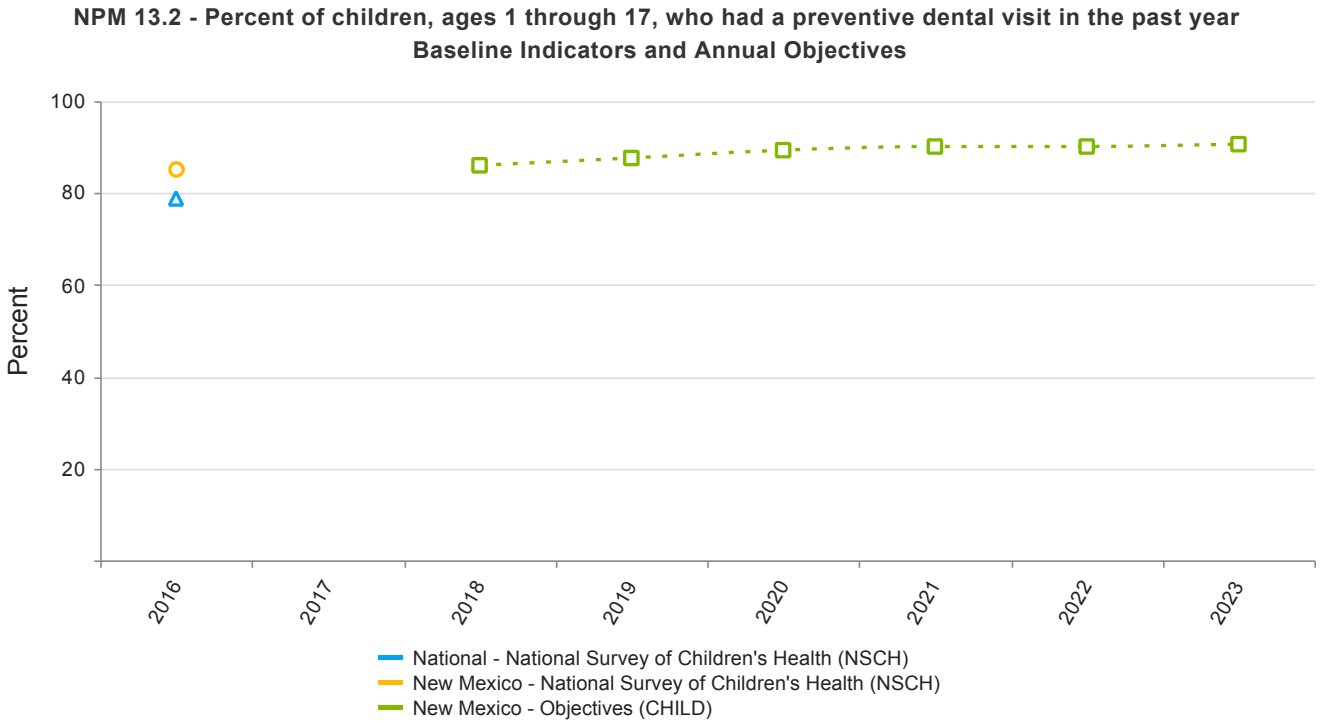
3. Combine child protective and calming techniques in trainings, and evaluate cultural adaptability and suitability for different community settings. Work with Tribal Epidemiology Centers, UNM and NM Pediatric Society to assess approaches to safe sleep products and education. Work with Many Mothers, Young Women United and Tewa Women United to evaluate Baby Box distribution, other similar product distribution and recommend next steps.

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	14.0 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.9 %	NPM 13.2

National Performance Measures



NPM 13.2 - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		85.0
Numerator		386,111
Denominator		454,417
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	85.9	87.5	89.2	90.0	90.0	90.5

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percentage of pregnant women having a dental visit during pregnancy

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	49.0	53.0	57.0	61.0	65.0

ESM 13.2.2 - Number of oral health promotion activities conducted within the year to promote the importance of oral and general health.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	18.0	23.0	28.0	33.0	38.0

ESM 13.2.3 - Number of oral health providers that provide dental sealants and fluoride varnish applications to low income and uninsured and pregnant women

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	9.0	11.0	13.0	15.0	17.0

ESM 13.2.4 - Number of students who have received oral health education through the programs facilitated by the NM Office of Oral Health

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	9,353.0	14,353.0	19,353.0	24,353.0	29,353.0

State Performance Measures

SPM 3 - Rate of Victims of Child Abuse per 1,000 Children in the Population

Measure Status:	Inactive - Collaboration with stakeholders has been challenging. Pending interagency agreements, we would like to reactivate this measure.

State Provided Data		
	2016	2017
Annual Objective		15.9
Annual Indicator	17.4	17.4
Numerator	8,684	8,684
Denominator	500,037	500,037
Data Source	NM CYFD	NM CYFD
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

State Action Plan Table

State Action Plan Table (New Mexico) - Child Health - Entry 1

Priority Need

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

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

Increase by 10% the children aged 1 to 17 who have had a dental visit, who participated in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program by 2020.

Increase by 10% the children receiving an application of a dental sealant or fluoride varnish, by June 30, 2020.

Increase by 5%, of pregnant women who have had a dental visit during pregnancy by July 2019.

Strategies

Provide oral health education to pregnant women and children through promotion of state wide campaigns, dental screening, fluoride varnish applications, dental sealants, health fairs and public service announcements.

Promote dental case management practices by dental and medical providers and other health care agents.

Promote the development of interagency partnerships championing and promoting oral health programs and initiatives through the work of the Oral Health Coalition and other advocacy or school related organizations.

ESMs	Status
ESM 13.2.1 - Percentage of pregnant women having a dental visit during pregnancy	Active
ESM 13.2.2 - Number of oral health promotion activities conducted within the year to promote the importance of oral and general health.	Active
ESM 13.2.3 - Number of oral health providers that provide dental sealants and fluoride varnish applications to low income and uninsured and pregnant women	Active
ESM 13.2.4 - Number of students who have received oral health education through the programs facilitated by the NM Office of Oral Health	Active

NOMs

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NPM: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

Objectives:

- Increase by 10% the children aged 1 to 17 who have had a dental visit, who participated in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program by 2020.
- Increase by 10% the children receiving an application of a dental sealant or fluoride varnish, by June 30, 2020.
- Increase by 5%, of pregnant women who have had a dental visit during pregnancy by July 2019.

Strategies:

- Provide oral health education to pregnant women and children through promotion of state wide campaigns, dental screening, fluoride varnish applications, dental sealants, health fairs and public service announcements.
- Promote dental case management practices by dental and medical providers and other health care agents.
- Promote the development of interagency partnerships championing and promoting oral health programs and initiatives through the work of the Oral Health Coalition and other advocacy or school related organizations.

The NM Department of Health (DOH) has identified 12 priority health indicators to address to improve the health status of New Mexico residents, oral health being one of these indicators. The Office of Oral Health's (OOH) mission is to reduce the incidence of tooth decay and other disease through prevention. Program strategies to improve the oral health status of New Mexicans include: promote oral health, provide preventive services to pre-school and school-aged children, increase the number of dental providers serving the uninsured and low-income populations, and increase the consumption of fluoridated water. One major program activity is a mobile prevention initiative. State staff and contractors travel throughout the state to provide oral health education (hygiene instructions, proper brushing of teeth, use of dental floss, eating healthy, drinking water) a dental examination, application of dental sealants/fluoride varnish, and dental case management services to selected pre-school programs and elementary and middle schools. OOH also contracts with dental providers to serve uninsured and low-income adults and children (prevention/treatment services). Additionally, OOH conducts an oral health education campaign promoting oral health, identifying risk factors to prevent disease, and making healthy eating recommendations.

During the 2016-17 school year, OOH staff and state contractors provided oral health screenings and dental sealants to 6,310 elementary school-aged children throughout the state. In addition, 1,510 pre-school children in Santa Fe, Rio Arriba, Mora, San Miguel, and Bernalillo counties had an oral health assessment, application of a cavity preventive agent, parental notification of the oral health status of the child and dental case management services. The dental case management service assists parents in finding a dental home to ensure a treatment plan is completed.

OOH collects data on each school/Head Start, which includes: the number of children eligible to participate in the program (usually the total number of students enrolled in a school), the number of children screened (parental consent required and received), the number of children receiving dental sealants/fluoride varnish application (three times a year), and parental notification and dental case management services for all children diagnosed with decay.

OOH staff also provide oral health education, toothbrushes, toothpaste and referrals to the Women Infants and Children program (WIC) clients in the Santa Fe, Española, Albuquerque, Anthony, Chaparral, Southern Park and Las Cruces. The educational materials address the importance of oral health for moms and their children at all stages of life.

OOH conducted an oral health Public Service Announcements (PSA) during "February Children's Oral Health Month" via KOAT TV (English and Spanish) and conducted a "Smile Campaign". The campaign was a partnership between NM Delta Dental, Hearst Corporation and NM OOH. The PSA promoted the importance of oral health and provided oral health tips. The campaign included spot announcements by KOAT TV anchor staff and on Facebook, Twitter,

and Instagram with over 6,000 individuals viewing PSA. Our smile campaign received over 2,900 submissions of children and families showing off their smile (good teeth).

Since 2014, the Albuquerque Water Authority ceased providing fluoridated water its customer (over 600,000 population). Community Water Fluoridation (CWF) is one of the preventive measures to reduce the incidence of tooth decay. A CWF coalition was formed to advocate for reinstating CWF. The coalition brought together many institutions, local state workers, academia, medical and dental providers to promote CWF. On numerous occasions, the coalition testified, advocating for the reinstatement, and on September 20, 2017 the Authority voted to support CWF. The next project for the CWF coalition is to promote consumption of fluoridated water once the system is up and running.

OOH, the Office of Nutrition and Physical Activity and the Maternal Child Health Program (MCH) partnered with the University of New Mexico Lier Corporation (UNM Lobo promoters) in the children healthy living campaign. The campaign promoted physical activity, oral health, and improving reading capacity. The campaign was conducted in Albuquerque through the auspices of the ABQ Public School system. Elementary schools were encouraged to participate in the campaign, over 300 students participated in the program and one southside school was selected as a winner. Each student received awards and a certificate from OOH along with being introduced at one of the UNM Lobo football games.

OOH continues to partner with the NM Oral Health Coalition (26 members), State MCH, Office of Physical Activity and Nutrition, NM TUPAC (a smoking cessation program), UNM Pediatric Advisory Committee, NM State Head Start Regional Office, the state Children Youth and Family Department (CYFD), DentaQuest Foundation, NM Pregnancy Risk Assessment Monitoring System (PRAMS), UNM Lobos, and a local news station, KOAT TV. The partnerships provide various avenues to promote oral health, preventive diseases, healthy eating, physical activity, and reduction of risk factors contributing to tooth decay and other childhood chronic disease such as diabetes and obesity.

Child Health - Application Year

The Office of Oral Health (OOH) will conduct an oral health education campaign promoting oral targeting pre-school and elementary school aged children and pregnant women. The education campaign is to improve the oral health literacy of children and adults. The campaign will address oral health hygiene, the need for a dental visit, eating healthy and other harmful activities. The campaigns will target low income and uninsured children in New Mexico Health Professional Shortage Areas. We will work closely with the NM Women Infant and Children's (WIC) program, Lobo Children's Healthy Living program and other local organizations serving pregnant women.

The oral health education campaign will consist of providing oral health information through the following activities: class room instruction, WIC meetings, PSA during February Children's Oral Health Month- to increase our PSA capacity to reach more New Mexicans via Facebook, Twitter, Instagram, newspaper articles, advertisements – New Mexico Nurses Association Newsletter, promote oral health at advisory committee meetings, parent nights, at community events and integrate oral health with other Maternal and Child Health Programs. On example of an activity that is planned is the mobile prevention program which conducts dental sealant/fluoride varnish applications throughout the state (including the collection of data). Contractors will be completing the second year of the grant awarded to continue this program. On July 1, 2018 a new two-year grant cycle will begin for the providers.

OOH will work with New Mexico Office of Physical Activity and Nutrition to promote the Office's healthy living program and integration of oral health and increasing the importance of oral health, healthy eating, exercise, and physical activity – contributing to healthy youth and the reduction of obesity. OOH will also work on promoting the consumption of fluoridated water in the cities of Santa Fe and Albuquerque, New Mexico. Albuquerque is the largest school district in the state and Santa Fe is the only other metropolitan area with fluoridated water. It is important that the school district educate its students regarding the importance of consuming fluoridated water verses sugar products.

Part of this work is funded by a grant that was created in response to CDC RFA DPA1810-18 Improving Oral Health Outcomes. The grant is to provide funding for five years to: increase the number of elementary and middle schools having a dental sealant program (will increase the number of 3rd graders receiving dental sealants), increase the number of communities providing water fluoridation/increase consumption, establish a surveillance system. The first year of this grant focuses on the process of conducting a 3rd grade surveillance survey and will repeat in year three and promote oral health. The grant also requires the grantee to develop and publish a "NM Oral Health Burden" document. Funding will begin on October 1, 2018.

OOH will work closely with the New Mexico School Health Alliance and the Office of School and Adolescent Health to promote oral health, provide prevention services, and dental case management at School Base Health Center's without a dental program. Oral health data will also be collected from the School Base Health Center's with a dental program on the number of children served including pregnant women identifying the children without disease, those receiving preventive services and referral for treatment.

OOH will also continue to fund providers to serve pre-school and school aged children and adolescents and pregnant teens providing them preventive and treatment services. OOH will provide oral health education, preventive services and dental case management services to pre-school and elementary school aged children throughout the state. OOH will continue serving teen parents in the Santa Fe City Schools.

Other work that the OOH is involved in moving forward is the work with organizations in New Mexico that provide in home services to pregnant women and their children promoting the importance of oral health and overall especially during pregnancy.

Oral health data will be collected from school-based health centers, OOH contractors, OOH program, and the New Mexico Health Services Department reporting oral health services provided to the targeted population.

The NM Youth Risk and Resiliency Survey (YRRS), NM Epidemiology and Response Division each year conducts a surveillance survey among middle and high school students on several medical health, oral health, behavioral health and other risk factors. During the school year 2019-2020 YRRS will be asking an oral health status question of middle and high school students. In the 2015-16 school year asked the students when the last time was you saw a dentist for a checkup, exam, teeth cleaning, or other dental work. 73.5% of participating students reported they had seen a dentist during the last 12 months, the NM rate was similar to the national rate of 74.4%.

Finally, in 2019, work will continue alongside the NM Oral Health Coalition towards the development of a "State Oral Health Plan" and continue our membership in the Santa Fe Head Start and Albuquerque city Head Start advisory committees.

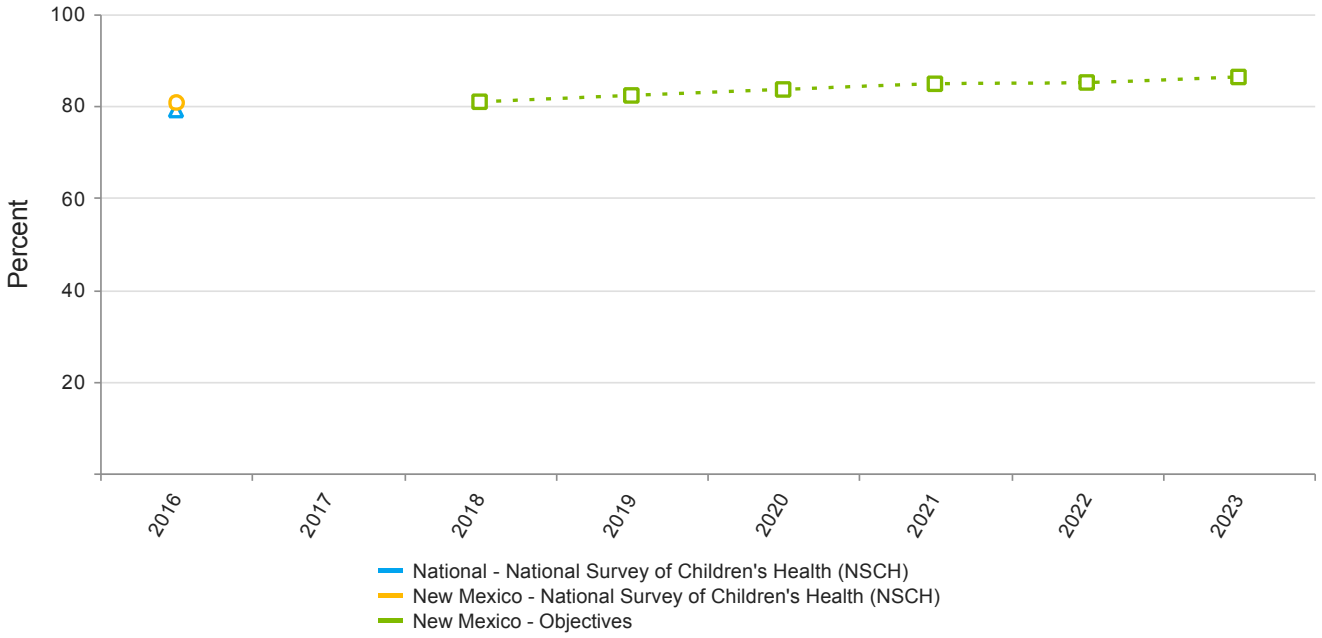
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	43.2	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	17.1	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	15.4	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	59.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.9 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	13.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	12.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	15.6 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	63.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	63.1 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	57.9 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	84.3 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2016	77.8 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	29.8	NPM 10

National Performance Measures

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



Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		80.5
Numerator		140,946
Denominator		175,148
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	80.8	82.2	83.5	84.7	85.0	86.2

Evidence-Based or –Informed Strategy Measures

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.

