

State of New Mexico



2006

Comprehensive Strategic Health Plan



FOREWORD BY GOVERNOR BILL RICHARDSON



The New Mexico Comprehensive Strategic Health Plan is a roadmap to *Building a Healthy New Mexico*. It reflects my administration's major health care priorities to address health care problems affecting New Mexicans. The Plan will guide state agencies, and provides an opportunity for businesses, elected officials, health planners, medical practitioners and educators with a strategic framework.

The Plan represents broad thinking about how to improve the health of New Mexicans--it is comprehensive, yet focused on some important health status priorities: continued improvement of our accomplishments with immunizations, obesity and nutrition, teen pregnancy and youth suicide. The Plan was designed to present strategic activities targeted at major priorities for the state based on our best opportunities to improve health, as well as clearly laying out objectives and expected outcomes such as addressing health care disparities, improving access and quality of behavioral health, emergency and disaster planning and increasing the health care workforce.

The Plan is not only about health, it is also about how health care and health coverage are linked to New Mexico's future economic development. We are on the forefront of opportunity for New Mexico to recruit and train new workers, provide education and social support for existing and new communities, and to ensure that our children and families lead healthy, productive lives in healthy communities.

Building a Healthy New Mexico is an opportunity for all New Mexicans to help improve our state and challenges individuals to make healthy lifestyle choices for themselves and their families. *Building a Healthy New Mexico* challenges clinicians to provide high-quality care and emphasize prevention and wellness in their practices. *Building a Healthy New Mexico* challenges communities, tribes and businesses to support health-promoting policies in schools, worksites, and other settings. It means everyone in New Mexico has a role to play. I call on all New Mexicans to participate fully with us, to forge new partnerships to address the health care issues and needs we are facing today.

MESSAGE FROM THE SECRETARY OF HEALTH



*Michelle Lujan Grisham
Cabinet Secretary
New Mexico
Department of Health*

Dear Fellow New Mexicans:

I am pleased to present you with the 2006 New Mexico Comprehensive Strategic Health Plan. The authors of this Plan are government agencies, businesses, elected officials, health professionals, and you, the consumers of our state's healthcare. Together, we selected goals, objectives and activities that will further our progress in protecting and improving the health of all New Mexicans.

In 2006, we see notable successes that were made in immunizations, obesity, teenage pregnancy, and youth suicide, the four health status indicators that were highlighted in the 2004 Plan.

Two years in a row, New Mexico was awarded for being the most improved state for immunizations by the Centers for Disease Control and Prevention. This year, the New Mexico Statewide Immunization Information System went live with 99 users and immunization records for 1,214,764 New Mexico children under the age of 6. This system will insure that a child is current with their recommended vaccination schedule, provide reminders when a vaccination is due, and ensure timely vaccinations for children whose families move or switch health care providers.

This year the Coordinated Approach to Child Health (CATCH) program was in 54 schools, reaching more than 16,600 elementary students with nutritional programs and physical activity training.

Nine thousand two hundred eighty-two teens ages 15-17 received family planning services in the Department of Health's clinics. School-Based Health Centers (SBHCs) have increased the number of students served from 7,000 last year to 12,799 this year so far - a 5,799 increase. We are one SBHC short of meeting our 2006 target of 60 new SBHCs. By 2007, our goal is to have 68 SBHCs which is double the number in 2005.

Youth suicide screening and prevention plans were implemented in 10 SBHCs this year with a goal of having plans in all 68 by the end of 2007.

We look forward to continued progress in these areas as well as in the additional health priorities covered in this Plan: health disparities, workforce issues, oral health, behavioral health, health care coverage and access, health emergency management, health care financing and long-term care.

Thank you for your contributions to this Plan and your efforts to implement its goals. As we all work together, we will be successful in improving the health of all New Mexicans.

MESSAGE FROM THE HEALTH POLICY COMMISSION



*Patricio Larragoite, D.D.S.
Executive Director
New Mexico
Health Policy Commission*

I am pleased to present to you, on behalf of the New Mexico Health Policy Commission, the New Mexico Comprehensive Strategic Health Plan. The goal of this Plan is to improve health status and outcomes for New Mexicans by creating and improving access to and quality of health care. Two additional issues to this plan include behavioral and oral health. Many of the issues addressed in this Plan may not be resolved within the next two years, but the strategies to address these issues are critical for success. It will take continued cooperative efforts of state government and public and private entities to achieve the goals of this Plan.

New Mexico is a diverse state that has many health assets and opportunities, but also critical health challenges that must be addressed. Creating a culture of health and fitness depends on addressing the resiliencies and challenges of different socioeconomic, racial, ethnic, and geographic groups. Despite the strong role individual behaviors can play in promoting the State's health, it must also be recognized that larger factors such as economic hardship, environmental problems, inadequate health infrastructure, and poor-quality health education, to name a few, are not changeable by individuals and must be addressed by state and local policies.

To make a difference in health status, New Mexico health system partners must work together to achieve common public health improvement goals. The state's public health system is comprised of many broad-based public and private health partners whose collective mission is to improve health status in New Mexico. No single entity can unilaterally move a population closer toward a culture of health. These partnerships are essential for better coordination of scarce resources directed at the most compelling challenges to health in this state. It is in this spirit of partnership then that this strategic plan must address to provide the vision of health care for the people of New Mexico.

Kind regards,

A handwritten signature in black ink that reads "Patricio C. Larragoite DDS". The signature is written in a cursive style.

Patricio C. Larragoite, DDS

Executive Director Health Policy Commission

TABLE OF CONTENTS

Foreword by Governor Bill Richardson	
Message from the Secretary of Health and The Health Policy Commission	
Introduction	1
Chapter One: Health Disparities.....	2-3
Chapter Two: Workforce Issues.....	4-7
Chapter Three: Immunizations	7-9
Chapter Four: Obesity	9-12
Chapter Five: Teenage Pregnancy.....	12-14
Chapter Six: Oral Health	14-16
Chapter Seven: Behavioral Health	17-22
Chapter Eight: Youth Suicide Prevention	22-25
Chapter Nine: Health Care Coverage and Access.....	25-30
Chapter Ten: Health Emergency Management	30-33
Chapter Eleven: Health Care Financing	34-37
Chapter Twelve: Long Term Care.....	38-40
Appendix A: Statistics by Race / Ethnicity in New Mexico	41
Appendix B: 2005 HPSA Primary Care.....	42
Appendix C: List of Collaborative Agencies	43
Appendix D: List of Advisory Group Members	43-45
Glossary of Acronyms.....	46

Introduction

In 2004, the New Mexico State Legislature determined that the Department of Health, in collaboration with the Health Policy Commission “*shall develop a comprehensive strategic plan for health that emphasizes prevention, personal responsibility, access and quality.*” This 2006 Comprehensive Strategic Health Plan builds upon the initial Plan presented in 2004 by addressing many of the same issue areas and by adding several new sections including oral health and behavioral health.

Government establishes broad priorities and sets policy to improve the health of its citizens. Individuals must be supported in making healthy lifestyle choices for themselves and their families. The job of public and private entities is to encourage positive personal choices and provide quality, affordable health care that is accessible to all. The goal of the Department of Health (DOH), the Health Policy Commission (HPC) and the administration of Governor Bill Richardson is to enhance New Mexico’s health care delivery system and substantially improve access, and the quality of health care in New Mexico.

New Mexico is making significant progress in addressing its health challenges. Alignment of legislative and executive health priorities has supported work at the community level, while private and public sector collaboration has enhanced health service delivery. New Mexico agencies and organizations are working cooperatively and more effectively to address the State’s health issues.

The process of developing this Plan included 15 community meetings throughout New Mexico; consultation with Health Advisory Boards and tribal leaders; Workgroup meetings were held with professionals and experts in each of the 12 chapter subject areas; and a web-based questionnaire to obtain feedback on goals and objectives was made available. The 12 chapter subject areas are as follows:

- Health Disparities
- Workforce Issues
- Immunizations
- Obesity
- Teenage Pregnancy
- Oral Health
- Behavioral Health
- Youth Suicide Prevention
- Health Care Coverage and Access
- Health Emergency Management
- Health Care Financing
- Long Term Care

Many of the issues addressed in this Plan may not be resolved within the next two years, but the strategies to address these issues are critical for success. It will take continued cooperative efforts of state government and public and private entities to achieve the goals of this Plan.

Good health is important to all New Mexicans. Healthy communities and access to quality health care are among the top incentives that attract business to a state. Giving children a healthy start in life is key to their future success. As this Plan is implemented, it is essential that agencies and other stakeholders that participated in its development remain engaged to ensure progress towards improving the health of all New Mexicans.

Chapter One: Health Disparities

Background and Baseline Data

Health disparities are “differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions between specific population groups,”¹ including groups identified by gender, race or ethnicity, education, income, disability, geographic location, or sexual orientation.² These are the same population groups used by the Centers for Disease Control and Prevention and the Healthy People 2010 initiative.

New Mexico has one of the most diverse ethnic populations in the U.S., comprised of 45% Whites, 43% Hispanics, 9% Native Americans, and approximately 2% African Americans. New Mexico has the second highest percentage of Native Americans in the country, and more than a third (36%) of the population speaks a language other than English at home. For examples of disparities experienced by different race/ethnicity groups, see Appendix A.

Compelling evidence indicates minorities suffer disproportionately from many illnesses. The impact of these disparities becomes even more profound when projected population growth is considered, since the minority groups currently experiencing the poorest health status are also the population groups likely to have the highest growth rates. These demographic changes, which are anticipated over the next decade, magnify the importance of addressing disparities in health status today.

Many minority patients who enter the health care system may have difficulty receiving culturally competent services. Culture plays an important role in how patients and families perceive their illness, who should be involved in the treatment, and the self-diagnosis of symptoms. There are cultural differences in beliefs about treatment which include beliefs about the use of technology, the nature of death and dying, and the appropriateness of invading the body. Clients and their families with limited English proficiency may also encounter many obstacles to receiving treatment including delays in making appointments and misunderstandings about their treatment and diagnosis. Health care providers must understand the impact that culture and language have on health and health care.

To reduce health disparities we must expand efforts and services geared toward preventing disease, and focus resources on targeted populations. To do this we will need to improve the collection and reporting of data to correctly identify high-risk populations and monitor the effectiveness of health interventions targeted at these groups.

In order to eventually eliminate health disparities we must improve access to culturally appropriate preventive and treatment services, and create innovative partnerships among health

¹ U.S. National Institutes of Health.

² US Centers for Disease Control and Prevention, Vital and Health Statistics July 2005 Series 2, Number 141.

care delivery systems, health care providers, national, state and local governments, tribal governments, colleges and universities, minority-serving organizations, advocacy groups, communities and community-based organizations including Community Health Improvement Councils (CHICs).

Strategies should include culturally appropriate health promotion efforts that engage individuals in healthy habits and reduce unhealthy behaviors with an understanding of the underlying social determinants of health disparities. Appreciation of these social determinants will help shape appropriate interventions as New Mexicans work collaboratively to eliminate health disparities.

**GOAL 1: Reduce Disparities in Four Priority Health Areas:
Pneumonia and Influenza, Teen Pregnancy, Diabetes, and Alcohol-Related Deaths.**

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Focus on diseases caused by chronic alcohol abuse. 2. Collaborate with health care and Community Health Improvement Councils (CHICs) to ensure appropriate case management models are utilized to target at-risk minority populations with diabetes. 3. Develop teen pregnancy and alcohol-related prevention interventions targeting at-risk minority groups. 4. Continue to work with tribes to utilize prevention and intervention programs and support disease management programs, including cooking schools for diabetics. 	<ol style="list-style-type: none"> 1. Number of CHICs that include health disparities in their plans.

GOAL 2: Mobilize Local, State and Tribal Governments to Reduce Health Disparities.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Promote initiatives that focus on health disparity issues in all community assessments, educational activities, and interventions addressing access to care. 2. Ensure that the process and development of Department of Health and Human Services Department’s plans complement the Statement of Policy and Process signed by the Indian Pueblo Governors of the Indian Pueblo Council, and the Navajo and Apache Nations. 3. Establish a Native American Health Advisory Council to address the health disparities of the Pueblos, Tribes, and Urban Indians. 	<ol style="list-style-type: none"> 1. Native American Health Advisory Council established by August 2006. 2. Increase the number of CHICs that focus on health disparity issues.

**GOAL 3: Expand Access to and Use of Health Care Services by
Improving Cultural Competency Throughout the Health Care System.**

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Develop statewide guidelines on cultural competency for all health-related agencies, and community-based health entities. 2. Collaborate with health care organizations to develop statewide guidelines on cultural competence curricula. 	<ol style="list-style-type: none"> 1. Cultural competency guidelines developed by August, 2007. 2. Number of cultural diversity, sensitivity trainings and educational opportunities provided to employers and the

<ol style="list-style-type: none"> 3. Promote diversity in the health care workforce to reflect the population it serves. 4. Improve access to both written and oral language interpretation for all health care settings, including Native American languages. 5. Consider reimbursements for Native Americans that provide traditional healing ceremonies. 6. Develop a health resource directory for pueblos and tribes, including an inventory of health education materials available in tribal languages. 	<p>employees.</p> <ol style="list-style-type: none"> 3. Written health care materials in appropriate languages for specific communities.
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GOAL 4: Promote the Use of Standardized Gender and Racial and Ethnic Categories for Reporting Health and Health Service Data.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Design standardized data categories dealing with gender, race and ethnicity. 2. Assist Tribes with efforts to develop an Epidemiology Center in Albuquerque by providing staff, technical assistance and consultation. 3. Support the Navajo Nation’s Epidemiology Center located in Window Rock, Arizona. 	<ol style="list-style-type: none"> 1. Increase to 25% the state’s data systems that use the standard health data categories. 2. Tribal epidemiology center established in Albuquerque.

GOAL 5: Increase Knowledge and Awareness Among Policy Makers and Local Governments, Regarding Health Disparities.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Produce a <i>Health Disparities Report Card</i> that provides focused health information and data. 2. Provide technical assistance and information about health disparities to Community Health Improvement Councils, doctors, hospitals, and community-based minority-serving agencies. 3. Include the impact of pending legislation on health disparities in agency bill analysis and fiscal impact reports. 	<ol style="list-style-type: none"> 1. Develop and disseminate <i>Report Cards</i> to hospitals, policymakers and health care providers.

Chapter Two: Workforce Issues

Background and Baseline Data

The lack of primary care and specialty providers is a barrier to access of health services in portions of New Mexico. According to the DOH Office of Primary Care and Rural Health, every New Mexico County except Los Alamos has at least one type of Health Professional Shortage Area (HPSA) classification. (HPSA is a federal designation which qualifies an area to receive special federal assistance. There can be numerous HPSAs within a county.) Primary care has 39

HPSAs, with 18 entire counties designated as shortage areas. Dental care has 35 HPSAs with 21 entire counties designated as dental shortage areas. In mental health there are 29 counties designated as mental health shortage areas. See Appendix B for a map of HPSAs.

New Mexico is a large and rural state with medical services concentrated in the north central part of the state. Nearly 65% of New Mexico physicians practice in Bernalillo, Los Alamos, and Santa Fe Counties, the majority of whom reside in urban areas. For example, 86% of radiologists practice in Bernalillo, Los Alamos and Santa Fe Counties. There is an overall shortage of physicians in New Mexico too. The average number of physicians per 100,000 population is 194 compared to 226 nationally.

Workforce issues are critical to every health priority and impact the entire spectrum of health care delivery – whether it is education (number of qualified faculty and students), distribution of care, recruitment and retention of health providers, cultural competency of providers, access to services, or simply having enough providers to cover the population. Recent research indicates that increasing one primary care physician per 10,000 persons was associated with a 6% decrease in all-cause mortality and an approximate 3% decrease in infant low-birth weight and stroke mortality.³

As of June, 2006, 22,767 licensed nurses have a New Mexico practice address; of these, 19,506 are Registered Nurses (RNs) and 3,261 Licensed Practical Nurses (LPNs). The New Mexico nurse workforce has increased over 15% since 2001. However, more than 44% of RNs and LPNs are over age 50, meaning that 44% of the workforce will need to be replaced within the next five years. The Department of Labor predicts the state will need an additional 4,520 RNs and 680 LPNs by 2012 to cope with an expected 35% increase in population and a rapidly aging population.

The lack of distribution of care is also affected by shortages of paramedics and other emergency medical personnel, pharmacists, behavioral health professionals, laboratory technicians, Advanced and Certified Nurse Practitioners (ANP’s and CNP’s), Physicians Assistants (PA’s), mid level health professionals and many allied health professionals such as medical technologists, physical therapists, and others. The complementary health field, consisting primarily of Doctors of Chiropractic Medicine, and Doctors of Oriental Medicine is not experiencing a crisis in workforce shortages. Current efforts are underway to provide additional training to allow these practitioners to supplement the health provider workforce.

GOAL 1: Increase the Number of Physical Healthcare, Allied Professionals, and Oral Health Workers Through Improved Recruitment and Retention Strategies.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Implement interim midwives provider agreement or voucher program so they can continue to serve pregnant women enrolled in Medicaid. 2. Consider recommendations for nurse recruitment from SJM 37. 3. Utilize retirees to assist in preventive or other health care 	<ol style="list-style-type: none"> 1. Number of practices provided with business management support through New Mexico Medical Society /Office of Workforce Development. 2. 30% of UNM School of Medicine graduates remain in practice in New Mexico.

³ “The Medical Home, Access to Care, and Insurance: A Review of Evidence” by Barbara Starfield, MD, MPH and Leiyu Shi, DrPH, MBA. Pediatrics Vol. 113 No. 5 May 2004, pp 1493-1498.