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		3
Annual Indicator	1	1
Numerator		
Denominator		
Data Source	OSAH	OSAH
Data Source Year	2015	2015
Provisional or Final ?	Final	Final

ESM 10.3 - Percentage of Well visits ages 10-25 for Medicaid patients

Measure Status:	Inactive - Replaced

State Provided Data	
	2017
Annual Objective	25
Annual Indicator	80.7
Numerator	140,946
Denominator	174,575
Data Source	National Survey of Children Health New Mexico
Data Source Year	2016
Provisional or Final ?	Provisional

ESM 10.4 - Number of youth and adults who are trained using the Youth Health Literacy Toolkit.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	75.0	100.0	125.0	150.0

ESM 10.5 - The number of clinics that respond that they have increased their youth friendliness practices by at least two points according to the pre and post surveys given after the Know Your Health Toolkit presentations.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	1.0	2.0	3.0	4.0	5.0

ESM 10.6 - Number of people attending Know Your Health Toolkit presentations

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	70.0	95.0	110.0	135.0	150.0

State Performance Measures

SPM 4 - Teen Birth Rate, Girls ages 15 to 19 years

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		31.6
Annual Indicator	34.2	29.4
Numerator	2,307	2,000
Denominator	67,519	68,117
Data Source	NM Vital Records	NM Vital Records
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	28.8	26.1	23.4	20.7	18.2	17.6

State Action Plan Table

State Action Plan Table (New Mexico) - Adolescent Health - Entry 1

Priority Need

To improve access and quality of comprehensive well exams for adolescents

NPM

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

Objectives

Increase annual adolescent well-exam visits by 5% for those who are on Medicaid, within 3-6 primary care clinics and/or school-based health centers by January 2020.

Strategies

Utilize the NM Youth Health Literacy toolkit in schools near the clinics that are piloting the Know Your Health toolkit (KYHT).

Collaborate with the clinics and public health offices that are 'Know Your Health' Pilot sites to implement the youth-friendly services and environment assessments.

Spread the KYHT to various adolescent health stakeholders in New Mexico to highlight the importance of well exams.

ESMs	Status
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.	Inactive
ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter	Inactive
ESM 10.3 - Percentage of Well visits ages 10-25 for Medicaid patients	Inactive
ESM 10.4 - Number of youth and adults who are trained using the Youth Health Literacy Toolkit.	Active
ESM 10.5 - The number of clinics that respond that they have increased their youth friendliness practices by at least two points according to the pre and post surveys given after the Know Your Health Toolkit presentations.	Active
ESM 10.6 - Number of people attending Know Your Health Toolkit presentations	Active

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, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 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
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

State Action Plan Table (New Mexico) - Adolescent Health - Entry 2

Priority Need

To reduce birth rates among teens 15-19

SPM

SPM 4 - Teen Birth Rate, Girls ages 15 to 19 years

Objectives

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

Strategies

Ensure teens receive confidential services in a youth-friendly environment including access to a broad range of methods.

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

Promote the use of social media to increase awareness about and availability of birth control and to reduce unintended pregnancies (BrdsNBz, digital media campaigns).

Adolescent & Young Adult Annual Well Visit

Domain: Adolescent Health (Definition: young people age 10-25)

NPM/SPM: NPM 10 Adolescent Well-Visit

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

Measure: Increase the percentage of adolescents who are on Medicaid who receive an annual adolescent well-visit.

Objectives & Strategies:

Implement strategies promoting the Positive Youth Development Approach and Prevention (i.e. adolescent annual well-visits) based the various levels of the Socio-Ecological Model.

Strategies based on Socio-Ecological Model levels:

- *Intrapersonal Level:* Increase health literacy education for adolescents age 10-25.
- *Interpersonal Level:* Promote health literacy, prevention (i.e. adolescent annual well-visit) and youth leadership via peer-to-peer education and youth-adult partnership.
- *Institutional/Community Level:* 1. Create the *NM Know Your Health Toolkit (KYHT)* with various adolescent heath stakeholders (including youth). 2. Pilot the KYHT with health care providers (i.e. primary care & school-based health centers) to increase a) Youth friendly services; b) Preventative services (i.e. adolescent annual well-visit; c) Quality health care services; and d) Youth health literacy
- *Policy Level:* Improve state and systems level policies and practices.

The NM Department of Health, Office of School & Adolescent Health (OSAH) funded 38 Natural Helper Programs across the state to promote peer-to-peer education and youth-adult partnership. There were 593 youth peer helpers statewide who were training, looking out for their peers and promoting health in their schools and/or community. These programs are required to incorporate strategies based on the evidence-based Positive Youth Development Approach (PYD) and Natural Helper Program.

PYD guiding principles include:

- Asset based (focus on strengths/supports);
- Place-based strategies reflect local cultural assets and needs
- Holistic and developmentally appropriate (heart, mind, body, & spirit across ages and stages);
- Informed by youth for children/youth;
- Supports ALL children/youth;
- Broad stakeholder input and support (i.e. families, schools, faith community, community based organizations, business, media, government, etc.)

The Natural Helper program is based on the premise that when young people have problems, they most often turn to friends whom they trust for help, and that every school has an informal “helping network.” The program sponsors at each school seek to identify this informal network of young people who represent the different subgroups within their school and provide training and support to those who are already serving as helpers.

Approximately 600 youth Natural Helpers participated in PYD, youth suicide prevention and peer helping skills. They had the opportunity to bond as a group (both youth and adults), creating a cohesive and supportive dynamic among what was a collection of very diverse individuals who thought they had little in common with one another prior to being part of the group. They continued to meet regularly throughout the year to develop the following skills:

- Effective ways to help and support their friends and peers;

- Positive ways to take care of themselves and be cognizant of their own physical and mental health; and
- Ways to contribute to creating safe and supportive school and community environments.

Each program planned and implemented one service learning project and one health promotion activity based on the needs of their school and/or identified needs in the community. To get more information on these activities, please see the final comprehensive report at:
https://docs.google.com/document/d/1XnRl1kbQTDhV4AjhMYKhx92EFyz6iHiAlAZX2Tc6RHU/edit?usp=sharing

The NM Adolescent & Young Adult (AYAH) Collaborative Improvement & Innovation Network (CoIIN), led by OSAH, continued to strive toward their project aim of increasing the percentage of adolescent and young adults that receive preventive care such as annual well exams, also referred to as Early & Periodic Screening, Diagnostic & Treatment (EPSDT) services. The project goal is for all NM adolescents and young adults to be healthy and engaged in self-care and community care. Adolescence is defined as age 10-25, however we refer to young adults for those ages 18-25 as this is the title they prefer.

In 2017, the NM AYAH CoIIN partnered with local and national partners, including youth, to develop the "*Know Your Health Toolkit*" (KYHT). This toolkit was created specifically for medical care providers in community clinics and offices. It contains pertinent information to aid healthcare providers in increasing youth-friendly services, increasing preventive and high-quality health care services, and increasing youth health literacy. The KYHT provides a comprehensive approach to promoting adolescent and young adult health and includes the following three sections:

- *Section I: Training & Educational Material for Healthcare Providers & Staff*- Get everyone within your health office or clinic to be on the same page when working with young people. Foster respect & youth-adult partnership so young people feel comfortable & want to come back to the clinic.

- *Section II: Assessments, Surveys & Questionnaires*- Assess where your clinic is on youth-friendly services/environment. Use a holistic approach to assessing young people's health & promoting preventative services. Ensure youth have a voice in their health!!

- *Section III: Know Your Health Campaign Materials*- Here are several resources (posters, memes, Piktocharts, handouts, resources) to promote youth health literacy and a safe and youth-friendly environment.

A remarkable feature about this toolkit is that healthcare clinics can work on implementing all three sections, implement just a single section, or just use some of the toolkit resources as they see fit. We know healthcare providers are busy providing patient care and don't have a lot of time to be doing research on new and innovative training opportunities and youth-friendly material resources. The KYHT was submitted for internal review and was approved for use by the NMDOH.

The KYHT has been presented to the National Network of Statewide Adolescent Health Coordinators, the National Improvement Partnership Network Annual Meeting and highlighted at the National Cohort 2 Adolescent & Young Adult Health CoIIN Summit and Association of Maternal & Child Health Program Conference.

In addition to the CoIIN work, OSAH continued to promote the importance of routine preventive care including annual well exams. School based health centers (SBHC) are uniquely positioned to provide acute care in many Health Professional Shortage Areas (HPSA) throughout the state. Even when an SBHC provides care for a student, that SBHC will link a student to a community provider or medical home for their routine care. The OSAH continues to work with SBHC sponsors, emphasizing the importance of routine preventive care for all adolescents.

In 2017, OSAH re-kindled its partnerships with Nor Lea Hospital and Miner's Colfax Hospital to enter into data

sharing agreements for SBHC's that were not part of the latest RFP cycle. The agreement allows OSAH to collect well-exam data from these partners in addition to the 50 DOH-funded school-based health centers statewide. OSAH also continued the work on quality improvement with a specific focus area for comprehensive well-exams as this is a great starting point for identifying early risk behaviors and referral for appropriate interventions. For Fiscal Year 2017, nearly one-third of all students who visited a SBHC received a well exam there.

Teen Birth Rates

Between October 2016 and September 2017, New Mexico Family Planning Program (NM FPP) has used a two-pronged approach to decrease the unintended teen birth rate through clinical services and 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 unintended teen pregnancy and bring about meaningful and measurable reductions in unintended teen births.

The state Title V program collaborates with the Family Health Bureau/Family Planning Program (FHB/FPP) to implement activities related to reducing unintended teen pregnancy in New Mexico. FHB/FPP collaborates with 44 Public Health Offices (PHOs), including three PHO outreach sites, and 19 primary care clinics and school-based health centers (SBHCs) through Contracts and Provider Agreements. In 2017, FPP provided reproductive health services to 15,035 unduplicated clients: 13,154 females and 1,881 males. Statewide activities include clinical services with on-site provision of methods including the most effective (implants, IUDs) or moderately effective (i.e., injectables, oral pills, or ring) methods of contraception, and community-based education for unintended teen pregnancy prevention. The percentage of teen clients at risk of unintended pregnancy that were provided a most effective (implants, intrauterine devices (IUD)) or moderately effective (injectables, oral pills, or ring) contraceptive method was 71%. Percent of clients less than 20 years old who were provided a long-acting reversible contraceptive (LARC) method (implants or IUD) was 18%. The long-term program impact related to Title V is to reduce unintended teen pregnancy.

Community education and outreach (CE&O) activities are primarily provided by Public Health Office (PHO) staff. The CE&O activities are done to promote the availability of Family Planning services and provide community education on topics related to family planning. Information on the following topics were provided during outreach activities conducted by PHOs: contraception, sexual responsibility, intimate partner violence, adult/teen communication, sexually-transmitted diseases, and accessing family planning services.

Educational programming is provided to teens across the state by local non-profits that are contracted through the NM FPP. These organizations provide the evidence-based educational programs, Wyman's Teen Outreach Program (TOP®) and Project AIM (Adult Identity Mentoring). TOP® promotes positive youth development by incorporating community service learning and curriculum-based activities in a program to decrease unintended teen pregnancy and increase school success. Community service learning allows the teens to select a project within their community that helps them feel engaged and incorporates a reflection component that fosters a sense of purpose. Project AIM encourages at-risk youth to imagine a positive future and discuss how current behaviors can impact a successful adulthood, through interactive and small-group activities, group discussions, and role-plays. The NM FPP promotes the use of the From Playground to Prom: Talking with Your Child about Sexuality curriculum, to increase parent-child communication, with the parents of the teens who participate in TOP® or Project AIM. In State FY17, there were 285 teens enrolled in both TOP® and Project AIM. In addition to this structured educational and experiential programming, the NM FPP provides funds to support the BrdsNBz warm-line text service that provides medically accurate, age-appropriate sexual health and sexual behavior answers to teens who text questions.

Strategies for unintended teen pregnancy prevention include a social media campaign about birth control and where

to find services. This campaign has been funded by a grant from a local foundation that supports children's issues. Digital ads on Facebook and other websites directed females aged 13-19 to age appropriate websites that give information on contraceptive choices available to teens. Teens 13-17 were directed to http://stayteen.org/sex-ed/birth-control-explorer, while teens 18-19 were directed to http://www.whoopsproof.org/nm.

Adolescent Well Visit

By 2019, we should have about six months' worth of data and will be able to asses our efforts with piloting the KYHT to determine barriers, solutions and updates needed to the KYHT and YHL training. Once adjustments are made, the KYHT implementation team will share the information with the local managed care organizations to solicit partnership & funding to produce several "Know Your Health Campaign Toolkits" and distribute them to some or all the following clinics such as: public health clinics, primary care health clinics, SBHC's in NM. The team will also look for possible funding opportunities such as requests for proposals (RFP) that are in alignment with the work we are doing.

State Fiscal Year 2019 will mark the end of another four-year contract cycle for our school-based health center sponsors. A new RFP is slated to be released in January 2019 so that new contracts can begin July 1, 2019. Attention will be given to SBHC sustainability to ensure adolescents have access to the right care, in the right place, at the right time. Sustainability entails each school based health center having a medical sponsor in place to coordinate the provision of services. It is also likely we will have several new school-based health centers submitting applications for funding. To date, there are 12 school-based health centers on our waiting list. Again, increasing the number of partnerships with community health care providers improves sustainability and ultimately increases the number of visits, including well exams, to school-based health centers.

Teen Births

New Mexico's teen birth rate for ages 15-19 declined 63% since the peak year (1991) and 14% since 2015. New Mexico is currently ranked seventh nationally, an improvement from fourth highest in the previous year, with a decline of 14% from 2015 to 2016, the second greatest decline in the nation. For 2019, NM FPP will continue to fund, monitor, and evaluate the implementation of the TOP® and Project AIM evidence-based programs to prevent unintended teen pregnancy. As a result of the Request for Proposal (RFP) for Youth Development Programs to Prevent Unintended Teen Pregnancy and award of contracts in State federal year 19 (FY19), TOP®, Project AIM, and From Playground to Prom will be offered at sites across NM.

In State FY19, TOP® will be implemented in nine counties at thirteen sites statewide by eight different organizations. Project AIM will be implemented in three counties by two different organizations. FHB/FPP will continue to work with community organizations and provide technical assistance and oversight to ensure curricula are implemented with fidelity. The parents and trusted adults, who complete the adult-teen communication curriculum, *From Playground to Prom*, will help with teen pregnancy prevention as adult-teen communication is a strong protective factor. FHB/FPP will continue to promote the BrdsNBz text messaging service statewide. Teens text "NMTeen" to 66746 to opt in to the service. A teen can then text a question and a trained health educator will respond within 24 hours; however, responses are usually received in real-time. BrdsNBz combines health education and personalized text messaging, to meet the public health needs of New Mexicans. This social media system offers teens 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 unintended teen pregnancy prevention/reduction. Components of the plan will include:

1. Fund, monitor and evaluate the implementation of evidence-based programs to prevent unintended teen pregnancy.

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

3. Ensure teens receive confidential services in a youth-friendly environment, including access to a broad range of methods.

4. Through community education and outreach, address the reproductive and other health needs of hard-to-reach and vulnerable populations.

5. Social media campaigns to increase awareness about birth control and where to find services.

6. Provide training for clinic staff (including site audits, webinars, Project ECHO [Extension for Community Healthcare Outcomes] and on-site mentors).

In addition, the Legislative Finance Committee allocated $250,000 in state general funds to the Department of Health for state FY19 specifically to be used for LARC training and stocking. The goal of the funding is to increase access to LARC in NM and decrease unintended births. The FHB staff will work closely with Medicaid on this project to ensure Medicaid federal funds are utilized to the fullest extent possible. Medicaid included in their 1115 waiver application a proposal for LARC stocking of School-Based Health Centers. We are issuing an RFP for the training and we are in discussions with the DOH pharmacy and Medicaid to determine a procedure for implementation of this project.