<p>delivery.</p> <ol style="list-style-type: none"> 4. Develop pilot projects in business management solutions, best practice clearing house and telemedicine support for health professionals to encourage them to practice in rural areas. 5. Work with the Legislature to review a wide range of tax incentives for healthcare providers and make recommendations for implementation. 6. Recommend legislation to add behavioral health professionals and complementary medicine to the Health Loan for Service and Loan repayment programs. 7. Continue SM 7 Malpractice Insurance Task Force Study of recommendations for malpractice insurance relief. 8. Support advanced practice certifications within the complementary professions. 9. Expand dental and pharmacy pre-clubs for getting qualified students into dental and pharmacy schools. 	<ol style="list-style-type: none"> 3. Increase by 30% the "loan for service" funding for nurses, counselors, and social workers with repayment options. 4. Increase the number of LPNs and RNs practicing in New Mexico. 5. Increase to 4,400 the number of licensed doctors practicing in New Mexico. 6. Increase to 700 the number of licensed dentists practicing in New Mexico. 7. Increase the number of health care practitioners recruited annually by 80.
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GOAL 2: Assess New Mexico’s Health Workforce.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Include health providers employed by Veteran’s Administration and Indian Health Service in NM’s licensure survey. 2. Create surveys for Health Professional Education Program Graduates to identify practice decisions. 3. Create a survey for key health sector employers to identify chronic vacancies. 4. Project long term needs by county to address health workforce shortages. 	<ol style="list-style-type: none"> 1. Number of boards that are participating in the licensure renewal survey. 2. Number of counties with long-term health workforce shortage needs identified with projections to year 2010. 3. Physicians’ surveys completed by December 2007.

GOAL 3: Increase the Number of Faculty in New Mexico’s Health Professional Education System.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Develop incentives for health faculty recruitment and retention. 2. Study the higher education funding formula as it relates to health faculty professionals. 3. Utilize telehealth capacity to develop distance learning programs to train health professionals. 4. Identify alternative funding sources for health profession scholarships. 5. Develop seamless curricula (K-20) to facilitate health related education from one level to the next. 6. Allow qualified state employees to supplement 	<ol style="list-style-type: none"> 1. Develop benchmark comparisons of health profession faculty salaries within bordering states. 2. Increase the number of faculty teaching in the health professions.

<p>teaching faculty at higher education levels.</p> <p>7. Remove barriers of placing UNM School of Medicine and School of Nursing students in private practice facilities.</p> <p>8. Implement the Governor’s Workforce Coordination and Oversight Committee recommendations about career pathways for health professionals.</p> <p>9. Develop and fund a joint UNM / DOH / NMSU faculty-share position.</p>	
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GOAL 4: Improve Regulation & Licensing

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Develop a common web portal and overall system to integrate the licensing processes of all boards and commissions related to health professions. 2. Ensure implementation of laws passed in 2006 to streamline the behavioral health licensing protocols and credentialing. 3. Improve the reciprocity procedure for all behavioral and health-related licenses. 4. Develop compacts with other states for licensing across all health professionals. 5. Integrate licensing with federal employers. 	<ol style="list-style-type: none"> 1. Turnaround time reduced for licensing process. 2. Coordinated operations for professional boards and licensing procedures. 3. Number of compacts signed with other states.

Chapter Three: Immunizations

Background and Baseline Data

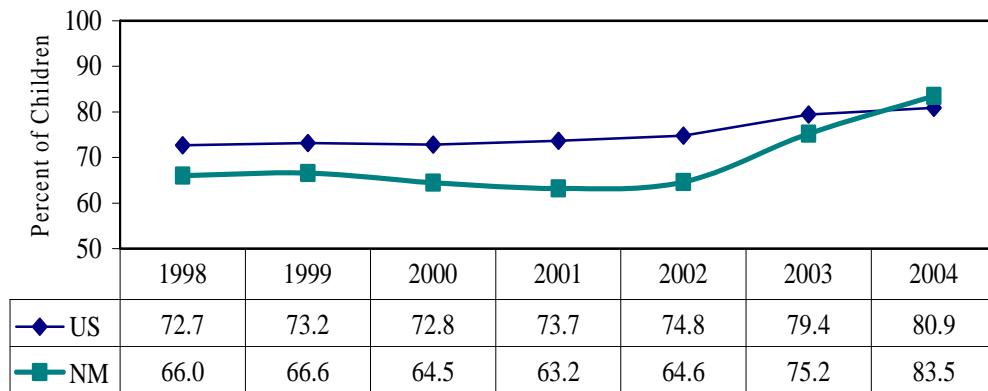
Immunizations are one of the most cost effective public health interventions of the 20th and 21st centuries. Most childhood diseases in the United States, with the exception of pertussis (whooping cough), have been totally or nearly eliminated as a result of routine childhood immunizations.

This incredible success in practically eliminating polio, diphtheria, measles, mumps, rubella and tetanus, among children is a tribute to both the science and the practice of childhood vaccinations. However, maintaining and improving upon these reduced rates of disease requires an ambitious public/private partnership involving the public health system, the medical care system, day care centers, schools, and parents. As new vaccines are developed, the requirements for age-appropriate immunization change. As the number of recommended immunizations increase, so do the challenges to keep children protected.

Barriers to timely immunizations include missed opportunities by health care providers, confusion over schedules by parents, difficulty accessing services, lack of understanding of the importance of immunizations, the number of immunizations required and no established centralized system for tracking children’s immunization status.

In the early 1980s, New Mexico passed a mandatory school entrance immunization requirement – an effective strategy for ensuring that the 90% vaccination rate established by Healthy People 2010 is achieved by school entry. The challenge over the past 25 years has been to complete the required immunizations before children reach the age of 2, in line with the national advocacy group’s campaign named “Every Child By Two.”

Required Immunization Pre-School Coverage Rates for New Mexico and the United States



To increase New Mexico’s immunization rates, the following strategies were implemented:

- Increased collaboration between the New Mexico Medical Society and DOH.
- Created the “Done By One Campaign” and a “Health Passport.”
- Developed a DOH nurse outreach program to assist immunization providers in improving their systems.
- DOH and Human Services Department collaborated to plan, develop, and implement a Statewide Immunization Information System (SIIS) to provide a centralized, accessible source of immunization record history for parents and providers.
- Increased efforts to ensure that “safety-net” vaccinations are provided by the public health system to at-risk children seen in public health offices and Women, Infants and Children programs.

As a result of these and other efforts, between 2001 and 2004, New Mexico’s childhood immunization rates improved dramatically from a low of 63.2% to a high of 83.5%.

GOAL 1: Increase Immunization Rates for All New Mexicans.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Increase vaccinations at School-Based Health Centers. 2. Increase vaccinations for all age groups at public health offices. 3. Vaccinate an additional 10,000 children by 2007. 4. Increase age appropriate immunizations in Native American communities. 	<ol style="list-style-type: none"> 1. At least 95% of preschoolers are fully immunized. 2. At least 98% of adolescents are fully immunized. 3. New Mexico ranks 3rd in the nation in number of children who are fully immunized.

GOAL 2: Increase the Number of Providers Who Will be Using the New Mexico Statewide Immunization Information System (SIIS).

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Populate SIIS and train practitioners on its use. 2. Utilize the Shot Team Nurse Program to review immunization provider records to ensure that they are using SIIS. 3. Increase partnerships with private vaccination providers. 	<ol style="list-style-type: none"> 1. 450 providers utilizing the statewide immunization registry. 2. Number of children younger than age 6 with at least 2 immunizations in SIIS. 3. Number of schools with the ability to access and use SIIS. 4. 80% of childrens’ shots record entered in the statewide immunization registry.

GOAL 3: Improve Immunization Practices in Provider Offices.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Provide on-site assessment, training, and consultation to Vaccines for Children (VFC) providers annually. 2. Develop and initiate a pertussis, pneumonia and influenza educational campaign to increase vaccinations for adults. 3. Increase number of vaccines provided by private providers such as pharmacies. 	<ol style="list-style-type: none"> 1. Number of providers who receive immunization training. 2. 50% of VFC providers will have annual site visits.

Chapter Four: Obesity

Background and Baseline Data

More than half of New Mexico adults are overweight or obese and this number of overweight New Mexicans has more than doubled since 1990. Approximately one in four New Mexico high school students and one in five 2- to 5-year-olds who participate in the Women, Infants and Children (WIC) Program are overweight or at-risk for being obese.

Health risks increase for people with a Body Mass Index (BMI) of 25 or higher, and risk of death increases with a BMI at or above 30. Being overweight or obese is associated with increased rates of chronic disease such as diabetes, cardiovascular disease, asthma, arthritis, and some

cancers.⁴ These chronic diseases are responsible for six out of every ten deaths in New Mexico.⁵ Heart disease and stroke, which also often result from excess body weight, are the leading causes of death in New Mexico, accounting for 30% of all deaths annually.⁶

According to the New Mexico Behavioral Risk Factor Surveillance System and the U.S. Census, an estimated 84,000 adults in New Mexico are currently diagnosed with diabetes, and 80% of them are overweight or obese. Type 2 diabetes, long associated with excess weight and considered an adult disease, is increasingly occurring in children and can no longer be referred to as “adult-onset diabetes.” Complications related to diabetes are serious and include blindness, amputations, kidney failure, and cardiovascular disease. Native Americans are three times as likely, and Hispanics and African Americans are twice as likely to develop diabetes compared to Whites.⁷

Cancer is the second most common cause of death in New Mexico. Excess weight increases the risk of developing a number of cancers, including endometrial, colon, kidney, esophageal and post-menopausal breast cancer. Excess weight can also make diagnosis and treatment of some cancers more difficult, thereby contributing to cancer deaths.⁸

Arthritis and chronic joint symptoms (CJS) affect an estimated 415,000 adult New Mexicans. Obese and overweight adults are 27% more likely than normal weight adults to have arthritis or CJS, and are also more likely to have limitations due to their symptoms.⁹ Weight control and appropriate physical activity are important in both the prevention and management of some of the most common forms of arthritis.

The economic burden of chronic diseases related to overweight and obesity is devastating to the state and national economy. The U.S. spends an estimated \$117 billion annually for direct and indirect medical costs related to obesity and overweight.¹⁰ New Mexico government spends an estimated \$324 million annually on direct adult medical expenditures (preventive, diagnostic and treatment services) that can be attributed to obesity.

The business sector also bears significant costs through lost work time, decreased productivity and health benefit costs. Although these and other indirect costs related to obesity and being overweight have not been measured in New Mexico, a national study shows them to be nearly as high as direct medical costs (Wolf, 1998).

Health promotion efforts focused on individual behavior change alone are moderately effective, but the magnitude of the problem and the rate at which it is increasing call for a broader strategy. Effective programs need to combine environmental supports and policy approaches with efforts that address individual behavior.¹¹

⁴ The Surgeon General’s call to action to prevent and decrease overweight and obesity, [Rockville, MD]: Public Health Service, Office of the Surgeon General; The Guide to Community Preventive Services, 2003.

⁵ Centers for Disease Control and Prevention. *The Burden of Chronic Diseases and Their Risk Factors: National and State Perspectives 2004*.

⁶ Centers for Disease Control and Prevention. *The Burden of Chronic Diseases and Their Risk Factors: National and State Perspectives 2004*.

⁷ (Mokdad et al., 2003).

⁸ Calle, E, Rodriguez C., Walker-Thurmond, K., Thun M (2003). Overweight, obesity, and mortality from cancer in a prospectively studied cohort of U.S. adults. *New England Journal of Medicine*, 348 (17), 1625-1637.

⁹ 2001 NM Behavioral Risk Factor Surveillance System (BFRSS).

¹⁰ Wolf, AM, Colditz, G.A. (1998). Current estimates of the economic costs of obesity in the United States. *Obes Res*, 6:97-106.

¹¹ The Surgeon General’s call to action to prevent and decrease overweight and obesity, [Rockville, MD]: Public Health Service, Office of the Surgeon General; The Guide to Community Preventive Services, 2003.

GOAL 1: Reduce the Number of New Mexicans Who are Obese or Overweight.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Provide additional training to medical providers, including mental health professionals, in the use of BMI for adults and pediatric patients. 2. Change reimbursement policies of public and private health insurance providers to assure obesity prevention and treatment services are being provided to patients. 3. Implement and monitor health education and school wellness policies such as physical education, and nutrition in all elementary through high schools. 4. Expand the “Envision New Mexico” program which trains community providers to measure BMI percentiles and do the appropriate medical work-up for children and youth at risk for diabetes. 	<ol style="list-style-type: none"> 1. 95% of New Mexican adolescents (grades 9-12) who are not overweight or obese. 2. 95% of WIC children 2-5 years who are not overweight or obese. 3. Increase the number of Community Health Councils with obesity listed as a leading priority. 4. Number of medical providers trained to diagnose and treat overweight/obese patients. 5. Number of public and private insurance providers offering overweight and obesity prevention and treatment coverage. 6. Seven sites implementing “Envision New Mexico” Program.

GOAL 2: Increase Positive Perception About Lifelong Engagement in Physical Activity.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Identify and develop strategies to address nutrition and physical fitness activities through the Governor’s Council on Physical Fitness. 2. Implement school wellness policies that include health education, physical education, and nutrition components. 3. Develop, construct and maintain safe and appropriate bicycle and pedestrian facilities, while addressing American with Disabilities Act requirements. 4. Initiate physical fitness activities as outlined in “<i>The New Mexico Plan to Promote Healthier Weight: 2006-2015.</i>” 5. Promote the second phase of the Governor’s “America on the Move Challenge for Healthier Communities and Worksites” to employers. 6. Implement the National Dance Institute of New Mexico’s Hip to be Fit program in public schools. 	<ol style="list-style-type: none"> 1. Number of school districts with wellness policies and addressing physical fitness. 2. Number of programs or campaigns that promote active transportation (walking, bicycling and public transportation) for daily trips such as to work or school.

GOAL 3: Improve Understanding Of, Access To, and Consumption of Nutritional Foods.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Continue the effort to eliminate unhealthy food in school vending machines and cafeteria programs to comply with state and federal regulations. 2. Continue to operate WIC programs and implement WIC FIT KIDS program. 3. Provide child obesity, nutrition, diabetes, and physical education 	<ol style="list-style-type: none"> 1. Number of schools offering the CATCH program. 2. 110 WIC clinics, including 55 statewide public health offices involved in nutritional counseling. 3. Percent of WIC mothers that breastfeed.

<p>information at all CYFD child care programs and Juvenile Probation and Parole Offices (JPPO).</p> <ol style="list-style-type: none"> 4. Implement strategies to address nutrition activities in New Mexico through the New Mexico Task Force to End Hunger. 5. Promote the use of the Coordinated Approach to Child Health (CATCH) program in all New Mexico schools. 6. Implement before and after school physical activity and nutrition programs specifically designed to address obesity and overweight. 7. Work with hospitals and insurance companies to develop and strengthen breastfeeding strategies. 8. Promote the CYFD food / nutrition programs among Native Americans. 	<ol style="list-style-type: none"> 4. Number of CYFD child care programs and JPPO programs providing health and nutrition information. 5. Number of before and after school programs designed to address obesity.
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Chapter Five: Teenage Pregnancy

Background and Baseline Data

Nationally and in New Mexico, teen birth rates have decreased. However, statistics show that New Mexico's teen birth rate is decreasing at a slower rate than the nation.¹² In 2004, New Mexico's teen birth rate was 1.5 times higher than the United States teen birth rate.¹³ The birth rate for Hispanic teens was 2.7 times the rate for White teens. Between 1990 and 2004, the New Mexico birth rate to teen mothers, ages 15-19, declined by 23% compared to a 31.2% reduction nationwide. In New Mexico, the birth rates to African American teens dropped 66.2% and 41.7% for Native American teens. Hispanic teen birth rates dropped 12.2%, while birth rates for White teens dropped by 39%.¹⁴

Teen pregnancy and childbearing are associated with adverse consequences for teen mothers and their children.¹⁵ Teenage mothers are less likely to complete high school or college, less likely to stay married or in a long term relationship, and more likely to require public assistance and live in poverty. Teenage mothers can expect to earn, after taxes, between \$50,000 and \$120,000 less over their lifetime than mothers who delay giving birth until at least age 20. An estimate of the annual extra cost on the State's welfare system for children of teenage mothers is between \$1 million and \$2 million. Overall, the economic impact on society is \$170,000 for each teenage mother, for a total of nearly \$590 million for the approximately 3,500 new teen mothers in New Mexico in 2004. Infants born to teen mothers, especially mothers under age 15, are more likely

¹² The teen pregnancy rate is based on the number of reported pregnancies. Many teen pregnancies are not reported and teen pregnancy statistics include the number of live births as well as the number of induced abortions and fetal deaths. Since not all induced abortions and fetal deaths are reported, teen birth statistics are usually used because they are considered more accurate and can be compared from state to state. The teen birth rate is the number of births to females in a defined population (e.g., county, state) divided by the total number of females in the same population, multiplied by a constant, usually 1,000.

¹³ Hamilton, BE, Martin, JA, Ventura, SJ, Sutton, PD, Menacker, F., Births: Preliminary data for 2004. National vital statistics reports; vol 54 no 8. Hyattsville, Maryland: National Center for Health Statistics. 2005.

¹⁴ New Mexico Selected Health Statistics Annual Report for 2004. New Mexico Department of Health, Bureau of Vital Records and Health Statistics. Forthcoming.

¹⁵ Vexler, E. & Suellentrop, K., Bridging Two Worlds: How Teen Pregnancy Prevention Programs Can Better Serve Latino Youth. Washington, DC: The National Campaign to Prevent Teen Pregnancy. 2006.

to suffer from low birth weight, neonatal death, and Sudden Infant Death Syndrome. The infants of teen mothers may be at greater risk of child abuse, neglect, and behavioral and educational problems at later stages.¹⁶

In New Mexico, more than three fourths (77%) of all births to teens ages 15-17 are unintended.¹⁷ More than half of teens who didn't use contraception thought they couldn't get pregnant. Nearly 31% of new teenage mothers with unintended births said they didn't use contraception because their husband or partner didn't want to use it, and approximately 20% of babies born to teenage mothers in 2003 were repeat pregnancies.