Children with Special Health Care Needs

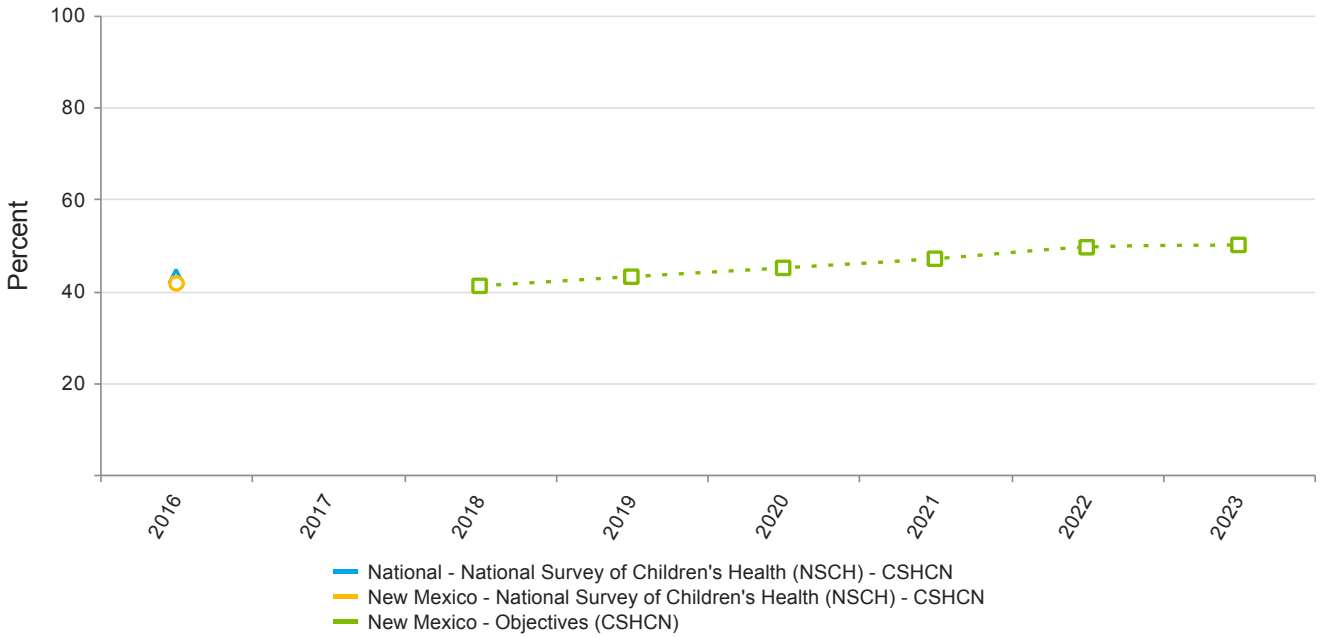
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	22.0 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	59.4 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	89.9 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016	4.2 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Baseline Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		41.6
Numerator		40,839
Denominator		98,104
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	41.1	43.1	45.0	47.0	49.5	50.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care for CYSHCN.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	CMS Training Roll	CMS
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	10.0	10.0	10.0	10.0	10.0

ESM 11.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.

Measure Status:	Inactive - This no longer relates to a strategy for this NOM

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	2
Numerator	
Denominator	
Data Source	2017
Data Source Year	2017
Provisional or Final ?	Provisional

ESM 11.3 - The number of outreach events to promote the Medical Home Portal

Measure Status:	Active

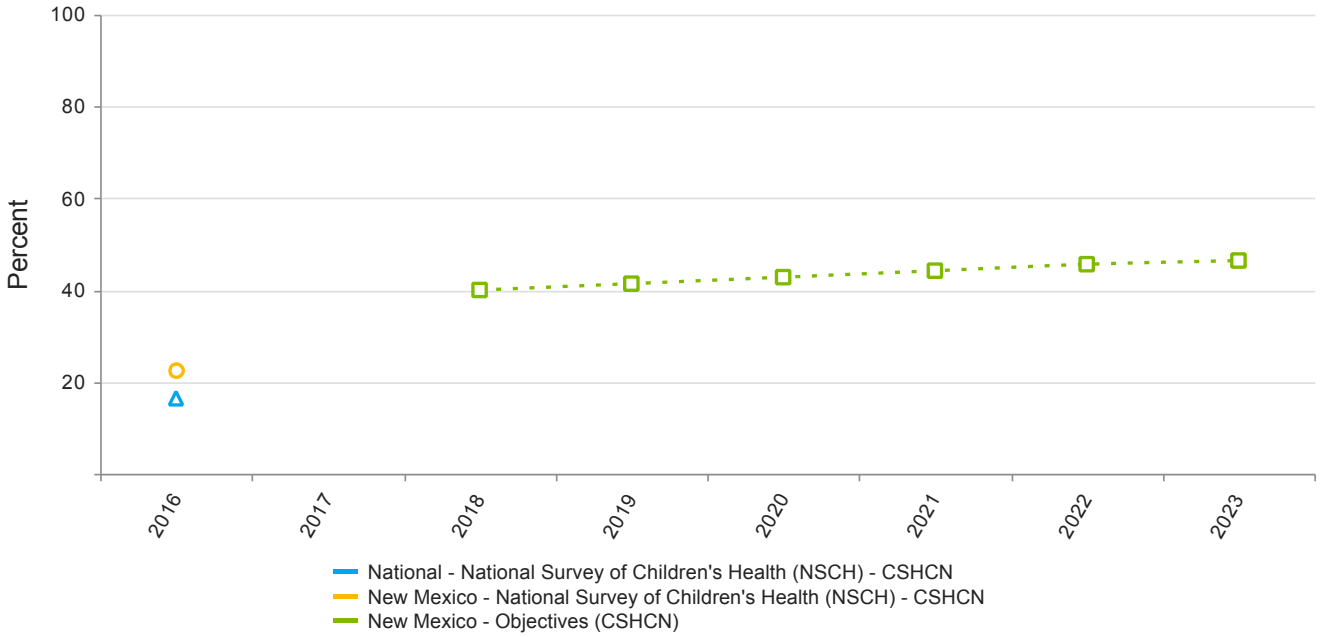
Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	1.0	2.0	3.0	4.0	5.0

ESM 11.4 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal that were accepted into policy.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		22.5
Numerator		8,575
Denominator		38,131
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	40.0	41.4	42.8	44.2	45.6	46.4

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Participating in at least one Quality Improvement Project for health care transition and training on the 6 core elements of transition

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	N/A	N/A
Data Source Year	N/A	N/A
Provisional or Final ?	Final	Final

ESM 12.2 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal regarding transition to adult health care that were accepted into policy.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	2
Numerator	
Denominator	
Data Source	Family Health Bureau - Title V
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

ESM 12.3 - The number of pediatric providers participating in at least one quality improvement project on transition

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	4.0	5.0

ESM 12.4 - The number of trainings to pediatric providers, families and youth that educate them on transition to adult health care.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	1.0	2.0	3.0	4.0	5.0

State Action Plan Table

State Action Plan Table (New Mexico) - 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

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

Increase by 2% the number pediatric clinicians with effective medical home practices in place by July 2019.

Increase by 2% the number of families who have access to patient and family centered care coordination by July 2019

Strategies

Develop trainings with the New Mexico Child Health Improvement project for pediatric providers to improve care integration and cross provider communications using evidenced based tools such as the shared plan of care.

Develop trainings with the New Mexico Child Health Improvement project to pediatric providers on care coordination and how to integrate the Title V CYSHCN care coordinators into their practice.

Collaborate with the Family to Family Health Information Center to recruit family leaders to provide input to Medicaid and the Managed Care organizations to the overall system of care specifically care coordination and family centered care.

The Title V CYSHCN program and the Medical Home portal staff will continue with outreach events to promote use of the Medical Home portal by primary care providers, families and other interested stakeholders by providing relevant and timely content and community resources to improve the care for CYSHCN and their families.

ESMs	Status
ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care for CYSHCN.	Active
ESM 11.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.	Inactive
ESM 11.3 - The number of outreach events to promote the Medical Home Portal	Active
ESM 11.4 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal that were accepted into policy.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (New Mexico) - 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

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase by 2% pediatric and pediatric specialty care practices who report that they have written health care transition policy and processes to help youth with special health care needs prepare and plan for transition to the adult physical and behavioral health care systems by July 2019.

Establish a baseline of youth and their parents/guardians in the Title V CYSHCN program CMS who report that they have the knowledge and tools to talk to their doctor about transition and be engaged in the planning process by July 2019.

Strategies

The Title V program will provide training on transition and the Six Core elements to a successful transition to CYSHCN and their families at the annual parent leadership conference sponsored by Parents Reaching Out and EPICS and with YSHCN in the CMS program.

Recruit family leaders in collaboration with the Family to Family Health Information Center to provide input to Medicaid and the Managed Care organizations around policy and procedure around transition to adult health care.

The Title V program will develop quality improvement projects with the NM Child Health Improvement project to engage pediatric providers to increase their understanding of transition and implement processes into their practices based on the evidenced based model developed by Got Transition.

ESMs	Status
ESM 12.1 - Participating in at least one Quality Improvement Project for health care transition and training on the 6 core elements of transition	Inactive
ESM 12.2 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal regarding transition to adult health care that were accepted into policy.	Active
ESM 12.3 - The number of pediatric providers participating in at least one quality improvement project on transition	Active
ESM 12.4 - The number of trainings to pediatric providers, families and youth that educate them on transition to adult health care.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Medical Home

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

Description: Increase access to care to a family centered comprehensive medical home for children and adolescents.

Objectives:

Increase by 2% the number of families who have a access to a pediatric clinician with effective medical home practices in place by July 2019.

Increase by 25 the number of families who have access to patient and family centered care coordination.

Strategies:

- Develop trainings and strategies with the New Mexico Child Health Improvement project for pediatric providers to improve care integration and cross provider communications using evidenced based tools such as the shared plan of care.
- Develop strategies with the New Mexico Child Health Improvement project to provide training to pediatric providers on care coordination and how to integrate the Title V CYSHCN care coordinators into their practice.
- Collaborate with the Family to Family Health Information Center to recruit family leaders to provide input to Medicaid and the Managed Care organizations to the overall system of care for CYSHCN in the Medical home.
- The Title V CYSHCN program and the Medical Home portal staff will devote time, attention and resources to promote use of the Medical Home portal by primary care providers, families and other interested stakeholders by providing relevant and timely content and community resources to improve the care for CYSHCN and their families.

The focus of the state action plan is to improve the system of care for Children and Youth with Special Health Care Needs (CYSHCN) with a focus on Medical Home. Children's Medical Services (CMS) will continue to provide leadership around care coordination that is family-centered and culturally competent for CYSHCN. CMS employs licensed medical social workers trained in the provision of 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. In rural areas CMS is seen as the only program that addresses the needs of CYSHCN. The CMS program, with its revenue source from Medicaid billing, focuses efforts on maintaining staffing in all regions of the State and defend the need and value of the work the social workers do in their communities to upper management. With our increased staffing we were able to resume outreach activities to underserved communities in rural frontier areas and within tribal communities and increase the number of our pediatric specialty outreach clinics.

New Mexico has benefited from the Affordable Care Act (ACA) as a Medicaid expansion State. This has helped close the gaps in health care access for youth age 18 and older who had historically transitioned into a system with limited health care financing. In 2017 Medicaid was in the process of renewing and revising the 1115 Waiver. Key components of the 1115 Waiver include: care coordination enhancements, patient centered medical homes and integrative behavioral/physical health homes. The Title V program has developed key partnerships with the Managed Care Organizations (MCO)'s and this provided the perfect opportunity to provide input into policy development

around key elements such as care coordination, medical home and transition. The interagency work group met several times and agreed on comments that were formally delivered to Medicaid during the public comment period. Comments were centered around care coordination for CYSHCN and the need to maintain contractual partnerships with community agencies such as CMS who have expertise in the provision of care coordination for this population and utilization of evidenced based practices as cited by the “Got Transition” and the six core elements to assure a successful transition for a youth with special health care needs into adulthood. Another key opportunity directed at financing is the Health Care Financing ECHO project lead by several key partners: Parents Reaching Out, Family to Family Health Information Center, Title V, Medicaid, and the MCO’s, among others. The ECHO project has provided a platform to address financing issues for CYSHCN and continued to be a successful method to eliminate barriers for families who are having trouble accessing medical care.

Although the uninsured rate in NM has dropped significantly with the ACA, over ten percent of New Mexicans remain uninsured. Many, but not all, 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. New Mexico utilizes a high-risk pool to address access to health care for uninsured CYSHCN. The pool is subject to political influences and requires continuous monitoring by the Title V program.

In a limited capacity, CMS also acts as secondary insurance to help families who have private insurance but meet program medical and financial eligibility guidelines. CMS closely monitors the developments at the federal level regarding ACA and its impact on insurance coverage for New Mexico children, especially CYSHCN.

CMS social workers and CMS management continued to work 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. Best practice for care coordination of CYSHCN 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.

Another responsibility of the CMS program is the Newborn Screening program. The program screens for 32 conditions, inclusive of critical congenital heart defect and congenital hearing loss. The program assures that all newborns receive these screens prior to discharge and have access to follow-up and treatment in coordination with the Medical Home. In 2017 there were several activities under way to improve this coordination and support families. The Newborn Hearing Screening program is engaging a target pilot community of Sandoval County which consist of rural, urban and tribal communities in a statewide learning community. The goals of the project are to: (1) measure improvements in patient/family care consistent with evidenced-based approaches to referral, access to care and care coordination at the local and state level for infants with hearing loss; (2) improve response to child and family health care and community needs consistent with evidenced-based approaches based on tenets of the patient centered medical home; (3) obtain measurable improvements in parent and family engagement; (4) develop a model for building capacity for quality improvement (QI) of the leadership in target community and (5) measure positive changes in knowledge, attitudes and provider practice in the content area of newborn hearing screening, referral to services and follow-up. This past year the learning community has been successful in recruiting and training participants in the QI process and have engaged in activities that that are moving the agenda forward. The Newborn

Genetic Screening program is part of the Mountain States Regional Collaborative and is participating in the Underserved Populations Project (UPP) which was undertaken to develop strategies to increase access to genetic services for individuals in rural, Hispanic, and American Indian communities in the Mountain States. The New Mexico team consists of the Title V program, Trish Thomas from Family Voices, Yolanda Sandoval a parent from the Navajo Nation, Parents Reaching Out and Dr. Dale Alverson from the University of New Mexico office of Telehealth. The purpose of the project is to support the outreach efforts of Ms. Sandoval who interviews families on the Navajo Nation. These families have children with genetic conditions and she provides these families with educational material, services, and community supports so that the team can understand the gaps and opportunities to improve resources and information for families.

New Mexico is a largely rural state with most all pediatric specialists located in Albuquerque at the University of New Mexico Health Sciences Center (UNMHSC). High poverty rates, lack of transportation and other socio-economic conditions can make accessing specialty care prohibitive for many families outside of the Albuquerque metro area. In partnership with UNMHSC, CMS facilitated over 140 multidisciplinary pediatric specialty clinics in rural areas of the state including cleft palate, nephrology, endocrinology, pulmonary, neurology, and genetics. Additional clinics were added including cardiology, neurology and gastroenterology to a lack of providers coupled with high need for these specialties in New Mexico. In 2017 CMS also added two neurology clinics in the Southwest due to high need and a lack of pediatric providers. CMS medical social workers follow CYSHCN through the multidisciplinary pediatric specialty outreach clinics, as well as assuring that specialists' recommendations are communicated to the local (community-based) primary care providers. Without these specialty clinics many CYSHCN would not be able to access this care.

In the summer of 2017, CMS submitted a proposal to the Association of Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) that was accepted for participation in an Action Learning Collaborative (ALC) around "Strengthening Medicaid Managed Care for Children with Chronic and Complex Health Care Needs". The ALC work began in the fall of 2017 with this specific goal in mind: to help states build upon and align their Medicaid managed care programs with existing federal and state initiatives and health care delivery system reforms impacting children with chronic and complex health care conditions, such as the, Patient-Centered Medical Homes (PCMH) or Health Homes, pediatric Accountable Care Organizations (ACOs), and Value-Based Payment models. For New Mexico specifically, the goals are:

1. Further developing and supporting diverse family leaders as partners across Title V and its partners including Medicaid, Managed care, the provider community.
2. Reaching consensus on the broader definition of CYSHCN including identification and developing strategies to address gaps in care delivery systems especially in rural areas of the State.
3. Improve collaboration with primary care providers, Title V and the MCO's to increase care coordination at the point of services and develop new partnerships.
4. Dissemination and buy in of best practice for successful youth transition into adulthood.