Teen pregnancy is a complex issue. In New Mexico, the diverse cultural and socio-economic backgrounds of teenage mothers has an impact on attitudes related to sexual behaviors. Factors that prevent early and unprotected sexual intercourse have their roots in family, school and community beliefs. The Longitudinal Study of Adolescent Health (ADD Health)¹⁸ documented that adolescents who report that their parents are caring, supportive and aware of their adolescent's activities are far more likely to delay intercourse than their peers. The ADD Health study also demonstrates that adolescents who feel connected to their school are at decreased risk for a number of risk behaviors including early and unprotected sexual intercourse. Teens with risky behaviors, including smoking, drugs and drinking alcohol, tend to have sexual intercourse earlier.

Young people need age-appropriate education for the knowledge and skills to make responsible decisions. Two broad categories of effective programs to delay sexual activity, improve contraceptive use and prevent teen pregnancy are: 1) curriculum-based sex education that discusses abstinence and contraception, and 2) youth development programs whose primary focus is keeping young people constructively engaged in their communities and schools.¹⁹

GOAL 1: Reduce Teen Pregnancy.

Activities	Performance Measures by 2008
1. Increase number of family planning visits through sites such as local public health offices, DOH-funded clinics and school based health centers.	1. Annual birth rate for females ages 15 to 17 reduced from 30 to 20 per 1,000 females.
2. Increase access to family planning services in 55 local public health offices and in DOH family planning clinics.	2. Annual number of births registered at Vital Records for females ages 15 to 17 reduced from 1,518 to 1,100.
3. Increase comprehensive sex education to adolescents in schools or community-based settings and in CYFD juvenile facilities and group homes.	3. At least 24,000 teens ages 15 – 17 receiving family planning services in School Based Health Centers (SBHC) and DOH / Family Planning Program-funded clinics.
4. Provide family planning information in CYFD facilities and through CYFD offices.	4. New Mexico ranks 30 th in the Nation in birth rate per 1,000 females ages 15-17 (down from 40 th in 2006).
5. Engage media to develop and carry consistent and regular messages on family planning and Medicaid enrollment benefits.	
6. Encourage eligible teenagers to access Medicaid funding for	

¹⁶ Healthy Youth 2010: Supporting the 21 Critical Adolescent Health Objectives. American Medical Association.

¹⁷ NMDOH 2003 weighted Pregnancy Risk Assessment and Monitoring System (PRAMS) Data Set.

¹⁸ Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health. JAMA, 1997.

¹⁹ National Campaign to Prevent Teen Pregnancy. (2006) What works: Curriculum-based programs that prevent teen pregnancy. www.teenpregnancy.org/works.

<p>family planning services.</p> <ol style="list-style-type: none"> 7. Utilize and expand Teen Outreach, Plain Talk, male involvement programs and “What Works Curriculum” to reduce the birthrate for second births and unintended births. 8. Include alcohol prevention strategies in teen pregnancy prevention programs. 9. Implement Carrera and/or other teen pregnancy prevention models. 	<ol style="list-style-type: none"> 5. Reduce the percentage of teens who report having unprotected sex.
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GOAL 2: Increase Community Involvement in Teen Pregnancy Prevention.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Provide youth development programs, service learning, employment training, mentorship and internship opportunities. 2. Increase community awareness regarding family planning and teen pregnancy. 3. Improve coordination of State agencies, other entities and services to reduce teen pregnancy. 	<ol style="list-style-type: none"> 1. Number of youth enrolled in youth development programs, service learning, employment training, mentorship and internship opportunities. 2. Number of family planning media campaigns implemented.

Chapter Six: Oral Health

Background and Baseline Data

The single most common chronic childhood disease in New Mexico is tooth decay. Among children, poor oral health leading to tooth decay is five times more common than asthma and seven times more common than hay fever. Tooth decay is a silent epidemic in New Mexico.

In the United States, 30% of all children’s health expenditures are devoted to dental care.²⁰ Although most dental diseases are preventable, many children unnecessarily suffer the consequences of dental diseases because of inadequate home care, and inability to access preventive and treatment services in a timely manner. Furthermore, lack of continuous insurance coverage is a problem for many children and adults.²¹ Nationally, nearly 36% of all children lack dental insurance coverage. For every person without health insurance coverage, there are as many as 2.3 persons without dental health insurance.²²

Oral diseases in adults negatively impact their ability to eat healthy food, their employability and ultimately, their overall health. Several reports link low-grade chronic infection in the mouth (periodontal diseases) to systemic illnesses such as cardiovascular diseases, respiratory ailments, and adverse pregnancy outcomes. Numerous studies indicate a bi-directional relationship between periodontal disease and diabetes.²³ Improved periodontal health in people with diabetes

²⁰ Lewit, EM, Monheit, AC. Expenditures on Health Care for Children and Pregnant Women. *Future Child* 1992; 2(2):95-114.

²¹ U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. 2000. Rockville, MD, National Institute of Health. <http://silk.nih.gov/public/hcklocv.@www.surgeon.fullrpt.pdf>.

²² Bloom, B, Gift, HC, Jack, SS., Dental services and oral health: United States 1989. 10:183. 1992. United States.

²³ Mealey, BI, Rethman ,MP. Periodontal disease and diabetes mellitus: Bi-directional relationship. *Dent Today* 2003, 22 (4): 107-113.

may lead to improved metabolic control and reduced risk of further development of this disease.²⁴ More recent research points to a relationship between periodontal disease and preterm or low birth-weight babies.²⁵

National data reveals a higher rate of disease that presents itself at a much earlier age in the low-income segment of the population. Disparities also exist among differing ethnic groups. Eighty percent of caries occur in only 25% of the children, with higher rates found in low-income populations and certain ethnic groups. Although the Academy of Pediatric Dentistry recommends children have their first dental visit by age 1, very few children in this age group are seen by a dental provider. Rampant decay in young children’s teeth often requires treatment in a hospital setting under general anesthesia, which not only increases the risk for the child but adds to the high cost of treating early childhood tooth decay. Ultimately, a child with poor oral health will likely faces major health problems later in life.

To address childhood dental needs DOH has initiated the following programs:

The Early Childhood Caries Prevention Program, offering oral health care services to infants, toddlers, and pre-school children aged 6 months to 5 years.

- The school-based Oral Disease Prevention Protocol, outlining services provided in the school setting to prevent caries and promote gingival health, and targeting children from 5-10 years of age (K-3rd grade).
- A school-based dental sealant program available in schools where at least half the students are eligible for the free lunch program. The sealant program focuses on students in second and third grades to seal their first permanent molars.
- Fluoridation activities supported by a grant from the federal Preventive Block Grant to support water fluoridation in small communities and provide fluoride mouth rinse for school programs.

A grant from the U.S. Department of Health and Human Services has been used to develop the New Mexico Oral Health Surveillance System (NMOHSS). The NMOHSS is gathering data from a variety of collaborating agencies, including state-level data on lack of dental care access, water fluoridation, dental visits and teeth cleaning, tooth loss among adults, incidence of cancer of the oral cavity and pharynx, the status of caries experience, sealants and untreated decay in third graders.

GOAL 1: Enhance the Infrastructure of New Mexico’s Oral Health Care System.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Continue the development of the New Mexico Oral Health Surveillance System. 2. Assess the current status of the oral health infrastructure and develop recommendations concerning the oral health 	<ol style="list-style-type: none"> 1. Percent of optimally fluoridated water supplies in New Mexico. 2. Number of dental sealant programs.

²⁴ Gossi, SG, et al. Treatment of periodontal disease in diabetics reduces glycated hemoglobin. *Periodontol* 1997; 69: 713-719.

²⁵ Gibbs, R., The relationship between the infections and adverse pregnancy outcomes: An overview. *Ann Periodontol* 2001; 6: 153-163).

<p>infrastructure.</p> <ol style="list-style-type: none"> 3. Increase dental sealant programs, particularly in rural areas. 4. Assess, test and monitor public water fluoridation. 5. Determine the feasibility of creating a dental school in New Mexico. 6. Consider recommendations of the Governor’s Oral Health Council on increasing dental workforce. 	
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GOAL 2: Increase Access to Oral Health Care.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Reduce statutory restrictions on hygienists. 2. Offer incentives to dentists who serve low-income patients and to community based dental programs. 3. Indemnify volunteer healthcare providers. 4. Increase access to prevention techniques such as fluoride varnish, sealants and xylitol. 5. Investigate potential changes to the State’s Medicaid delivery model (reimbursements, automatic Medicaid enrollment and renewal, post-natal coverage). 6. Develop a system to coordinate volunteer dental professionals to expand current efforts (Minnesota model). 7. Ensure access to oral healthcare for underserved populations (subsidized transportation, barrier reduction and provide incentives to dentists). 8. Develop a financing mechanism for community based non-profit dental clinics. 	<ol style="list-style-type: none"> 1. Percent of low-income and Medicaid eligible people receiving oral health care. 2. Number of programs that allow volunteer or part-time workers to provide oral healthcare. 3. Number of dentists who provide services to underserved patients.

GOAL 3: Improve the Awareness of the Importance of Oral Health.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Update school-based health and physical education benchmarks to include oral health. 2. Promote oral health as an integral component of general health. 3. Develop oral health campaigns, including public service announcements. 4. Work with the Higher Education Department to make oral health an integral component for all health professionals education curriculum. 	<ol style="list-style-type: none"> 1. Number of public service announcements. 2. Number of health care professional curriculums with an oral health component. 3. Percent of allied health professionals who think oral health is important. 4. Percent of New Mexicans who think oral health is important. 5. Number of school based health centers that provide oral healthcare.

Chapter Seven: Behavioral Health

Background and History

A large number of New Mexicans are affected by mental illness/emotional disturbance and/or substance abuse or dependence. It is estimated that 14,660 New Mexican youth ages 12 through 17 and 82,235 adults are dependent on alcohol or drugs. This is a rate of 6.5% in New Mexico compared to 4.8% nationally, and a higher rate than any other state except Alaska.²⁶

In the past, New Mexico's behavioral health care was characterized by multiple, disconnected and fractured delivery systems. This resulted in problems obtaining consistent, complete and reliable data for accountability and planning. Other problems included inadequate services, poor benefit design, insufficient resources and the lack of capacity to meet the need for services.

In September 2003, Governor Bill Richardson announced the creation of a collaborative approach to purchasing behavioral health services across multiple state agencies and funding streams. Governor Richardson's vision was stated simply: better access, better services, and better use of taxpayers' dollars.

The Interagency Behavioral Health Purchasing Collaborative, a legal entity with responsibilities for planning, designing and implementing a single statewide behavioral healthcare system, was created by statute in the spring of 2004. As a consequence, the Collaborative statute embeds transformational structures into the authorizing environment of each involved agency. This change does not depend on a particular administration or a particular set of leaders. It is supported by the New Mexico legislature, the involved state departments and agencies, and the consumers, families, advocates, and providers whose work resulted in the statutory framework creating the Collaborative and related structures such as the Behavioral Health Planning Council (BHPC) and the Local Collaboratives (LC's). For a list of agencies comprising the collaborative, see Appendix C.

The BHPC is the Collaborative's single advisory structure, and an important means for consumers and families to play a central role in New Mexico's transformation. By statute, the BHPC is more than one-half consumers and families, and also includes providers, advocates, state agencies, tribal representatives and others the Governor may appoint to assure geographical and ethnic diversity. The BHPC is designed to incorporate the mental health block grant planning activities required by federal law, but also incorporates all previous disparate and fragmented advisory structures as the single advisory council to the Collaborative, the legislature, and the Governor on all matters affecting behavioral health (mental health and substance abuse) prevention, services, planning, resources (grants, block grants, Medicaid, etc.) and advocacy. The BHPC has a voice as a standing agenda item at each Collaborative meeting and has independent responsibility to assess needs and report to the legislature and Governor annually. It is a critical partner in the development of local collaboratives to mirror the state Collaborative and the BHPC in composition and provide local input on needs, planning, resource utilization, and quality oversight statewide. The Collaborative, Local Collaboratives, and the BHPC work together to create points of vision, input, and planning, as well as single-system approaches to purchasing and guiding behavioral health services (prevention and intervention) statewide.

²⁶ <http://www.state.nm.us/hsd/behavioralhealth/DExecutiveSummary.pdf>.

The Collaborative's vision is to create [a] “single behavioral health service delivery system in New Mexico in which available funds are managed effectively and efficiently; the support of recovery and development of resiliency are expected; mental health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and behavioral health customers [consumers] are assisted in participating fully in the life of their communities” (Interagency Behavioral Health Purchasing Collaborative.)

- In July 2005, the Collaborative contracted with ValueOptions of New Mexico (VONM) to act as the statewide entity which would build a statewide Network of over 231 providers and 674 individual practitioners to service children and adults for their behavioral health needs. Twelve months later, ValueOptions reports having served approximately 46,000 persons, 20,000 of whom were uninsured adults with substance abuse or mental disorders.

Accomplishments to Date

Over the past twenty-four months, the following steps have been accomplished:

- Collaborative and BH Planning Council (BHPC) established
- Cross-agency staff workgroups activated (a “virtual department” across agencies, acting as one state)
- RFP issued, proposals reviewed, vendor selected, contract negotiated with ValueOptions
- More cohesive contract for Phase Two developed
- 15 Local Collaboratives developed and recognized within five common geographical regions (13 judicial districts) and a sixth common “region” for 2 Native American populations Common service definitions developed
- First revision of rates toward commonality
- Comprehensive planning efforts started
- First plan due September 30, 2006
- Comprehensive BH planning special appropriation in federal budget
- Legislative priorities for FY 2008 identified
- Intervention in specific trouble spots locally and regionally
- Creation of 34 additional school-based health centers with BH components
- Additional suicide prevention activities
- Additional drug abuse (esp. methamphetamine) funding
- Children’s residential treatment services study and redesign
- Housing plan beginning, with emphasis on adults with serious mental illness and youth in transition to adulthood
- Primary care and BH interface to address pharmacy and psychiatric consultation based on acuity rather than diagnosis, especially for rural areas

- Provider capacity survey, report, and training
- Executive Order to address licensing and credentialing of professional workforce (psychologists, social workers and counseling professions); three pieces of legislation to make reciprocity easier
- Consortium for BH Training and Research (CBHTR) kicked off with new Department of Higher Education to address workforce and evidence-based practices development and dissemination
- Multiple grants sought and supported
- Transformation Grant obtained from SAMHSA to fund 20+ staff and assist with technical assistance and consumer/family involvement
- Methamphetamine/Substance Abuse Grant with local providers
- Telehealth services grant to develop curriculum and capacity (just received word that 2nd year funding is in federal budget)
- Evaluation efforts begun; evaluation resources obtained
- Initial data from first six to nine months started to come in and be reconciled
- Claims payment issues identified and being addressed at state, VO and provider levels; DOH and HSD planning meeting with providers and VO about identified issues
- 21 performance measures (40+ metrics) identified for Phase Two and Three
- Medicaid state plan changes done or underway – ACT, MST, IOP, CCSS, telemedicine
- Increased Medicaid expenditures with additional federal funds
- Reinvested over \$5 million in local communities in FY 2006; developed criteria and process for over \$6 million for FY 2007
- Creating coordinated legislative process with Local Collaboratives
- Cross agency teams solidified and work plan set

In the area of substance abuse prevention, the Behavioral Health Service Division has conducted comprehensive planning since 2002. Building on the success of the previous two plans, New Mexico's third five-year strategic plan for prevention services clearly demonstrates the positive growth of New Mexico's Alcohol, Tobacco and Other Drug Abuse (ATODA) Prevention System. Embracing evidence-based practices, New Mexico has established effective prevention programming at the community and state level and, since its inception, has built capacity in urban and rural communities statewide.

The second Five-Year ATODA Prevention Plan (2002-2006) moved New Mexico forward in the areas of planning, implementing, and evaluating evidence-based prevention. The first Five-Year ATODA Prevention Plan (1996-2001) provided the direction for the New Mexico State ATODA Prevention System, bringing the state system to par with the current best-practices of ATODA prevention in our nation.

Moving on to a higher level, New Mexico will utilize the third Five-Year ATODA Prevention Plan (2007-2012) to guide it in the state’s journey to enhance the high quality of effective prevention programs and services to New Mexicans. This coordinated effort, along with the use of data-driven planning, the use of proven effective practices, along with the implementation of evidenced-based programming statewide, will continue to move New Mexico forward. Based on the Strategic Prevention Framework (SPF), New Mexico’s plan has set goals and measurable objectives in each of five components: Assessment, Capacity, Planning, Implementation, and Evaluation. (For a more detailed analysis, see *State of New México: Alcohol, Tobacco and Other Drug Abuse Prevention, Five Year Statewide Plan, 2007-2012* at <http://captus.samsha.gov/southwest/SWCAPTNew.cfm>).

The state is in the process of developing a Methamphetamine Plan to address that growing problem in New Mexico. Governor Richardson signed legislative bills in 2006 that appropriate funding for substance abuse facility development, specific initiatives targeted at methamphetamine prevention and treatment, and initiatives that can target methamphetamine users as part of increased substance abuse and treatment services in schools and communities. The plan will include strategies for the prevention of new methamphetamine use and for the implementation of new treatment models.

Priority Needs, and Issues and Implications for the Planning Process

The challenge of the Comprehensive Planning effort is to integrate a range of priority need areas and establish reasonable, clearly communicated operational goals through an inclusive and transparent process. The Collaborative is in the process of finalizing its legislative priorities for behavioral health. Integral to these priorities is the input provided by each Local Collaborative through focus groups and by the BHPC. An initial review suggests clear priority need areas with some consistency statewide. Priorities identified through the needs and resource inventory process are being mapped with the overarching New Freedom Commission Goals, the goals of the Governor’s Contract for a Healthy New Mexico, and the Collaborative’s performance measures and phased goals of the Behavioral Health Collaborative.

GOAL 1: Improve Access, Quality, and Value of Mental Health and Substance Abuse Services Through an Interagency Collaborative Model.