CMS took the lead in this ALC and enlisted several partners including Medicaid, Parents Reaching Out (NMF2F) and all four Managed Care organizations and Envision New Mexico. This nine-month project is slated to finish by the end of the calendar year, in 2018. The ALC also has had access to technical assistance from the National Centers on Medical Home and Got Transition as well as AMCHP and NASHP staff. The ALC has been meeting regularly to address its work plan however there is some delay currently due to a restructuring of the Medicaid Managed Care plans.

New Mexico has had a Managed Care arrangement for Medicaid clients for many years. Native Americans have always been exempt from participating in Managed Care but all other Medicaid recipients were required to enroll into an MCO. This includes all CYSHCN as well. coordination needs. The Title V CYSCHN program has a long history of providing intensive care coordination for complex medically involved children. The contracting requirements with the MCO's presented a unique opportunity for NM Title V to develop closer relationships and negotiate how the

program and the MCO's can best work together, avoid duplication and improv the system of care for CYSHCN in the State. The New Mexico F2F is still closely involved in this transformation. However, gaps continue to occur around care coordination for high-risk families, access to specialty care, financing, and the need to improve partnerships to train and utilize family leaders who represent our diverse cultures and languages to provide input into MCO service delivery. Other issues that were not addressed include development of a coordinated approach to identifying CYSHCN in the state, better utilization of EPSDT, as a monitoring tool and dissemination of best practice around youth transition. A new RFP was issued in 2017 and the MCO's that were offered a contract were Blue Cross Blue Shield, Presbyterian and Western Sky/Centene, a company new to New Mexico. United and Molina were not offered a contract and they are currently involved in a lawsuit with the State. CMS continues to monitor this situation as the MCO a CYSHCN is enrolled in can significantly affect access and ability to have health care needs met.

Family Engagement/Family Leadership

Parents Reaching Out (PRO) and the NM Title V CYSHCN program are committed to provide support for New Mexico families of children and youth with special health care or education needs, especially those who have challenges accessing current systems. Within our vast state, the aim is to reach all families, especially those who may be isolated due to language, citizenship status or geographic location. We work with diverse cultural, ethnic, linguistic and populations with varying citizenship status within the state of New Mexico. The parents and partners with whom we work reflect New Mexico's demographic makeup which is majority Hispanic with significant Native American representation. Organizations with whom we partner include, Education of Parents of Indian Children with Special Needs (EPICS), Hands & Voices, Growing in Beauty (Navajo), the Mescalero Apache Early Childhood Program and the Asian Family Resource Center. In 2017, PRO was the recipient of the Polly Arango Mentorship Initiative grant which helped 10 families receive leadership training and mentoring from established family advocates throughout the state. The project utilized the "Cultural Broker "model developed by Georgetown University Ultimately, the new family participants were able to provide leadership within their communities using culturally and linguistically appropriate tools. Participants included six monolingual Spanish-speaking families and four Native American families representing four New Mexican tribal communities. Over time, their voices will also influence our work and those of policy makers. CMS sponsored and participated in the PRO and EPICS Family Leadership conferences which are held annually. Each conference attracts over 400 participants and consists mostly of families who have children with special needs. Participants from across the state come for mutual support and learning about a range of topics that support the core outcomes for family professional partnership.

In 2017, CMS continued its partnership with the state's lead agency for child welfare, the Children, Youth and Family Department (CYFD). The CYSHCN/Child Protective (CYFD) project aims to provide CYFD staff with an efficient means to improve overall care of children with chronic medical conditions on their caseloads. CMS social workers provide consultation and co-management for this population as they are specially trained in care coordination for children with chronic medical conditions. In this partnership, the social workers provided the link between specialty care-patient-primary care offices and dental practices in the local communities. CMS social workers continued to work with the clients until they turn 21, which serves to provide both continuity of care for those CYFD clients who are aging out of their system at 19, as well as providing intensive work around youth transition in all areas (healthcare, educational and vocational). They also work with foster families to teach them about the medical needs of the child, how to navigate the specialty healthcare system, and how to assure a medical and dental home. Additionally, efforts continued statewide to address the needs of children with Neonatal Abstinence syndrome. In New Mexico, these children are often jointly managed by CYFD protective services and CMS social workers. A training was developed for CMS social workers to address the medical/psycho/social needs of these children and their families.

New Mexico needs increased family leadership and advocacy, especially with regards to the system of care for CYSHCN. 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 complex managed care system. The Title V program continued 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. PRO enlisted CMS to be part of a State Team to address this issue. Through a training grant from Family Voices the New Mexico team developed a list of advisory/stakeholder committees that should have or require consumer/family participation and will be utilizing the Family Leadership conference to recruit parents who are interested and prepared for this leadership role.

The ECHO™ financing clinic at the NM F2F at Parents Reaching Out continues to address health care financing issues and access to care for CYSHCN. This model uses the “hub” and “spoke” approach to addressing health care needs. 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. This project has been increasingly successful over the past year and there has been an increase in utilization by CMS social workers and CYFD. PRO has helped outfit CMS offices in Gallup, Roswell and Farmington with equipment so that staff can participate using the “Zoom” technology and staff will be encouraged to present cases and invite families to participate during clinics.

To improve the quality of CMS social worker care coordination for CYSHN and improve integration with the Medical Home, the contract with Envision (ENM) the Child Health Improvement program in the Department of Pediatrics at the University of New Mexico continued into its second year. Year one of the project focused on focus groups in five target communities to identify areas of improvement in coordination of are and family engagement. Groups in the target communities were composed of primary care providers, CMS personnel, families and representatives of community organizations that serve CYSHCN. Other partners include the NM Pediatric Society. Projected outcomes of the process were: (1) a plan for implementing positive changes in knowledge, attitudes and provider practice around 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. In year two the plan included: (1) summarizing the findings of the focus groups and evaluation and offering recommendations for a plan to improve NM rates on core Maternal Child Health Bureau (MCHB) outcomes; (2) defining and implementing quality improvement activities statewide based on these results which will include and evaluation process; and (3) implementing trainings based on the needs identified through the focus groups. The work was also integrated into the AMCHP/NASHP ALC which will engage the MCO’s in the overall systems improvement project. Another outcome for this project was an updated CMS website to provide useful information on the program to provider and families.

The MCH Epidemiology program continued its partnership with the Department of Health Asthma Epidemiology program to address unmet needs of children with moderate to severe asthma. The asthma program uses surveillance data to provide MCH with a list of children who have been hospitalized or had an ED visit due to asthma. The parents are called and ask a series of questions regarding access to a medical home and other services and offered a referral to CMS for care coordination. The program has been successful linking families to local CMS social workers who assess the family’s needs and prioritizes that the child has a Medical Home. An evaluation component will be developed in 2018. MCH Epidemiologist Glenda Hubbard assists the program to complete the annual EHDI survey for the CDC. Ms. Hubbard’s salary is paid out of the SSDI grant.

New Mexico does have the mosquito capable of Zika transmission in several of its southern counties bordering Texas and Mexico. In response, the NM Department of Health (DOH) received federal funding for Zika emergency preparedness including the development of a pregnancy registry. In April 2017, the DOH Birth Defects program in

the Epidemiology Division created a position to address linking families with birth defects into services and assuring a Medical Home. The position is funded out of Center for Disease Control (CDC) Birth Defect grant but housed in the CMS program. This position is part of the DOH Zika emergency preparedness planning and will play an essential role in coordinating information between prenatal care providers and the DOH Birth Defects Surveillance program to improve reporting of microcephaly and other associated birth defects to the DOH. A primary function of this position is to link identified infants and their families to essential services including CMS care coordinators, Developmental Disabilities staff (including early intervention providers and waiver programs) and to close the loop between identification of birth defects and access to needed services and family support. This new position also serves on the DOH Core Communication team around Zika emergency preparedness and is involved in decision making to provide guidance on community needs and issues. As part of a long overdue process to move from a passive birth defects surveillance system to an active birth defects surveillance system, CMS moved to address unmet needs for families with congenital conditions. Along the New Mexico-Mexico border CMS continues to support and promote the use of the Medical Home Portal maintained at the University of Utah as a useful resource for families and providers to obtain accurate information on pediatric medical conditions. It also links families to community resources to address psychosocial needs as well. The community resources page is kept up to date in partnership with the University of New Mexico Center for Development and Disability Information Network.

Transition

NPM: Percent of adolescents with and without special health care needs, ages 12 through 17 who received services to make transitions to adult health care.

Description: To increase the amount of services available to assist adolescents to make successful transitions to health care services.

Objectives:

Increase by 2% 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 by July 2019.

Establish a baseline of youth and their parents/guardians in the Title V CYSHCN program CMS who report that they have the knowledge and tools to talk to their doctor about transition and be engaged in the planning process by July 2019.

Strategies:

- The Title V program will provide training on transition and the Six Core elements to a successful transition to CYSHCN and their families at the annual parent leadership conference sponsored by Parents Reaching Out and EPICS and with YSHCN in the CMS program.
- Collaborate with the Family to Family Health Information Center to recruit family leaders to provide input to Medicaid and the Managed Care organizations to the overall system of care for CYSHCN around transition to adult health care.
- The Title V program will develop quality improvement projects with the NM Child Health Improvement project to engage pediatric providers to increase their understanding of transition and implement processes into their practices based on the evidenced based model developed by Got Transition.

In 2017, Children's Medical Services (CMS) continued to enhance foundational program activities to improve medical transition for Youth with Special Health Care Needs (YSHCN).

Since 2002, CMS has had an established transition program for YSHCN. Transition guidelines and transition plans were developed by the CMS Transition Team and today, CMS staff in all five regions of the state utilize the Transition Plans. Transition plans have been reviewed by several CMS social workers and YSHCN to assess effectiveness. The plans have been helpful in raising issues such as employment, secondary school, medical management of their chronic health condition and inspiring youth to think about transition. They also help to assist teens in identifying their own needs and ways to access resources. CMS social workers are required to use this plan for transitioning youth aged 14-21, ideally as part of the CMS renewal process. It is suggested that transition planning occur every other year for youth aged 14-17 and be updated every year for those 17 and older, at the discretion of the social worker. The transition plan is designed to be reviewed and discussed in person with the client.

CMS social workers complete a transition assessment and develop a plan of care for youth starting at age 14. This assessment addresses youth knowledge and ability to manage their medical condition, use of health care services, daily living activities, what areas they continue to need assistance with or anticipate needing assistance with, living arrangements, transportation, recreation, social relationships, and future education/training/employment planning. CMS social workers work with the youth to identify adult providers that will assume care from the pediatric providers during the transition process and assist in addressing health care financing. NM participates in the Affordable Care Act (ACA) Medicaid expansion and this has been very beneficial to YSHCN who are 18 because this enables them to move onto the expansion coverage when they age out of Medicaid/CHIP. For youth that are not eligible for Medicaid ACA or private insurance, the social workers transition these YSHCN onto the NM High Risk Pool at age 21. The High-Risk Pool offers a low income premium plan that offers monthly premiums based on a sliding scale fee.

Assisting youth with the transition to an adult health care provider can still be challenging in some areas of the state. CMS social workers have close working relationships with pediatric providers but feel limited in their connections with adult providers. The program continued to work on partnering more closely with the adult providers (either medical home or specialist) through a warm hand off to help bridge the gap between pediatric and adult providers and to improve the transition and transfer process. The goal was to increase satisfaction of the provider, youth and family with the transition process. CMS provides training and mentoring for social workers and medical providers to help providers understand the benefits of partnering with the CMS social worker as well as to help the social worker be comfortable in this role. Many communities have Family Medicine Physicians as primary care providers which can ease the transition process. This focus on individual community needs is the basis of a successful transition.

CMS social workers continued to receive training and support around transition planning with youth. The data system CACTUS has integrated the transition assessment and includes a care plan that is 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. The plan of care was modified to identify who has primary responsibility for completing tasks. Every year efforts are made to participate in the Baylor University Transition conference through a live stream to support the training of the CMS social workers and in 2017 some staff participated remotely. Regional staff meetings continue the focus on different aspects of transition and social workers earn CEU's towards their social work licenses.

The CMS Management team continues to review the materials from Got Transition, the national center that supports evidenced-based transition methodology and other transition resources and incorporate questions and processes into the transition plan. As a best practice, the CMS statewide program manager attends webinars and trainings that are sponsored by Got Transition and shares this information with the CMS Management team.

The Action Learning Collaborative (ALC) with the Association of Maternal and Child Health Programs (AMCHP) and

the National Academy of State Health Policy (NASHP) set a goal to develop a NM specific tool kit for transition. At the first stakeholder meeting there was consensus that a toolkit was necessary. Team members reviewed the Six Core Elements which includes policy, tracking, readiness, planning, transfer and evaluation and other state examples as part of the team meetings to identify components that will be applicable to NM families and providers. This year the team focused on making recommendations during the public input phase of the Medicaid 1115 waiver renewal. The Six Core Elements were integrated into the written comments that were submitted to Medicaid on behalf of the ALC as transition was a focus of the waiver application. From this process, transition was identified by the MCO's and Medicaid as an essential component of care that needs to be addressed. The definition of transition was quite broad and incorporated transitions such as juvenile justice, transition from hospital to home etc. and did not specifically include youth transition, but our goal was specifically to introduce the concept of transition as a best practice and to further dialogue with Medicaid. Since the winter of 2017, this project is on a temporary hold due to the RFP for MCO's and contracting issues that are still being resolved. We hope to resume the project in 2019 has after the State has awarded and finalized the new Medicaid MCO contracts.

Three years ago, the University of New Mexico Center for Development and Disability 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, to include 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 for youth with cerebral palsy. The Learning Portal 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. There have been funding challenges to getting this portal fully launched and it is on hold for now.

A transition track at the annual family leadership conference sponsored by Parents Reaching Out (PRO) the NM F2F continued to be supported through funding and professional presentations to train families who have CYSHCN. Families throughout New Mexico and some CMS staff members attend this conference. Transition training is also part of the annual family leadership conference sponsored by EPICS (Education of Parents of Indian Children with Special Needs), a parent organization that is geared towards Native American families. CMS continues to provide funding to EPICS as part of parent leadership training and helps the program serve as a liaison to Native American families in the State. The annual conference attracts over 400 attendees and includes families with CYSCHN from other Tribes across the country as well as New Mexico families. EPICS has started a webinar series on transition as well and CMS will continue to maintain partnership and collaboration. CMS presented on transition using the 6 Core Elements and the PRO and EPICS conference in the Spring of 2018. Several years ago, CMS developed a DVD entitled "What Comes Next" which follows three YSCHN through the transition experience and highlights the need for interagency collaboration, which is still relevant today. A curriculum guide accompanies the film and creates a springboard for interaction and discussion with conference participants. The DVD and audience discussion was well received by conference participants and raised numerous issues that parents had questions on such as guardianship and the role of their youth's primary care physician in initiating transition planning.

In 2017, CMS continued to 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. CMS social workers and other staff have presented transition related cases to the ECHO participants to highlight the needs of CYSHCN and seek input. During the didactic phase of the ECHO clinic the 6 core elements of transition, the need for best practice, and identification of barriers to using best practices were presented. The Project ECHO Clinic participants consist of a cross-section of providers and partners across the state including CYFD, the MCO's, Medicaid, parents,

advocates, the Center for Law and Poverty, legislators, medical providers, therapists, early intervention providers, behavioral health providers among others.

Medical Home

Children's Medical Service (CMS) will continue to support the medical home concept in New Mexico, through discussions at professional meetings and conferences and continuing work on the Medical Home Portal, which provides accurate and comprehensive information on health information and community resources for families in English and Spanish. The CMS Program Manager will be participating in the Medical Home Portal Advisory committee that will be meeting to review portal metrics and usefulness and to provide input into additions that would be helpful for New Mexico families. CMS has a family-centered approach to care coordination, a critical component of the Medical Home. CMS employs licensed medical social workers trained in the provision of 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, including connecting families with a medical home. 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. CMS social workers will continue to empower parents and youth to partner with their primary care provider to ensure their needs are met within the Medical Home. In rural areas CMS is seen as the only program that addresses the needs of CYSHCN. The CMS program, with its revenue source from Medicaid billing, focuses efforts on maintaining staffing in all regions of the State and defends the need and value of the work the social workers do in their communities to the Managed Care Organizations.

CMS is entering into a contract with the Center for Development and Disability (CDD) at the University of New Mexico to evaluate the effectiveness of the care coordination that is provided to CYSHCN in the state. The purpose of this project is to design and implement an evaluation that will capture valid, reliable information on the impact that CMS social workers and other CMS staff have on clients and their families served by the program including health-related outcomes and quality of life measures. The CMS services include, but are not limited to:

- Linking clients to health, psychosocial and social service-related programs and services;
- Coordinating clinics in various specialties at locations across the state;
- Providing care coordination for clients who interact with multiple health and social service providers to maximize the effective and efficient utilization of health and other services and ensure that clients remain in appropriate programs and services; and
- Assisting YSHCN with medical transition issues.