Activities	Performance Measures by 2008
1. Evaluation process underway including process, system performance and customer/family outcomes.	1. Percent of people receiving substance abuse treatment who demonstrate improvement on three or more domains on the Addiction Severity Index (ASI).
2. Identify matching funds and include increased evidence-based and promising practices in the Medicaid state plan.	2. Percent of individuals discharged from inpatient facilities who receive follow-up services at 7 and 30 days.
3. Increase provider capacity to deliver evidence based practices and new changes to Medicaid state plan.	3. Number of customers / families reporting satisfaction with services.
4. Continue implementation of standardized service definitions across Collaborative Agencies and begin coordination with county services, and services purchased through Administrative Office of the Courts.	4. Percent of adults with serious mental illness receiving services in competitive
5. Continue development and technical assistance for local	

<p>collaboratives, especially regarding community and family involvement.</p> <ol style="list-style-type: none"> 6. Focus statewide entity reinvestment funding on priorities needed to improve access, quality and outcomes. 7. Complete and implement service capacity development plans in priority areas. 8. Implement new intensive substance abuse and methamphetamine capital and services plan with FY state general funds approved by the collaborative. 9. Complete consumer / family satisfaction surveys for FY 06. 10. Increase availability of services to underserved populations. 14. Set standards and implement telehealth rural psychiatry capital projects and telehealth behavioral health workforce efforts. 	<p>employment of their choice.</p> <ol style="list-style-type: none"> 5. Percent of children and adolescents with severe emotional disturbances receiving services who are successful in school. 6. Percent of individuals with mental illness and/or substance abuse disorders receiving services with decent, safe, affordable housing. 7. Percent of individuals with mental illness and/or substance abuse disorder receiving services who are homeless. 8. Percent of adults with substance abuse who are screened for psychiatric issues. 9. Percent of adults presenting with psychiatric issues who are screened for substance abuse. 10. Percent of adults and youth served who have contact with juvenile justice or adult corrections. 11. Number of individuals served annually in substance abuse and mental health programs through the statewide entity. 12. Percent of expenditures for community-based services operated by consumers / families as share of total community-based expenditures.
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GOAL 2: Provide Enhanced Services to High-Risk and High-Need Individuals.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Provide intensive services/supports for children/ adolescents with behavioral health needs in custody or at-risk of out-of-home placement. 2. Implement Functional Family Therapy statewide for at-risk child welfare and juvenile justice adolescents. 3. Increase services for persons with behavioral health needs leaving jails or prisons, including youth leaving the juvenile justice system. 4. Explore and implement inclusion of traditional healers and culturally specific healing practices in service definitions. 5. Work with State and local military and veteran’s organizations to develop programs and services that address suicide-related issues for veterans and their families. 6. Develop a state-wide pool of therapists that are specifically trained to treat veterans with Post Traumatic Stress Disorder associated with service in war zones and the related challenges facing their families. 	<ol style="list-style-type: none"> 1. Number of individuals served in evidence-based practice programs. 2. Percent of children with improved functional assessments between intake and return to the community. 3. Veteran’s Health Summit by December, 2007. 4. Number of therapists trained to treat Veterans’ mental health issues. 5. Number of Veterans seeking services that are seen within 3 days of requesting services. 6. Number of high-risk individuals served in substance abuse and mental health programs. 7. More than 84% of program participants between the ages of 12-17 perceiving drugs as harmful. 8. More than 13,700 parents participating in

<ol style="list-style-type: none"> 7. Train providers in Eye Movement Desensitization and Reprocessing, a therapeutic intervention recommended for Post Traumatic Stress by the Veterans Administration and the Department of Defense. 8. Train providers in veteran’s opportunities and benefits provided by the state and federal government. 9. Conduct an Employment Barrier Screening and Assessment to identify personal and family barriers to employment. 10. Provide trainings to Medicaid providers, including Indian Health Services and Tribal 93-638 Self Determination facilities, to ensure timely and accurate Medicaid reimbursement for behavioral health services. 11. Provide technical assistance to tribal entities for recognition as local collaboratives. 12. Work with state and federal agencies to equalize reimbursements for behavioral health care, among various providers and with various payment schedules. 	<p>substance abuse prevention programs.</p> <ol style="list-style-type: none"> 9. More than 40% of clients completing Functional Family Therapy who do not become re-involved with the juvenile justice system, within one year post-discharge. 10. Number of DWI arrests among persons receiving substance abuse treatment / services. 11. Number of illicit drug arrests among persons receiving substance abuse treatment / services.
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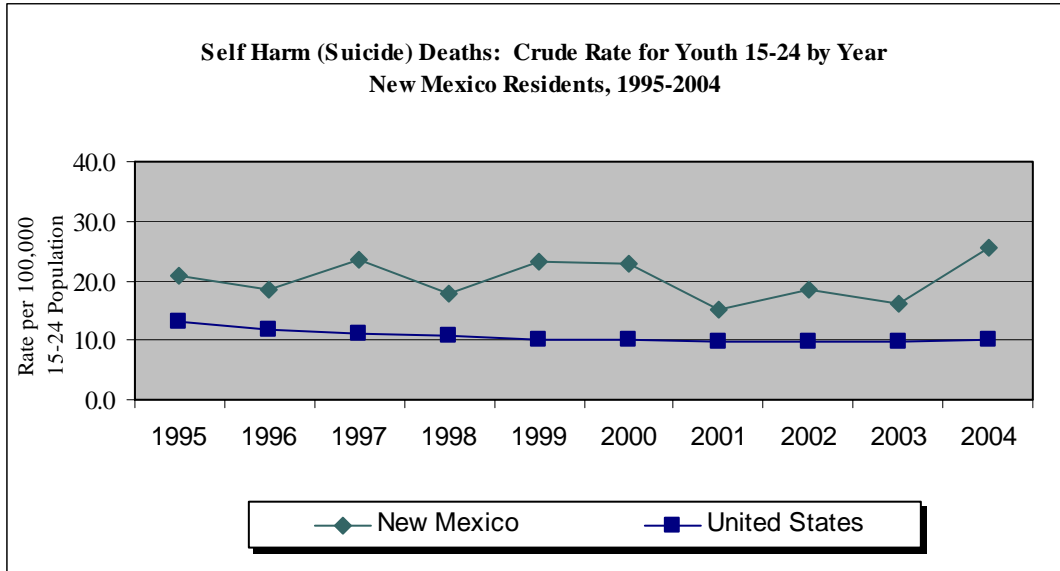
GOAL 3: Increase Rural, Frontier, and Border Access to Behavioral Health Services.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Increase the use of promotoras, peer specialists, and practitioners / programs designed specifically for persons who are Native Americans or who are Spanish-speaking as part of capacity development in the area of cultural competence. 2. Expand telehealth services in rural New Mexico. 3. Seek funding for development of ACT team, mobile crisis team, and crisis residential unit in Las Cruces. 4. Implement 2007 substance abuse and methamphetamine plan. 5. Coordinate with Native American populations to expand the Tribal Healing to Wellness Court Program. 	<ol style="list-style-type: none"> 1. Percent of individuals in rural and frontier locations with access to an appropriate behavioral health provider within 60 and 90 miles respectively. 2. Number of programs/agencies using promotoras, peer specialists, and practitioners / programs designed specifically for persons who are Native Americans or who are Spanish-speaking.

Chapter Eight: Youth Suicide Prevention

Background and Baseline Data

Suicide among youth aged 15-24 is a major health crisis in New Mexico. In 2004, the national youth suicide rate was 10.1 per 100,000, while New Mexico’s rate was an alarming 25.5 per 100,000. Nationally, suicide is the third leading cause of death for this age group. In New Mexico it is the second leading cause of death. The graph below illustrates a comparison of the trend in suicide deaths for New Mexico and the United States over the past 10 years.



Suicide is more common in adolescent and young adult males than in females. However, suicide attempts are three times more common in females than in males. The following chart shows that youth suicide in New Mexico is highest among Native Americans and is higher among Hispanics than among Whites.

Self Harm (Suicide) Deaths: Number and Rate for Youth 15-24 by Race/Ethnicity New Mexico Residents, 2000-2004				
Race/Ethnicity	5-Year Total Number	Average Number	2002 Population	Rate /100,000
All Races	280	56.0	284,935	19.7
American Indian or Alaska Native	49	9.8	37,718	26.0
Asian or Pacific Islander	6	1.2	5,269	22.8
Black or African American	5	1.0	8,270	12.1
Hispanic	132	26.4	131,602	20.1
White	88	17.6	102,077	17.2

Rate per 100,000 age 15-24. Rates based on fewer than 20 events may be statistically unreliable and should be interpreted with caution. Rate numerator is the 5-year average. The denominator is the mid-year population (2002).

Note: The Hispanic category does not include American Indian, Asian or Pacific Islander or Black decedents.

Source: New Mexico Vital Records and Health Statistics.

New Mexico ranks alarmingly high in a number of other indicators and risk factors related to youth suicide, including:

- There are only 36 licensed child psychiatrists in the state. The rural areas rarely have a continuum of community-based, affordable behavioral health care providers.
- In 2002, New Mexico had the 3rd greatest proportion of children living in poverty among all 50 states, the 16th highest teen death rate for homicide, suicide and accidents combined, the 4th highest percentage of teens not in school or working and the 2nd highest teen dropout rate.²⁷

The New Mexico Suicide Prevention Coalition and DOH have created the New Mexico Youth Suicide Prevention and Early Intervention Initiative, a comprehensive model that has increased statewide and local capacity to prevent and respond to suicide.