One important goal of the project is to produce information that can be used by CMS staff with senior staff of the Department of Health; policymakers, including legislators; and funders, including federal agencies and Medicaid Managed care organizations. Reports prepared will incorporate results from each project component. The goal of this component of the project is to identify information from existing data sources which can be used to analyze the impact of CMS services on the health and other quality of life-related indicators of CMS clients. These data sources include Medicaid data, internal CMS data and other data sources identified by CMS. The search for variables will focus on data elements that can be used to compare health and other outcomes for CMS clients measured against comparable populations (e.g., traditional Medicaid services). Data will also be sought that addresses the cost-effectiveness of CMS services, including cost-avoidance. At this point, little is known about what data is available that meets the criteria listed above. An important part of this project component will be to assess what relevant data is available, develop an analysis plan based on the best available data which will be approved by CMS, implement the analysis plan and prepare one or more written and/or oral reports.

CMS will closely monitor the impact of the changes and additions to the 1115 Medicaid Waiver. Some of these changes include: care coordination enhancements, patient-centered medical homes and integrative behavioral/physical health homes, changes to eligibility, and cost sharing. The Managed Care Organizations that are

awarded a contract will play a key role in terms of access to care, especially specialty care for CYSCHN. CMS will engage the MCO's in partnership to work on a coordinated system of care.

In the summer of 2017 CMS submitted a proposal to the Association of Maternal and Child Health Programs (AMCHP) and the National Academy for State Health Policy (NASHP) that was accepted for participation in an Action Learning Collaborative (ALC) around "Strengthening Medicaid Managed Care for Children with Chronic and Complex Health Care Needs". The work of the ALC will be concluding this upcoming year with plans to transition this work group into a newly created Children's Care Coordination Collaboration, whose goal would be to institutionalize this collaborative to address systemic issues around access to care for CYSCHN. Stakeholders will include Title V, the MCO's, Medicaid, families, advocacy organizations and other key partners. The National Standards for Systems of Care for CYSHCN will be used as the roadmap to formulate strategies. The Title V CYSCHN program has a long history of providing intensive care coordination for complex medically involved children. However, gaps continue to occur around care coordination for high-risk families, access to specialty care, financing, and the need to improve partnerships to train and utilize family leaders who represent our diverse cultures and languages in the State to provide input into MCO service delivery. Other issues that need to be addressed are: development of a coordinated approach to identifying CYSHCN in the state, better utilization of EPSDT as a monitoring tool and dissemination of best practice around youth transition.

CMS social workers and CMS management will continue to work 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. Best practice for care coordination of CYSHCN 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 Newborn Hearing (NBH) and Newborn Genetic Screening (NGS) Programs will continue to include the medical home during follow-up when an infant is identified through newborn screening. The Newborn Hearing program will continue the Sandoval Learning Community project that is developing a shared plan of care to be used by the Medical Home and to assist families in accessing resources. The Newborn Genetic Screening program will continue its work with the Mountain States Regional Genetics Collaborative project that is assessing access to resources and care for families that have a child with a genetic condition that live on tribal lands. This project is parent driven and targeted at families from underserved regions of the state.

For the upcoming year CMS, in partnership with UNMHSC, will increase the number of multidisciplinary pediatric specialty clinics in rural areas of the state by 15 due to increased need for a total of 160. Clinics currently include cleft palate, nephrology, endocrinology, pulmonary, cystic fibrosis, neurology, cardiology, gastroenterology and genetics. CMS medical social workers will continue to follow CYSHCN through the multidisciplinary pediatric specialty outreach clinics, as well as assuring that specialists' recommendations are communicated to the local (community-based) primary care providers. Without these specialty clinics many CYSHCN would not be able to access this care.

The Birth Defects program will continue it surveillance and outreach to families with birth defects. With funding for the Zika Virus ending, the Department of Health in New Mexico Birth Defects program will focus on the 12 core birth defects. The program will work on developing educational materials around each of the diagnosis and prevention materials as well. In the upcoming year assessment and coordination of services will continue with all babies and

children (birth to four years) identified with a birth defect through Epidemiology being referred to CMS. Contact is being made with families who are not linked to services. Families identified through Newborn Hearing Screening will also be contacted if the Hearing Screen results in further need of services and multiple medical diagnosis are identified.

Babies identified with a Neonatal Abstinence Syndrome (NAS) code will continue to be reported through Birth Defects Surveillance from the large hospital systems in New Mexico (UNMH, Presbyterian and Lovelace). Even though NAS is not a birth defect, it is noted that many more babies are at potential risk. For example, many babies with a substance hit to their systems also will have a higher incidence of a cardiac condition such as ventricular septal defect. Submucosa Cleft Palate is another birth defect that can be linked to smoking and potential poly substance use as well. Children's Medical Services is a partner with Children, Youth and Families currently in implementing the state plan for CARA 2018. This is part of statewide effort to address the opioid epidemic

Family Engagement/Family Leadership

CMS will sustain 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 will maintain contracts 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 will continue to provide funding to PRO 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 their care. Parents Reaching Out (PRO) and the NM Title V CYSHCN program are committed to provide support for New Mexico families of children and youth with special health care or education needs, especially those who have challenges accessing current systems. Within our vast and diverse state, the aim is to reach all families, especially those who may be isolated due to language, citizenship status or geographic location. We work with diverse cultural, ethnic, linguistic and populations with varying citizenship status within the state of New Mexico. Specifically, the parents and partners with whom we work reflect New Mexico's demographic makeup which is majority Hispanic with significant Native American representation. Organizations with whom we partner include: Education of Parents of Indian Children with Special Needs (EPICS), Hands & Voices, Growing in Beauty (Navajo), the Mescalero Apache Early Childhood Program and the Asian Family Resource Center.

CMS will continue its partnership with the state's lead agency for child welfare, the Children, Youth and Family Department (CYFD). The CYSHCN/CYFD project aims to provide CYFD staff with an efficient means to improve overall care of children with chronic medical conditions on their caseloads. CMS social workers provide consultation and co-management for this population as they are specially trained in care coordination for children with chronic medical conditions. In this partnership, the social workers provided the link between specialty care-patient-primary care offices and dental practices in the local communities. CMS social workers continued to work with the clients until they turn 21, which serves to provide both continuity of care for those CYFD clients who are aging out of their

system at 19, as well as providing intensive work around youth transition in all areas (healthcare, educational and vocational). They also work with foster families to teach them about the medical needs of the child, how to navigate the specialty healthcare system, and how to assure a medical and dental home. Additionally, in CMS will continue with effort statewide to address the needs of children with Neonatal Abstinence syndrome with participation in the CARA planning group that meets to improve the statewide system for children born exposed to substance.

The Title V program will continue to strengthen the existing family networks to help families with CYSHCN be fully prepared, mentored and connected to meaningful opportunities of program and policy partnership and ensure that the Managed Care Organizations (MCOs), Medicaid, and state polices that can affect CYSHCN are guided by patient and family voices. CMS will continue to work with PRO as part of a State Team to address this issue of family representation. Through a training grant from Family Voices, the New Mexico team developed a list of advisory/stakeholder committees that should have or require consumer/family participation and will be utilizing the Family Leadership conference to recruit parents who are interested and prepared for this leadership role. Additionally, the ECHO™ financing clinic at the NM F2F at Parents Reaching Out will continue to function and to address health care financing issues and access to care for CYSHCN. This project continues to be successful over the past two years and there has been an increase in utilization by CMS social workers and CYFD.

The contract with Envision (ENM) the Child Health Improvement program in the Department of Pediatrics at the University of New Mexico will continue into year. In year three the plan will continue to address the need to improve NM rates on core Maternal Child Health Bureau (MCHB) outcomes including Medical Home and Transition. The work will focus on identifying primary care practices that are interested in participating in an evaluation of barriers, opportunities and challenges for implementing a coordinated system of care in their communities. The local CMS staff will be included in the evaluation process.

With regards to asthma specifically, our most common of the eligible diagnoses, CMS social workers will continue to receive referrals from the Asthma Epidemiology program on children who have had a recent emergency visit for asthma. The goal of this project is to address unmet needs of children with moderate to severe asthma, working with the family to find reliable primary care in their community and referring to the CMS asthma outreach clinics if appropriate. The MCH Epidemiology program will continue using surveillance data to pull a list of children who have been hospitalized or had emergency room an ED visit due to asthma. The parents are called and ask a series of questions regarding access to a medical home and other services and offered a referral to CMS for care coordination. The program has been successful linking families to local CMS social workers who assess the family's needs and prioritizes that the child has a Medical Home. An evaluation component will be developed in this upcoming year.

CMS has been awarded additional funding to assist in linking the program to the Maintenance Management Information System (MMIS) which is currently in its design phase. The goal is to streamline eligibility for all benefit programs and create a data warehouse for all programs that interface with Medicaid.

Transition

Children's Medical Services (CMS) will continue to enhance foundational program activities to improve medical transition for Youth with Special Health Care Needs (YSHCN).

CMS social workers will continue to initiate a transition assessment and develop a plan of care for youth starting at age 14 to address youth knowledge and ability to manage medical conditions, use of health care services, daily living activities, what areas they continue to need assistance with or anticipate needing assistance with, living arrangements, transportation, recreation and social relationships and future education/training/employment planning. CMS social workers will work with the youth to identify adult providers that will assume care during the transition

process and assist in addressing health care financing. The social workers will assess eligibility for expansion Medicaid for YSHCN who are 18 to assure continuity of insurance coverage. For youth that are not eligible for Medicaid ACA or private insurance, the social workers will continue to transition these YSHCN onto the NM High Risk Pool at age 21. The High-Risk Pool offers a low income premium plan that charges monthly premiums based on a sliding scale fee.

Activities related to assisting youth transition to an adult health care provider can still be challenging in many areas. In the contract for the third year with Envision New Mexico, CMS is requesting that a needs assessment be completed with the pediatricians who are willing to participate. The focus will be to identify barriers, successes and other areas were improvements could be made when transitioning YSHCN to adult medical care. CMS social workers have close working relationships with pediatric providers but feel limited in their connections with adult providers. Part of the goal with this new project will be to work on partnering more closely with the adult providers (either medical home or specialist) through a warm hand off. This will be done to help bridge the gap between pediatric and adult providers and to improve the transition and transfer process. The work of Envision will also be to provide training and mentoring for social workers and medical providers to help providers understand the benefits of partnering with the CMS social worker as well as to help the social worker be comfortable in this role. They will also be mentored on the need to incorporate best practices into the transition process, as recommended by the national training center Got Transition. Many communities have Family Medicine Physicians as primary care providers, which can ease the transition process. This focus on individual community needs is the basis of a successful transition. CMS and Envision have been working on revising a tool that the social workers have been using for many years called the CHUMS. It is wallet sized and holds several inserts where the youth can document their medical conditions, medication, emergency contact numbers, doctors etc. It can be easily updated and brought to appointments to facilitate information transfer from the youth to the providers. It has been very popular with families. In the upcoming year the CHUMS prototype will continue to be tested and revised and it has also been translated into Spanish. There have been requests for different formats of CHUMS that will be worked on as well in 2019.

CMS social workers will continue to receive training and support around transition planning with youth which includes a focus on utilizing the transition care plan to develop specific tasks with timelines and persons responsible for completion for transitioning youth. Our goal is to see better utilization of the care plan by CMS social workers and youth.

The CMS Management team will continue to review the materials from Got Transition, the national center that supports evidenced based transition methodology and other transition resources and incorporate questions and processes into the transition plan. As a best practice, the CMS statewide program manager will continue and support other CMS staff to attend webinars and trainings that are sponsored by Got Transition and shares this information with the CMS Management team. A statewide meeting is being planned for late fall 2018. The meeting will be for all CMS staff and transition for YSHC will be included in the curriculum.

The Action Learning Collaborative (ALC) with the Association of Maternal and Child Health Programs (AMCHP) and the National Academy of State Health Policy (NASHP) set a goal to develop a NM specific tool kit. Team members reviewed the Six Core Elements which includes policy, tracking, readiness, planning, transfer and evaluation and other state examples as part of the team meetings to identify components that will be applicable to NM families and providers. Since the winter of 2017 this project is on a temporary hold due to contracting issues that are still being resolved. We hope to resume the project in 2019 with the eligible MCO’s that the State has chosen to contract with.

CMS will continue to support the work of the Medical Home portal which does house information on transition and will be shared as a resource statewide. An article will be placed in the NM Pediatric newsletter highlighting transition of YSHC and providing resources and tools to use to support successful transition.

A transition track at the annual family leadership conference sponsored by Parents Reaching Out (PRO), the NM F2F, will continue to be supported through funding and professional presentations to train families who have CYSHCN. Families throughout New Mexico and some CMS staff members attend this conference. Transition training is also part of the annual family leadership conference sponsored by EPICS (Education of Parents of Indian Children with Special Needs), a parent organization that is geared towards Native American families. CMS continues to provide funding to EPICS as part of parent leadership training and helps the program serve as a liaison to Native American families in New Mexico. The annual conference attracts over 400 attendees and includes families with CYSCHN from other Tribes across the country as well as New Mexico families. EPICS has started a webinar series on transition as well and CMS will continue to maintain partnership and collaboration as this series develops. CMS plans to do a joint presentation at the family leadership trainings next year with the social worker from Carrie Tingley Hospital, a state pediatric hospital, on preparing parents for their YSHCN to transition.

CMS will continue to utilize the Project ECHO Health Care Financing clinics to address various challenging issues, including some related to transition. This will be done to highlight the needs of transitioning youth and elicit feedback on policies and practices that have been effective. CMS social workers and other staff will present cases to the ECHO participants to highlight the needs of YSHCN and seek input. During the didactic phase of an ECHO clinic, the 6 core elements of transition, the need for best practices, and identification of barriers to using best practices were presented. The Project ECHO Clinic consists of a cross-section of providers and partners across the state including CYFD, the MCO's, Medicaid, parents, advocates, the Center for Law and Poverty, legislators, medical providers, therapists, early intervention providers, behavioral health providers among others.

A new partnership with the Office of School and Adolescent Health (OSAH) in the Department of Health, Health Systems Bureau will be developed to collaborate on transition education for all youth in NM. OSAH engages in adolescent health promotion and disease prevention activities directly and through collaboration with public and private agencies across New Mexico. OSAH staff guide policy development on school and adolescent health issues and are involved in workforce development and trainings for those providing services to New Mexico youth. They also provide on-going technical assistance and training to school health personnel. NM has an extensive school-based health program. The Adolescent Health Coordinator in OSAH has developed a tool kit under the Title V program, and the goal this coming year is to combine our work around transition to help inform and improve this process for all youth in our state.

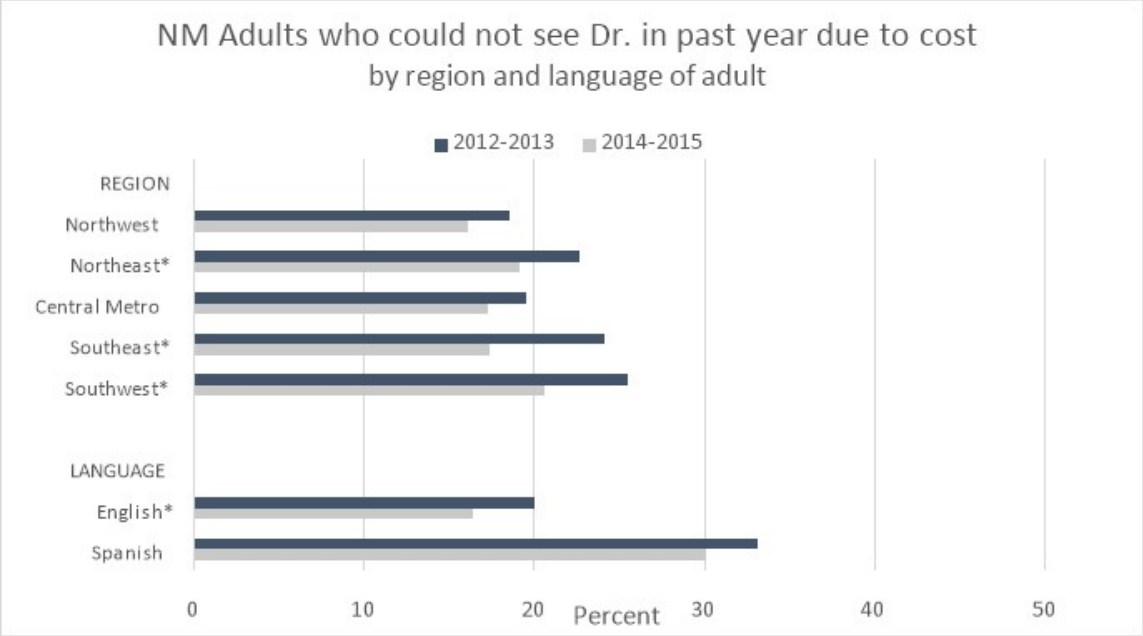
ADEQUATE INSURANCE – NEW MEXICO TITLE V Data Update, 2017 TVBG REPORT

What we know about:

All NM adults

Source: NM Behavioral Risk Assessment Monitoring System (BRFSS) 2012-2015

Disparities persist by geography and language- despite improvements with ACA



* indicates statistical significance in change

NM Women of childbearing age, 18-49 years

Source: NM Behavioral Risk Factor Surveillance System (BRFSS) 2016

Disparities observed in insurance coverage by income level indicate high uninsured rates for low income women.

Percent of NM Women with no Insurance Coverage by Household Income Level, 2016

Income level	Weighted Percent	Lower	Upper	Sample size
$0-<15k	13.8%	8.0	22.7	147
15k-<25k	24.3%	17.4	32.8	254
25K-<50K	10.3%	5.7	18.1	209
>50k	3.2%	1.5	9.4	295

Women without insurance, prior to pregnancy, among live births, 2013-2016

Source: NM Pregnancy Risk Assessment Monitoring System (PRAMS)

Year	Weighted Percent	Lower	Upper	Sample size
2013	20.3%	18.1	22.6	1621
2014	10.3%	8.2	11.8	1408
2015	9.6%	7.8	11.3	1373
2016	10.5%	8.7	12.3	1176

Women without insurance *during* pregnancy, among live birth, 2013-2016 PRAMS

Year	Weighted Percent	Lower	Upper	Sample size
2013	11.7%	9.9	3.5	1605
2014	9.3%	7.6	10.8	1411
2015	9.6%	7.9	11.4	1376
2016	3.2%	2.2	4.2	1155

By maternal characteristics

Federal poverty level	Weighted Percent	Lower	Upper	Sample size
<=100%	11.9%	10.4	13.4	2191
101-185%	7.4%	5.8	9.0	1221
>185%	4.0%	2.9	5.0	1657
Geography-Nativity	Weighted Percent	Lower	Upper	Sample size
All non-Border NM	9.5%	8.1	10.8	2236
Border Non-US born	44.5%	30.8	58.3	107
Border US-born	3.4%	.6	6.2	225
Border non-Hispanic	5.6	2.3	8.9	256
Region	Weighted Percent	Lower	Upper	Sample size
Northwest	5.8%	4.0	7.6	797
Northeast	12.8%	10.1	15.6	664
Metro	7.4%	6.2	8.7	2046
Southeast	9.7%	7.8	12.1	866
Southwest	9.3%	7.4	11.3	1174

Cross-Cutting/Systems Building - Application Year

Adequate Insurance performance measures are discussed in the Maternal Health Domain

III.F. Public Input

New Mexico has made many efforts to open dialogue and include community members in 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. The Title V Epidemiologist has formed a partnership with the Regional and Community Epidemiologists to compile an ongoing County-level MCH health profile for input since 2014. MCH Epidemiology met with the NMDOH tribal epidemiologist, the NW Regional Epidemiologist and SE Regional Epidemiologist several times to consolidate data and agree on topics potentially valued by community and tribal health councils. The first profiles were released and shared with communities in 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 in Santa Fe which houses the Public Health Division Director, two Deputy Directors, and other staff that serve the entire Division. The state is divided into five public health Regions, each with their own Regional Director; but our Public Health Regions are rural, expansive and diverse, both geographically and demographically. It is therefore paramount that we continue to interact with tribal leadership and regional leadership to align our goals and objectives across jurisdictions. 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. Health Promotion staff in the regions attend local community meetings and participate in local Health Councils to continually receive input and feedback on community needs and priorities.

Family Organizations are invited to provide input into the CYSHCN Program activities and the Title V Block Grant during scheduled MCH Collaborative meetings. Input is also obtained when 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. An exit interview is conducted with each family after the clinic to provide input on effectiveness and processes. Family Health Bureau representatives participate in many councils that provide direct input into Title V Services, needs and gaps such as 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. CMS recruited a parent representative to join the Newborn Genetic Screening Advisory Council, which includes participation in the Mountain States Regional Advisory Collaborative. 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. CMS staff attend the Family Leadership conferences hosted by PRO and EPICS and this provides a forum for families to provide feedback on the gaps in services and hardships in accessing health care services for CYSHCN. This information helps the program set priorities at a community level and at a policy level.

Each year, the domain group leader distributes the final block grant and/or Executive Summary to stakeholders and requests input, specifically on the state selected priorities, the state performance measures, the evidence or informed-based strategy measures and the action plan for the application year. Most recently, SurveyMonkey was

utilized as another avenue for input. The survey was disseminated to a wide range of MCH champions, including state agencies, hospitals, early childhood professionals, community-based organizations, university programs, advocacy groups, family and children's legal services, independent consultants, midwives, business representatives, social workers, private foundations, behavioral health professionals, education, medical organizations, and Native American entities. Through email, they were contacted and provided a link to the FY2018 Application/FY2016 Annual Report for their review. After reviewing the grant, they were asked to respond to eight questions through SurveyMonkey.

All existing public input is compiled and summarized prior to grant submission. We 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 also share the developed action plans directly with stakeholders to assure we were articulating plans which reflected their initial input and brainstorming. Because 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 during the needs assessment cycle. This allows 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 exploring different avenues for gathering feedback. One such idea includes hosting a webinar with those who contributed to the reporting for Title V this year. This would provide a way to obtain feedback orally instead of written or by survey which may increase those willing and able to give feedback.

III.G. Technical Assistance

The MCH program at NM DOH is currently receiving technical assistance (TA) from the MCH Workforce Development Center in Chapel Hill, NC. The MCH Epidemiology program as well as Maternal Health and partners at the University of New Mexico are working to address follow up care for mothers diagnosed with gestational diabetes (GDM). The TA is provided from the period of February-September of 2018. The proposed intervention will address prevention efforts through the life course by attempting to lower the rate of Type II diabetes for mothers diagnosed with GDM.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Medicaid IAA MOU.pdf

V. Supporting Documents

No Supporting documents were provided by the state.

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MCH_Epi_Org Chart_2018 updated.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: New Mexico

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,067,381	
A. Preventive and Primary Care for Children	$ 1,254,677	(30.8%)
B. Children with Special Health Care Needs	$ 1,714,831	(42.1%)
C. Title V Administrative Costs	$ 282,429	(7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 3,251,937	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 8,430,253	
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)	$ 8,818,600	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 17,248,853	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,087,900		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 21,316,234	
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)	$ 52,117,307	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 73,433,541	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 336,080
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,806,704
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 47,543,195
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 780,457
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 151,371
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 99,500

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,075,191		$ 3,505,374	
A. Preventive and Primary Care for Children	$ 1,609,537	(39.5%)	$ 1,119,500	(31.9%)
B. Children with Special Health Care Needs	$ 2,202,722	(54.1%)	$ 1,608,593	(45.8%)
C. Title V Administrative Costs	$ 262,932	(6.5%)	$ 281,270	(8.1%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 4,075,191		$ 3,009,363	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,963,800		$ 9,686,381	
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)	$ 6,501,745		$ 13,650,046	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,465,545		$ 23,336,427	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,087,900				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 17,540,736		$ 26,841,801	
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		$ 39,695,243	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 63,315,999		$ 66,537,044	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 117,154	$ 137,118
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 140,123	$ 139,338
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 128,582	$ 41,678
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374	$ 41,679
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 227,280	$ 224,653
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,239,000	$ 3,113,583
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 41,493,779	$ 35,662,855
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 333,971	$ 334,339

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Matches Form SF424	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Includes infants under one year and children 1-21	
3.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: From federal draw sheets	
4.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: FHB Admin plus indirect (off draw sheets)	
5.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: From FY19 IBAs - revenue and state Title V match @47% Includes revenue CMS, FPP, FF, Epi, and Maternal Health and includes GF match for all programs	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**

	Column Name:	**Application Budgeted**
	Field Note: From IBA 06104 and 06105	
7.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: The $500,000 that is still unspent will be spent by the end of the project period 9-30-18	
8.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: We are still spending down this grant so final numbers will be higher	
9.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Grant project period is still being spent down	
10.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: FHB Admin plus Indirect	
11.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: SHARE pivot State general funds. We budgeted lower anticipating possible budget cuts in GF that did not occur	
12.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**

	Field Note: From SHARE pivot table. This includes all program revenue including Medicaid and newborn screening. Previous budgeted number did not include newborn screening by mistake. Program revenues were also higher than had been anticipated since the contracts were new at the time.	
13.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: Some funds were carried over from previous year	
14.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: grant ended	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: New Mexico

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 596,376	$ 496,010
2. Infants < 1 year	$ 715,395	$ 661,879
3. Children 1 through 21 Years	$ 858,350	$ 457,622
4. CSHCN	$ 1,614,831	$ 1,608,593
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 3,784,952	$ 3,224,104

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	$ 1,721,350	$ 2,491,339
2. Infants < 1 year	$ 3,262,369	$ 5,630,913
3. Children 1 through 21 Years	$ 2,951,396	$ 3,084,063
4. CSHCN	$ 9,313,728	$ 11,533,264
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 17,248,843	$ 22,739,579
Federal State MCH Block Grant Partnership Total	$ 21,033,795	$ 25,963,683

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Plan to increase funding for maternal health in FY19	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: For form 2 Preventive and Primary Care for Children we included both Children 1-21 and Infants under 1 year	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: For form 2 Preventive and Primary Care for Children we included both Children 1-21 and Infants under 1 year	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Plan to move 100k to maternal health for FY19	
5.	**Field Name:**	**IB. Non-Federal MCH Block Grant, Non Federal Total of Individuals Served**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: This non-federal total includes GF and Revenue (which was not always done in previous years)	
6.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1 through 21 years**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: This does not match form 2 Preventive and Primary care for Children because the number on form 2 is our total of infants under one and children 1-21	

Data Alerts:

- Children 1 through 21 Years, Application Budgeted does not equal Form 2, Line 1A, Preventive and Primary Care for Children Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. A field-level note indicating the reason for the discrepancy was provided.
- Children 1 through 21 Years, Annual Report Expended does not equal Form 2, Line 1A, Preventive and Primary Care for Children, Annual Report Expended. A field - level note indicating the reason for the discrepancy was provided.

Form 3b
Budget and Expenditure Details by Types of Services

State: New Mexico

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 489,523	$ 359,780
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 462,354	$ 356,507
B. Preventive and Primary Care Services for Children	$ 27,169	$ 3,273
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 2,181,984	$ 2,333,284
3. Public Health Services and Systems	$ 1,395,874	$ 812,310
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		$ 0
Physician/Office Services		$ 178,253
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 178,254
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 3,273
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 359,780
Federal Total	$ 4,067,381	$ 3,505,374

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	$ 10,590,879	$ 3,920,696
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 452,800	$ 359,880
B. Preventive and Primary Care Services for Children	$ 824,430	$ 665,679
C. Services for CSHCN	$ 9,313,649	$ 2,895,137
2. Enabling Services	$ 4,210,474	$ 3,730,572
3. Public Health Services and Systems	$ 2,447,500	$ 1,033,887
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 304,779
Physician/Office Services		$ 429,956
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 288,026
Dental Care (Does Not Include Orthodontic Services)		$ 98,116
Durable Medical Equipment and Supplies		$ 13,547
Laboratory Services		$ 2,765,820
Other		
CMS		$ 20,452
Direct Services Line 4 Expended Total		$ 3,920,696
Non-Federal Total	$ 17,248,853	$ 8,685,155

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: Used revenue for this type of service	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, Federal Total Budgeted**
	Fiscal Year:	**2019**
	Column Name:	**Application Budgeted**
	Field Note: does not include indirect (25,121)	
3.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. C. Services for CSHCN**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: CMS does not spend federal money on direct services	
4.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Physician/Office Services**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: From SHARE MH 547300	
5.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Hospital Charges (Includes Impatient and Outpatient Services)**
	Fiscal Year:	**2017**
	Column Name:	**Annual Report Expended**
	Field Note: from SHARE MH and FPP account code 535300 and 531100	
6.	**Field Name:**	**IIA. Federal MCH Block Grant, 4. Laboratory Services**

Fiscal Year:	**2017**
Column Name:	**Annual Report Expended**

Field Note:
No expenditures from lab account code 544200

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: New Mexico

Total Births by Occurrence: 23,708 **Data Source Year: 2017**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	21,806 (92.0%)	2,397	78	78 (100.0%)

Program Name(s)				
3-Hydroxy-3-methyglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Critical congenital heart disease
Cystic fibrosis	Glutaric acidemia type I	Hearing loss	Holocarboxylase synthase deficiency	Homocystinuria
Isovaleric acidemia	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency	Methylmalonic acidemia (cobalamin disorders)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Mucopolysaccharidosis Type 1	Primary congenital hypothyroidism	Propionic acidemia	S, ßeta-Thalassemia
S,C disease	S,S disease (Sickle cell anemia)	Severe combined immunodeficiences	ß-Ketothiolase deficiency	Trifunctional protein deficiency
Tyrosinemia, type I	Very long-chain acyl-CoA dehydrogenase deficiency			

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

New Mexico (NM) long term follow up starts at the time of diagnosis up to age 21. Any client diagnosed with a condition identified by Newborn Screen is offered long term follow up. NM long term follow up is a case management system set up to support parents/client after diagnosis. We have social workers though out the state located at every public health office. Once 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, after age 21, follow up is as needed. The Newborn Screening Program wants to ensure that there are no barriers to health care. A follow up form is completed by the social worker at the time of visit and it consists of questions involving how often they see their Primary Care Physician, Specialist, do they have insurance, are developmental milestones achieved, any barriers/challenges in Housing, financial, transportation, obtaining medication etc.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Total Births by Occurrence**
	Fiscal Year:	**2017**
	Column Name:	**Total Births by Occurrence Notes**
	Field Note: Final birth count from NM Vital records for 2017	
2.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2017**
	Column Name:	**Data Source Year Notes**
	Field Note: Provisional	

Data Alerts: None

Form 5a
Count of Individuals Served by Title V

State: New Mexico

Annual Report Year 2017

		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	2,068	27.5	0.0	0.0	72.5	0.0
2. Infants < 1 Year of Age	2,397	59.0	0.0	34.1	6.9	0.0
3. Children 1 through 21 Years of Age	18,524	52.8	0.0	42.0	5.2	0.0
3a. Children with Special Health Care Needs	5,039	66.2	0.0	5.8	28.0	0.0
4. Others	0					
Total	22,989					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2017**
	Field Note: 2017 data. Data Source: NM High Risk Prenatal Care Fund counts and NM Pharmacy vitamin distribution. LM-attended births are included in the total as they are directly licensed and reviewed through Title V. Payer source was estimated based on services provided. Those eligible for Title XIX were estimated because they represent a WIC population, and are therefore eligible for Medicaid. The remaining women served by the HRF have no other source of coverage.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2017**
	Field Note: 2017 data. Data source: NM Children's Medical Services Program. Includes infants served by the Newborn Hearing NBHS and Newborn Genetic Screening NBGS program that attended a follow up appointment for an abnormal screening.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: 2017 data. Data Source: Includes counts from NM DOH programs of Family Planning programming in Title V , Adolescent Health and Injury Prevention.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: 2017 data. Data source: NM CMS client data. Includes data counts from those who receive care from CMS social workers and/or payment of insurance premiums as well as those who are served by but do not qualify for CMS services.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: Others are not reported	

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: New Mexico

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	100
2. Infants < 1 Year of Age	98
3. Children 1 through 21 Years of Age	67
3a. Children with Special Health Care Needs	100
4. Others	0

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2017**
	Field Note: 2017 data. Data Source: WIC clients estimated via weighted PRAMS data. Numerator is the estimated number of pregnant women served in WIC as well as the number of births attended by licensed midwives and certified nurse midwives. Denominator used was the total deliveries number on Form 6. One hundred percent of pregnant women were served by Title V through the perinatal regionalization and the Locate survey.	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2017**
	Field Note: number screened/total birth pop for 2017.Those missing opt out from newborn screening and include missed screens.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2017**
	Field Note: 2017 data. Numerator includes the program-specific counts included in form 5a along with the estimation of the CYFD family visiting program, Oral Health Program, and Child Health Program. Denominator includes the total population estimate for the age group for New Mexico. Missing data includes counts from immunization programs.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2017**
	Field Note: 2017 data. Data source: CMS client data. Denominator is the population of NM CSHCN from the national survey.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2017**
	Field Note: not finalized	

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: New Mexico

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	23,708	6,518	492	13,310	2,812	505	0	0	71
Title V Served	12,807	2,224	247	7,849	2,061	0	0	0	426
Eligible for Title XIX	15,649	3,220	282	8,913	2,606	0	0	0	628
2. Total Infants in State	25,907	6,686	708	15,380	2,749	384	0	0	0
Title V Served	21,806	6,273	379	12,075	2,671	408	0	0	0
Eligible for Title XIX	17,929	4,627	490	10,643	1,903	266	0	0	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: 2017 provisional data. Data source: NM Vital Records	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: 2016 WIC clients served estimated via weighted PRAMS dataset PRAMS estimates were checked against actual WIC counts to verify accuracy. PRAMS estimates were used for the racial breakdown accuracy as WIC did not have that breakdown. We are representing the word 'served' to mean 'administered through Title V' not directly funded.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: 2016 Data. Data Source: Estimated from PRAMS. Weighted data	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: 2016 data. Source: NM IBIS population estimate query We will be updating to 2017 data when available	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2017**
	Column Name:	**Total**
	Field Note: 2017 data. Source: NM DOH Newborn Genetic Screening Program. Racial breakdown estimated from birth population demographics	

6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2017**
	Column Name:	**Total**

Field Note:
2016 data. Source: National Survey of Children's Health estimates for eligibility at 0-299% FPL, ages 0-5 years old. We applied the percentage of those in this age group eligible to the total infants in state population for New Mexico to estimate.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: New Mexico

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(855) 662-7474	(877) 725-2552
2. State MCH Toll-Free "Hotline" Name	New Mexico Crisis and Access Line	Nurse Advice NM
3. Name of Contact Person for State MCH "Hotline"	Optumhealth New Mexico	Connie B Fiorenzio
4. Contact Person's Telephone Number	(505) 798-5640	(505) 855-7744
5. Number of Calls Received on the State MCH "Hotline"		28,931

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address	https://nmhealth.org/about/phd/fhb/mch/	
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:

This hotline is no longer used

Form 8
State MCH and CSHCN Directors Contact Information

State: New Mexico

1. Title V Maternal and Child Health (MCH) Director	
Name	Janis Gonzales
Title	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
Title	Director, Childrens Medical Services
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
Title	Family Voices National Director of Diversity & Outreach
Address 1	Family Voices
Address 2	PO Box 37188
City/State/Zip	Albuquerque / NM / 87176
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 2019

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

Field Note:
Was identified as an emerging need in 2016 cycle. It has been chosen as an NPM for the 2017_2019 submission

Form 10a
National Outcome Measures (NOMs)

State: New Mexico

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

The objectives for adequate insurance are based on the most recent BRFSS data for percent of women ages 18-49 with health insurance coverage. For 2016 that is 89.6%
Percentages for SOM-1 Percent of infants who were usually placed to sleep in crib or bassinet are not mutually exclusive from percent of infants who usually sleep with another person or in a bed.

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
2016	69.6 %	0.3 %	16,669	23,943
2015	72.4 %	0.3 %	17,960	24,802
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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	163.5	9.6	296	18,105
2014	153.3	8.1	367	23,948
2013	155.9	8.0	382	24,502
2012	148.7	7.8	373	25,090
2011	158.0	7.9	403	25,501
2010	135.8	7.3	353	25,988
2009	129.2	6.9	353	27,333
2008	102.7	6.1	284	27,642

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
2012_2016	21.5	4.1	28	129,982
2011_2015	25.7	4.4	34	132,579
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 - 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
2016	9.0 %	0.2 %	2,227	24,680
2015	8.7 %	0.2 %	2,244	25,767
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 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.0 %	0.2 %	2,464	24,676
2015	9.5 %	0.2 %	2,462	25,803
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 - 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
2016	27.6 %	0.3 %	6,814	24,676
2015	27.3 %	0.3 %	7,040	25,803
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
2016/Q2-2017/Q1	1.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			
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
2015	4.3	0.4	111	25,871
2014	5.1	0.4	134	26,117
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
2015	5.1	0.4	131	25,816
2014	5.2	0.5	136	26,052
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
2015	3.1	0.3	79	25,816
2014	3.5	0.4	92	26,052
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
2015	2.0	0.3	52	25,816
2014	1.7	0.3	44	26,052
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
2015	108.5	20.5	28	25,816
2014	180.4	26.3	47	26,052
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
2015	116.2	21.2	30	25,816
2014	46.1	13.3	12	26,052
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
2015	4.5 %	0.5 %	1,044	23,133
2014	6.4 %	0.7 %	1,507	23,569
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 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.4	0.7	171	18,157
2014	9.2	0.6	218	23,723
2013	8.4	0.6	203	24,283
2012	7.7	0.6	193	25,135
2011	5.8	0.5	148	25,553
2010	4.0	0.4	105	26,078
2009	3.5	0.4	94	26,896
2008	3.9	0.4	89	22,828

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 year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.0 %	1.9 %	65,406	466,421

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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
2016	21.8	3.0	53	242,659
2015	23.7	3.1	59	248,557
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
2016	43.2	4.0	120	277,524
2015	43.0	3.9	119	276,621
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
2014_2016	17.1	2.0	71	415,064
2013_2015	13.7	1.8	57	416,705
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
2014_2016	15.4	1.9	64	415,064
2013_2015	14.9	1.9	62	416,705
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 (CSHCN), ages 0 through 17

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.7 %	1.8 %	98,104	497,964

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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), ages 0 through 17, who receive care in a well-functioning system

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	22.0 %	4.6 %	21,538	98,104

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, 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
2016	2.3 %	0.8 %	9,182	404,196

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, 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
2016	9.3 %	1.4 %	37,202	400,344

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, 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
2016	59.4 %	6.6 %	35,427	59,639

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, 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
2016	89.9 %	1.5 %	447,456	497,964

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	12.5 %	0.2 %	2,559	20,515
2012	13.5 %	0.2 %	2,856	21,220
2010	15.7 %	0.3 %	3,438	21,968
2008	13.1 %	0.2 %	2,949	22,514

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
2015	15.6 %	0.4 %		
2013	12.6 %	1.1 %		
2011	12.8 %	1.0 %		
2009	13.5 %	1.2 %		
2007	10.9 %	0.9 %		
2005	12.0 %	1.1 %		

Legends:

Indicator has an unweighted denominator <100 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)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.1 %	2.4 %	25,652	195,211

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.6 %	0.6 %	27,172	486,671
2015	4.4 %	0.5 %	22,133	498,999
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
2016	68.5 %	3.4 %	26,855	39,230
2015	70.1 %	4.0 %	27,390	39,050
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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	63.8 %	2.5 %	295,923	464,048
2015_2016	68.9 %	2.2 %	329,679	478,767
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) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	63.1 %	4.3 %	42,234	66,905
2015	66.7 %	3.9 %	45,476	68,188
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) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	57.9 %	4.3 %	40,311	69,572
2015	54.3 %	4.3 %	38,476	70,913
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	84.3 %	2.3 %	115,084	136,477
2015	85.9 %	2.2 %	119,455	139,101
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) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	77.8 %	2.6 %	106,233	136,477
2015	72.5 %	2.7 %	100,907	139,101
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

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	29.8	0.7	2,019	67,667
2015	34.3	0.7	2,320	67,674
2014	37.5	0.7	2,543	67,756
2013	43.0	0.8	2,959	68,749
2012	47.0	0.8	3,275	69,721
2011	48.4	0.8	3,452	71,318
2010	53.2	0.9	3,872	72,827
2009	60.3	0.9	4,438	73,571

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	11.4 %	0.9 %	2,609	22,818
2014	11.4 %	0.9 %	2,695	23,640
2013	12.6 %	0.9 %	3,048	24,260
2012	14.1 %	1.2 %	3,479	24,737

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

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	4.2 %	1.1 %	21,003	496,705

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New Mexico

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	**2017**
Annual Objective	58.7	62
Annual Indicator	61.1	60.6
Numerator	213,517	212,186
Denominator	349,603	349,927
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	62.3	63.5	64.8	66.1	67.3	68.0

Field Level Notes for Form 10a NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	78.5	87
Annual Indicator	85.5	83.2
Numerator	21,270	20,438
Denominator	24,890	24,563
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	88.4	89.8	91.2	92.6	94.0	95.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	**2017**
Annual Objective	25.6	27.2
Annual Indicator	26.6	24.0
Numerator	6,319	5,708
Denominator	23,784	23,807
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	28.0	28.8	30.4	32.0	33.8	34.0

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.

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		80.5
Numerator		140,946
Denominator		175,148
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	80.8	82.2	83.5	84.7	85.0	86.2

Field Level Notes for Form 10a NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		41.6
Numerator		40,839
Denominator		98,104
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	41.1	43.1	45.0	47.0	49.5	50.0

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	**2017**
Annual Objective		
Annual Indicator		22.5
Numerator		8,575
Denominator		38,131
Data Source		NSCH-CSHCN
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	40.0	41.4	42.8	44.2	45.6	46.4

Field Level Notes for Form 10a NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	**2017**
Annual Objective		
Annual Indicator		85.0
Numerator		386,111
Denominator		454,417
Data Source		NSCH
Data Source Year		2016

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**
Annual Objective	85.9	87.5	89.2	90.0	90.0	90.5

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)

Measure Status:	Inactive - Ongoing work will be reported in annual updates but recording progress over one year with short term goals will limit our state in showing changes.

State Provided Data		
	2016	2017
Annual Objective		83
Annual Indicator	81.3	81.3
Numerator	209	209
Denominator	257	257
Data Source	NM Vital Records	NM Vital Records
Data Source Year	2015	2015
Provisional or Final ?	Final	Provisional

Field Level Notes for Form 10a SPMs:

None

SPM 2 - Percent of infants placed to sleep on their backs

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		80.3
Annual Indicator	75.4	78
Numerator	17,707	17,558
Denominator	23,487	22,517
Data Source	NM PRAMS	NM PRAMS
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	80.9	81.5	83.1	85.7	86.5	87.2

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
NM PRAMS weighted estimates, 2016 births

SPM 3 - Rate of Victims of Child Abuse per 1,000 Children in the Population

Measure Status:	Inactive - Collaboration with stakeholders has been challenging. Pending interagency agreements, we would like to reactivate this measure.

State Provided Data		
	2016	2017
Annual Objective		15.9
Annual Indicator	17.4	17.4
Numerator	8,684	8,684
Denominator	500,037	500,037
Data Source	NM CYFD	NM CYFD
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a SPMs:

None

SPM 4 - Teen Birth Rate, Girls ages 15 to 19 years

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		31.6
Annual Indicator	34.2	29.4
Numerator	2,307	2,000
Denominator	67,519	68,117
Data Source	NM Vital Records	NM Vital Records
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	28.8	26.1	23.4	20.7	18.2	17.6

Field Level Notes for Form 10a SPMs:

None

SPM 5 - Adequate Insurance Across the Lifespan

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	90.0	92.0	94.0	96.0	98.0

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Objectives are based on insurance coverage for women of child-bearing age, NM BRFSS. Adequate insurance is measured in different ways for the perinatal and total population. The measure presented is a representation of any insurance coverage for women of childbearing age.

Form 10a
State Outcome Measures (SOMs)

State: New Mexico

SOM 1 - Percent of Infants who were usually placed to sleep in a crib or bassinet

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	82.0	84.0	86.0	88.0	90.0

Field Level Notes for Form 10a SOMs:

1.	**Field Name:**	**2019**
	Column Name:	**Annual Objective**

Field Note:
Objectives may reflect the indicator exclusive of bed sharing in the future.

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: New Mexico

ESM 1.1 - Percent of completed postpartum visits by maternal clients followed at the Title V Maternity and Family Planning Clinic in metro Albuquerque.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	0
Numerator	0	0
Denominator	100	100
Data Source	UNM Cerner Hosptial Medical Records	UNM Cerner Hosptial Medical Records
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	75.0	80.0	83.0	85.0	87.0	89.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.2 - Number of training opportunities to midwives in the areas of appropriate coding and billing

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Maternal Health Program	Maternal Health Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Field Level Notes for Form 10a ESMs:

None

ESM 1.3 - Out of those who tested positive for pregnancy at the three pilot sites (Teen Resource Center, NMDOH Public Health Office and La Clinica de Familia), the percentage of women who received and completed a first trimester prenatal visit.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	70.0	80.0	90.0	93.0	95.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.4 - Percentage of primary providers that have received training and/or consultation in assessing and treating behavioral health needs.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	10.0	25.0	50.0	75.0	90.0

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

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		29
Annual Indicator	27.2	28.2
Numerator	5,679	5,574
Denominator	20,855	19,734
Data Source	NM PRAMS	NM PRAMS
Data Source Year	2015	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	30.0	31.3	33.0	35.0	37.0	39.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: numerator and denominator were corrected for 2016 and updated for 2017 Definition: percent of women with live birth reporting 8 baby-friendly-related indicators	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Denominator slightly lower than resident in-state birth population due to survey design.	

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.

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		3
Annual Indicator	1	1
Numerator		
Denominator		
Data Source	OSAH	OSAH
Data Source Year	2015	2015
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 10.3 - Percentage of Well visits ages 10-25 for Medicaid patients

Measure Status:	Inactive - Replaced

State Provided Data	
	2017
Annual Objective	25
Annual Indicator	80.7
Numerator	140,946
Denominator	174,575
Data Source	National Survey of Children Health New Mexico
Data Source Year	2016
Provisional or Final ?	Provisional

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Proxy data were used from the National Survey of Children's Health.
Starting in 2019, AYAH CoIIN program data may be used to monitor progress toward objectives for ESM 10.3.

ESM 10.4 - Number of youth and adults who are trained using the Youth Health Literacy Toolkit.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	50.0	75.0	100.0	125.0	150.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.5 - The number of clinics that respond that they have increased their youth friendliness practices by at least two points according to the pre and post surveys given after the Know Your Health Toolkit presentations.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	1.0	2.0	3.0	4.0	5.0

Field Level Notes for Form 10a ESMs:

None

ESM 10.6 - Number of people attending Know Your Health Toolkit presentations

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	70.0	95.0	110.0	135.0	150.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care for CYSHCN.

Measure Status:	Active

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	4	4
Numerator		
Denominator		
Data Source	CMS Training Roll	CMS
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.

Measure Status:	Inactive - This no longer relates to a strategy for this NOM

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	2
Numerator	
Denominator	
Data Source	2017
Data Source Year	2017
Provisional or Final ?	Provisional

Field Level Notes for Form 10a ESMs:

None

ESM 11.3 - The number of outreach events to promote the Medical Home Portal

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	1.0	2.0	3.0	4.0	5.0

Field Level Notes for Form 10a ESMs:

None

ESM 11.4 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal that were accepted into policy.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - Participating in at least one Quality Improvement Project for health care transition and training on the 6 core elements of transition

Measure Status:	Inactive - Replaced

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	N/A	N/A
Data Source Year	N/A	N/A
Provisional or Final ?	Final	Final

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal regarding transition to adult health care that were accepted into policy.

Measure Status:	Active

State Provided Data	
	2017
Annual Objective	2
Annual Indicator	2
Numerator	
Denominator	
Data Source	Family Health Bureau - Title V
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.3 - The number of pediatric providers participating in at least one quality improvement project on transition

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	2.0	2.0	3.0	4.0	5.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.4 - The number of trainings to pediatric providers, families and youth that educate them on transition to adult health care.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	1.0	2.0	3.0	4.0	5.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.1 - Percentage of pregnant women having a dental visit during pregnancy

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	49.0	53.0	57.0	61.0	65.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.2 - Number of oral health promotion activities conducted within the year to promote the importance of oral and general health.

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	18.0	23.0	28.0	33.0	38.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.3 - Number of oral health providers that provide dental sealants and fluoride varnish applications to low income and uninsured and pregnant women

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	9.0	11.0	13.0	15.0	17.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.4 - Number of students who have received oral health education through the programs facilitated by the NM Office of Oral Health

Measure Status:	Active

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	9,353.0	14,353.0	19,353.0	24,353.0	29,353.0

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) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Inactive - Ongoing work will be reported in annual updates but recording progress over one year with short term goals will limit our state in showing changes.
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

Measure Status:	Active
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 - Rate of Victims of Child Abuse per 1,000 Children in the Population
Population Domain(s) – Child Health

Measure Status:	Inactive - Collaboration with stakeholders has been challenging. Pending interagency agreements, we would like to reactivate this measure.
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, Girls ages 15 to 19 years
Population Domain(s) – Women/Maternal Health, Adolescent Health

Measure Status:	Active
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 in population, ages 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

SPM 5 - Adequate Insurance Across the Lifespan
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To improve access to healthcare across the lifespan via adequate insurance options for MCH populations across New Mexico
Definition:	**Numerator:** (n=912) Number of adult women ages 18-49 with health insurance coverage **Denominator:** (1031) Number of adult women ages 18-49 **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	AHS-1 Increase proportion of persons with health insurance AHS-6 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care or prescription medicines
Data Sources and Data Issues:	NM Behavioral Risk Factor Surveillance System (BRFSS), NM-IBIS
Significance:	New Mexico struggles with access to and timely utilization of health services due to chronic poverty, rural and frontier geography and health professional shortage areas. Adequate insurance is an important part of perinatal and childhood healthcare access we seek to address through programs and partnerships in Title V, which many times involves working with different systems to provide coverage. 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. The New Mexico state high-risk prenatal care fund (HRF) provides a safety net for families with otherwise inadequate subsidies or eligibility for Medicaid may be served in this program. Partner programs take a systems approach to making birthing options available to the Medicaid population, not just those with private insurance. Between 62 and 74% of New Mexico's birth population is covered by Medicaid, but Medicaid does not permit for billing lactation consultants or birth doulas. And, although home births by licensed midwives are billable to Medicaid, there have been significant problems with reimbursement to the midwives through Managed Care Organizations.To address the above problem, planning began in 2017 with the Human Services Department/Medicaid Division for a formal training with the licensed midwives (LMs) and the Managed Care Organizations.

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: New Mexico

SOM 1 - Percent of Infants who were usually placed to sleep in a crib or bassinet
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To increase the percentage of infants who were usually placed to sleep in a crib or bassinet
Definition:	**Numerator:** number of women reporting infants that were usually placed to sleep in a crib or bassinet **Denominator:** number of resident occurent births in PRAMS **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-20 Increase the proportion of infants who are put to sleep on their backs with a target of 75.8%
Data Sources and Data Issues:	PRAMS The percent of women whose infant slept in a crib was not mutually exclusive with those who slept in a bed with another person.
Significance:	AAP recommendation to prevent sudden, unexpected death for infants

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: New Mexico

ESM 1.1 - Percent of completed postpartum visits by maternal clients followed at the Title V Maternity and Family Planning Clinic in metro Albuquerque.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To increase the completion postpartum visit under the care of midwives to increasing the likelihood of comprehensive well exam in the maternal population.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Attended post-partum visits within the MF& P clinics in the UNMH Healthcare system</td></tr>
<tr><td>Denominator:</td><td>The number of post partum visits scheduled</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>UNMH Cerner Database</td></tr>
<tr><td>Significance:</td><td>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.</td></tr>
</table>

ESM 1.2 - Number of training opportunities to midwives in the areas of appropriate coding and billing
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Replaced
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:** 1
Data Sources and Data Issues:	Maternal Health Program
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 1.3 - Out of those who tested positive for pregnancy at the three pilot sites (Teen Resource Center, NMDOH Public Health Office and La Clinica de Familia), the percentage of women who received and completed a first trimester prenatal visit.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase by 10% from baseline the number of pregnant women who seek prenatal care in the first trimester from three sites in the Dona Ana County area.
Definition:	**Numerator:** # of pregnant women who received prenatal care within their 1st trimester **Denominator:** # of pregnant women who were identified as pregnant in the specified clinics in the same time period as the numerator **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NMDOH Electronic Health Record System, Teen Resource Center data, and LCDF visit data
Significance:	Early prenatal care is associated with improved birth weight and decreased risk of preterm delivery, both of which are important contributors to infant mortality. It increases the opportunity for mothers and families to access other supports (health, social, legal, environmental, etc.) that can impact the health of both mother and baby across the life course. It is a proxy indicator for access to health care in general, and finally, it is a National Healthy People 2020 goal.

ESM 1.4 - Percentage of primary providers that have received training and/or consultation in assessing and treating behavioral health needs.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	To increase the number of New Mexico health care providers who receive evidence-based training in the assessment and management of behavioral health disorders in prenatal patients.
Definition:	**Numerator:** # of prenatal care providers who have completed training **Denominator:** # of prenatal providers in the state **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NMDOH Bureau of Primary Care; NM Medicaid Provider Enrollment Data; UNM Project ECHO data
Significance:	Women in New Mexico are a particularly high-risk group. Nineteen percent of New Mexican women report symptoms of postpartum depression and that number increases to 24% in teen mothers. Additionally, in a Center for Disease Control comparison study of 17 states, New Mexico had the highest rate of self-reported symptoms of postpartum depression. In addition, many of these women live in disadvantaged environments, which are associated with increased risk for maternal distress. In 2016, the New Mexico Department of Health published a report on concentrated disadvantage and the effects on pregnancy. Concentrated disadvantage is a measure of social wellbeing of a neighborhood including availability of services and opportunities to access health care. Alarmingly, of New Mexico's 499 census tracts, 15.8% were categorized as high concentrated disadvantage and 36.9% fell into medium concentrated disadvantage. Thus, over half of New Mexico's census tracts are classified as medium to high concentrated disadvantage. Finally, a report by the New Mexico Health Care Workforce Committee (2017) gave estimates on numbers of primary care physicians, certified nurse practitioners and certified nurse specialists (CNPs/CNSs), physicians assistants (PAs), obstetrician and gynecology physicians, certified nurse-midwives and licensed midwives in the state. A related analysis of these data revealed that due to the location of these providers, many areas of the state are Health Professional Shortage Areas (HPSA). Forty percent of New Mexico women live in a primary care Health Professional Shortage Area. Critically, 55% of New Mexico women live in a mental health HPSA. If this project is successful, it will provide an innovative care and provider support models that overcomes barriers to accessing symptom management resources for perinatal mental health disorders in this high-risk population leading to healthy maternal-infant dyads and families.

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 B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of birth facilities that have achieved baby-friendly status
Definition:	**Numerator:** Number of PRAMS respondent mothers who report experiencing 8 baby friendly steps at the hospital where they gave birth **Denominator:** Number of PRAMS respondent mothers who gave birth at a birthing facility and started breastfeeding **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	The New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	The 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 designates 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 8 questions that correspond to baby friendly experience, so this ESM will allow New Mexico to assess 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 baby-friendly experience and the number of births in New Mexico.

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.

Measure Status:	Inactive - Replaced
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 visit is of 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 10.3 - Percentage of Well visits ages 10-25 for Medicaid patients
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Replaced
Goal:	To improve the percentage of preventive services among adolescents in CoIIN site clinics
Definition:	**Numerator:** The number of Medicaid recipients ages 10-25 who received an adolescent well visit at each site. **Denominator:** The number of Medicaid recipients ages 10 - 25 who are patients in each site. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	AYAH CoIIN site clinic visit clinic encounter data. Proxy data from YRRS or National Survey of Children's Health
Significance:	Improving Access and Utilization of Preventive Services will increase the number of Well visits ages 10-25 for Medicaid patients. Annual well-visits for adolescent is crucial to improving adolescent health outcomes.

ESM 10.4 - Number of youth and adults who are trained using the Youth Health Literacy Toolkit.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To increase, each year, the number of youth and adults (health educators, clinic staff etc.) that recieve education on youth health literacy in New Mexico.
Definition:	**Numerator:** Number of youth and adults who attend the Youth Health Literacy Workshop **Denominator:** The number of sites that would be appropriate to hold a Youth Health Literacy Workshop in New Mexico **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	NM DOH Office of School & Adolescent Health
Significance:	Training youth and adults such as health educators and teachers in Youth Health Literacy Toolkit, would help to improve adolescent health. Adults are trained to take the information back to their school and/or community to train other youth. This toolkit covers the following topic areas 1)the 7 areas of health, 2) why young people do and don't go to the doctor, 3) what to do before, during and after a doctors appointment, 4) the HEADSSS Model and the importance of preventative annual well exams, 5) Confidentiality and 6) Self-Care. According to Pediatrics Perspectives: Promotion Health Literacy for Children & Adolescents "only 12% of American adults have proficient health literacy, defined as a set of skills needed to effectively function in the health care system. 1 This is troubling given that health literacy is a stronger predictor of health than age, income, employment status, educational level, or race. 2 A growing body of research also shows that low health literacy is associated with worse child health outcomes, 3 higher health care costs, and elevated mortality rates." (Source: http://pediatrics.aappublications.org/content/pediatrics/early/2016/11/08/peds.2016-1937.full.pdf) An annual projection of your measurement for the next 5 years (through 2023): 2017 50 people, 2018 75 people, 2019 100 people Increase one class of 25 people each year.

ESM 10.5 - The number of clinics that respond that they have increased their youth friendliness practices by at least two points according to the pre and post surveys given after the Know Your Health Toolkit presentations. NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To increase the adoption of youth friendly practices and environments in clinical settings that serve adolescents.
Definition:	**Numerator:** The number of clinics that self-report an increase of 'youth-friendliness' by at least 2 points **Denominator:** The total number of clinics that take the survey **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NM DOH Office of School & Adolescent Health
Significance:	The Know Your Health Toolkit promotes Best Practices for Youth Friendly Clinical Services discussed on the Advocates for Youth publication such as ensuring youth confidentiality and respectful treatment from all staff within the clinic (Source: http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services).

ESM 10.6 - Number of people attending Know Your Health Toolkit presentations
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To annually increase the number of people receiving training on youth friendly practices through the Know Your Health Toolkit presentations
Definition:	**Numerator:** The number of individuals who attended a Know Your Health Toolkit presentation in New Mexico **Denominator:** Adolescents and those who serve the health care needs of adolescents in New Mexico **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	NM DOH Office of School & Adolescent Health
Significance:	The more we share information about the Know Your Health Toolkit the more people will utilize it and also share other resources that could be included in the toolkit as we continue to update it.

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care for CYSHCN.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
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:** The number of providers participating in QI around care coordination. **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
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 11.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Inactive - This no longer relates to a strategy for this NOM
Goal:	To implement recommendations that result in policy changes in Medicaid and for the Managed Care organization that strengthen the system of care for CYSHCN.
Definition:	**Numerator:** NA **Denominator:** NA **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	The number of recommendations submitted to Medicaid will counted.
Significance:	Care coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and long-term care services and support and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes. Improvements to care coordination will 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.

ESM 11.3 - The number of outreach events to promote the Medical Home Portal
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To increase the number of outreach events
Definition:	**Numerator:** The number of outreach events completed to promote the Medical home portal in the upcoming year **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NM DOH Childrens Medical Services Program
Significance:	The Medical Home Portal is a project of the Department of Pediatrics, University of Utah Health. Since its inception in 2001, funding for the Portal has come from a variety of foundations, grants, contracts, and gifts from many organizations, none of which involve any commercial stipulations or expectations. One of the numerous premises behind the Portal is that physicians and families sharing information and working together as partners in the Medical Home Model will improve outcomes for CYSHCN. The Portal's Vision: All children and youth with special health care needs (CYSHCN) and their families achieve the best possible outcomes for their health, well-being, and success The Portal's Mission: To assist and support professionals and families in working together (the Medical Home model) to care and advocate for CYSHCN by providing reliable and useful information about their conditions and caring for them and knowledge of valuable local and national services and resources The Portal's Long-Range Goal: To improve outcomes for CYSHCN and their families by enhancing the availability and quality of healthcare, related services, and coordination of care

ESM 11.4 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal that were accepted into policy.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	To get at least one recommendation accepted into a policy change per year
Definition:	**Numerator:** The number of accepted recommendations into policy **Denominator:** N/A **Unit Type:** Count **Unit Number:** 10
Data Sources and Data Issues:	NM DOH Childrens Medical Services Program
Significance:	Care coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and long-term care services and support and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes. Improvements to care coordination will 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.

ESM 12.1 - Participating in at least one Quality Improvement Project for health care transition and training on the 6 core elements of transition
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Inactive - Replaced
ESM Subgroup(s):	CSHCN and non-CSHCN
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
Data Sources and Data Issues:	CMS Program
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.Collaboration with the NM Family to Family Health Information Center and the Center for Development and Disability to provider resources, supports training to adult health care providers, and to families and youth on physical and behavioral health care transition will invariably increase the number of Health Care providers participating in health care transition education and training on the 6 core elements of transition.

ESM 12.2 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal regarding transition to adult health care that were accepted into policy.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To implement recommendations that result in policy changes in Medicaid and for the Managed Care organization that strengthen the system of care for CYSHCN.
Definition:	**Numerator:** The number of recommendations accepted into policy **Denominator:** NA **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	The number of recommendations accepted into policy to Medicaid will counted.
Significance:	Care coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and long-term care services and support and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes. Improvements to care coordination will 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.

ESM 12.3 - The number of pediatric providers participating in at least one quality improvement project on transition
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase the number of pediatric providers who are using QI related to transition
Definition:	**Numerator:** The number of pediatric providers that participate in one or more QI projects about transition. **Denominator:** The number of possible providers that can engage in QI around transition **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Childrens Medical Service Program
Significance:	QI initiatives are used as one strategy by professional organizations to help ease the transition from pediatric-based care to adult-based care. 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. "Transition planning between youth, family and provider has been associated with improvements in satisfaction, continuity of care, and greater adherence to care". Reference: Gabriel et al, 2017; McDanagh et al, 2007; Wojciechoski et al, 2002

ESM 12.4 - The number of trainings to pediatric providers, families and youth that educate them on transition to adult health care.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To increase the number of trainings provided
Definition:	**Numerator:** The number of trainings presented **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Childrens Medical Services Program
Significance:	Continuing education for providers is important, if not mandated by professional medical associations, if not by the employer. The reason is that it is important to stay current on best practices. Specific training provides practitioners with and in-depth understanding of the importance of health care transition. Providing trainings to families, patients and providers creates a greater likelihood that transition is handled correctly in order to maintain continuity of care and medical adherence.

ESM 13.2.1 - Percentage of pregnant women having a dental visit during pregnancy
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Through dental education with WIC participants, the goal is to see more women attending a dental visit, of any kind, during pregnancy so as to avoid gum disease development.
Definition:	**Numerator:** number of women in WIC attending a dental visit during pregnancy **Denominator:** number of pregnant women served by the WIC program **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	NM PRAMS and NM DOH Oral Health Surveillance Data
Significance:	Pregnancy can affect the dental health of a woman due to rising hormone levels. These changes raise the risk of women developing dental health problems which can, in turn affect the health of the baby in utero. The risks to the baby can include pre-term birth and low birth weight (March of Dimes, 2018). Getting a checkup during pregnancy is safe and important for good oral health of pregnant women and their children. Seeing a provider can take care of cleanings and provide procedures like cavity fillings before the baby is born, a dental visit can help with any pregnancy-related dental symptoms a woman might be experiencing. The American Dental Association, the American Congress of Obstetricians and Gynecologists and the American Academy of Pediatrics all encourage women to get dental care while pregnant.

ESM 13.2.2 - Number of oral health promotion activities conducted within the year to promote the importance of oral and general health.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	The goal is to increase the exposure that children and pregnant women in New Mexico have to education on the importance of dental health.
Definition:	**Numerator:** Number of dental health promotion activities done through the NM DOH Office of Oral Health **Denominator:** 100 **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NM DOH Office of Oral Health
Significance:	Being informed about health issues relating to pregnancy will help women to make informed choices about their health and the health of their children. Oral health education teaches skills for good oral hygiene in order to prevent oral diseases and other dental problems. Oral health is important to the overall health and the well-being of infants, children, adolescents and adults. Oral health promotion covers a range of health promotion and disease prevention concerns, including dental caries; periodontal (gums) health; proper development and alignment of facial bones, jaws, and teeth; other oral diseases and conditions; and trauma or injury to the mouth and teeth. Promoting oral health includes integrating chronic diseases as they relate to general health. The oral health promotion campaign will be designed to target New Mexico residents.

ESM 13.2.3 - Number of oral health providers that provide dental sealants and fluoride varnish applications to low income and uninsured and pregnant women
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	To increase the number of providers who are serving low income and uninsured pregnant women
Definition:	**Numerator:** Number of oral health providers that provide dental sealants and fluoride varnish applications to low income and uninsured and pregnant women **Denominator:** Number of dental providers who serve low income and uninsured pregnant women **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	NM DOH Office of Oral Health
Significance:	The New Mexico Departments Health Improvement Plan calls for an increase of preventive services for children (dental sealants/fluoride varnish) a preventive strategy to reduce the incidence of tooth decay and other risk factors. Additional providers in New Mexico will reduce the potential of tooth decay by offering additional preventive services to children especially those residing in rural/frontier Health Professional Service Areas. The New Mexico Office of Oral Health “School Based Preventive Services” Program has been designated as a “Best Practice” by the Association of State and Territorial Dental Directors.

ESM 13.2.4 - Number of students who have received oral health education through the programs facilitated by the NM Office of Oral Health
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	To ultimately increase the number of adolescents that attend a dental visit in the past year by providing health education on oral health directly to adolescents.
Definition:	**Numerator:** The number of students in attendance at health education presentations given through the NM Office of Oral Health **Denominator:** Total number of students that could receive an oral health training by the NM Office of Oral Health **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	NM DOH Office of Oral Health Program
Significance:	To improve the oral health status of children they should understand the importance of good oral hygiene, seeing a dental provider, eating healthy and reduce those risk factors that develop poor oral health. Educating children and adults will improve their oral health literacy; and implement good oral health and eating habits and impacting the use of tobacco and other risk factors.

Form 11
Other State Data

State: New Mexico

The Form 11 data are available for review via the link below.

Form 11 Data