Goal 1: Reduce Suicides in Youth ages 15-24 By Developing Effective Suicide Prevention/Intervention and Postvention Programs.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Increase the number of behavioral health encounters in SBHCs. 2. Provide prevention strategies, education and outreach to 5,000 at-risk families per year. 3. Increase reliance on telehealth counseling to 8 school-based health centers and juvenile justice facilities. 4. Increase screening of teens at schools, public health clinics and private providers to identify at-risk youth. 5. Promote positive youth development opportunities in communities, schools and workplaces, Juvenile Probation and Parole offices and juvenile justice facilities. 6. Increase the number of Intergovernmental Agreements with tribes and pueblos to refer Native American youth to Tribal Healing-to-Wellness courts. 7. Implement the Substance Abuse and Mental Health Services Administration (SAMHSA) prevention and early intervention grant for youth suicide in Gallup, Pojoaque, Carlsbad and Mescalero. 8. Develop post intervention resources in communities, including survivor support and community responsiveness. 9. Establish programs to address specific needs of returning U.S. Military (and non-military contractor) Veterans aged 17 – 24. 	<ol style="list-style-type: none"> 1. Youth suicide rate among 15 to 19 year olds is reduced from 10 to 3 per 100,000. 2. Youth suicide rate among 20 to 24 year-olds is reduced from 16.0 to 6.3 per 100,000. 3. New Mexico ranks 30th nationwide (down from 41st) in number of youth suicide among 15 to 24 year-olds. 4. Reduction from 19% to 14% of youth reporting they have considered suicide. 5. Reduction from 7.5% to 0% of youth who report they have attempted suicide. 6. Number of calls to DOH-funded youth response hotlines. 7. Number of SBHC’s utilizing Suicide Prevention Plan / Protocol. 8. Number of Mental Health providers trained in crisis response. 9. Number of contractors with the ability to provide postvention resources.

Goal 2: Develop Youth Suicide Prevention Regional Coalitions.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Strengthen the collaboration between all entities that address 	<ol style="list-style-type: none"> 1. Number of CHICs engaged with youth

²⁷ Annie C. Casey Foundation, 2006. <http://www.ascf.org/kidscond/sid>.

<p>behavioral health and youth suicide issues.</p> <ol style="list-style-type: none"> Support the existing Grassroots Suicide Prevention Coalition. Ensure that youth voices are represented in all School Health Advisory Councils and in regional coalitions. 	<p>suicide prevention activities.</p> <ol style="list-style-type: none"> Number of youth on School Health Advisory Councils.
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Goal 3: Develop a Social Marketing Campaign and Implement Outreach Efforts to Raise Awareness and Reduce Stigma.

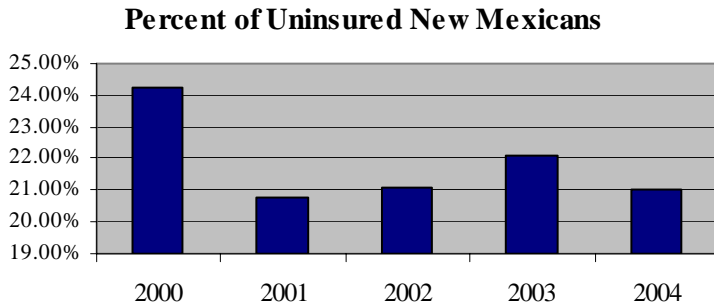
Activities	Performance Measures by 2008
<ol style="list-style-type: none"> Educate families and communities on youth suicide issues, including stigma reduction through social marketing and outreach campaigns. Facilitate discussion with Native American communities on the youth issues of suicide, teen pregnancy, domestic violence, substance abuse and alcohol as identified in the DOH produced video “REZ Hope” to increase awareness and promote community action. Advertise the toll-free crisis hotline and address the stigma associated with seeking help for depression and suicidal thoughts. Increase the number of outreach and behavioral health educational presentations to youth. Develop outreach programs that acquaint the public with the early warning signs of suicide and provide information on how to best respond to at risk individuals. Develop a youth speakers’ network to present information regarding youth suicide prevention. Develop a web-based suicide prevention resource page. 	<ol style="list-style-type: none"> Number of calls to the DOH-funded youth response hotline. Number of youth who are trained to make presentations about youth suicide prevention. Number of youth suicide prevention presentations made by suicide prevention trained youths. Number of people who are familiar with signs and symptoms of depression.

Chapter Nine: Health Care Coverage and Access

Background and Baseline Data

New Mexico has one of the highest uninsured rates in the country. To better understand the extent of the problem, several surveys related to the issue of uninsured residents have been conducted throughout the state, including a 2004 household survey and an employer survey conducted in 2004-2005 by the Health Policy Commission (HPC). Smaller studies were conducted by the General Services Department and NGO-New Mexico (Non Governmental Organization), a statewide non-profit organization.

Percent and Number of Uninsured New Mexicans.

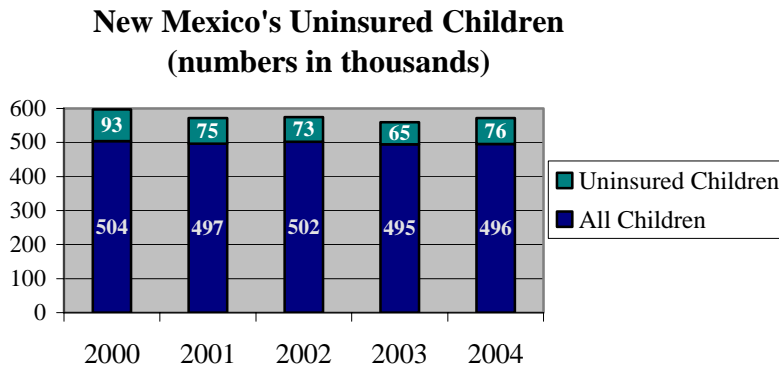


Year	Number Uninsured
2000	435,000
2001	373,000
2002	388,000
2003	414,000
2004	399,000

Estimated by US Census Bureau Current Population Survey²⁸

The table below shows the number and percent of New Mexicans 0-18 years of age that were uninsured during the past five years. Uninsured children ages 0-5 are particularly at-risk for preventable childhood illnesses, undetected developmental disorders, and other delays in healthy childhood development.

Number and Percent of Uninsured Children 18 Years of Age and Younger.



Year	Percent Uninsured
2000	18.5%
2001	15.0%
2002	14.5%
2003	13.2%
2004	15.3%

Source: U.S. Census Bureau, Historical Health Insurance Table HI-06.

In 2004, the Human Services Department (HSD), in conjunction with the State’s Health Policy Commission, administered a statewide household survey on the uninsured in the state. The key findings of the household survey are as follows:

- Native Americans are most likely to be uninsured (28%). Hispanics are twice as likely (23%) to be uninsured, as compared to Whites (11%).

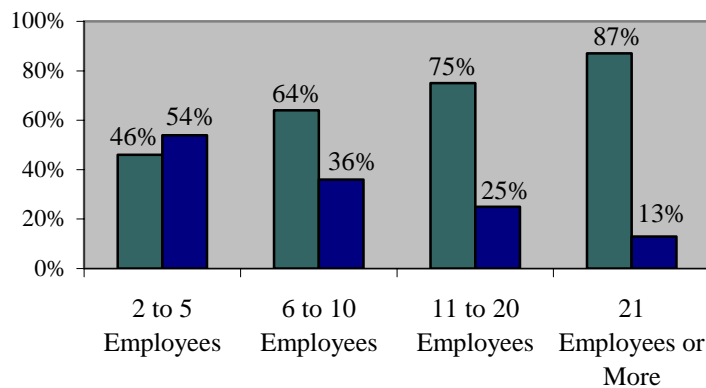
²⁸ 2004-2005 Health Policy Commission survey.

- Uninsured rates peak among 18 to 24 year olds at 31% and drop to 29% for 25 to 34 year olds and 22% for 35 to 49 year olds.
- Adult women are slightly more likely than adult men to be insured. The uninsured rates are 17% for women and 19% for men.
- Northwestern and Southern New Mexico have the highest uninsured rates. The Albuquerque metro area has the lowest rate, although there are significant differences within Albuquerque depending on income levels and geographic areas.
- Among households below the Federal Poverty Level (FPL), 35% had at least one household member who was uninsured. Among households earning less than 185% of the FPL, 30% had a household member who was uninsured. Among households earning less than 235% of the FPL, 18% had an uninsured household member.
- Among uninsured adults, 17% report working full-time, 31% are self-employed, 31% work in seasonal employment, and 41% work multiple part-time jobs.

In 2004, the HPC initiated an employer survey that indicated 41% of New Mexico’s employers (with two or more employees) did not provide health insurance coverage for their employees. A correlation was seen between average salary level paid to employees and whether the organization offered a company sponsored plan. When salaries were less than \$30,000, the rate of insurance coverage dropped. When compared to larger organizations, small employers were more likely to pay their employees less than \$30,000.

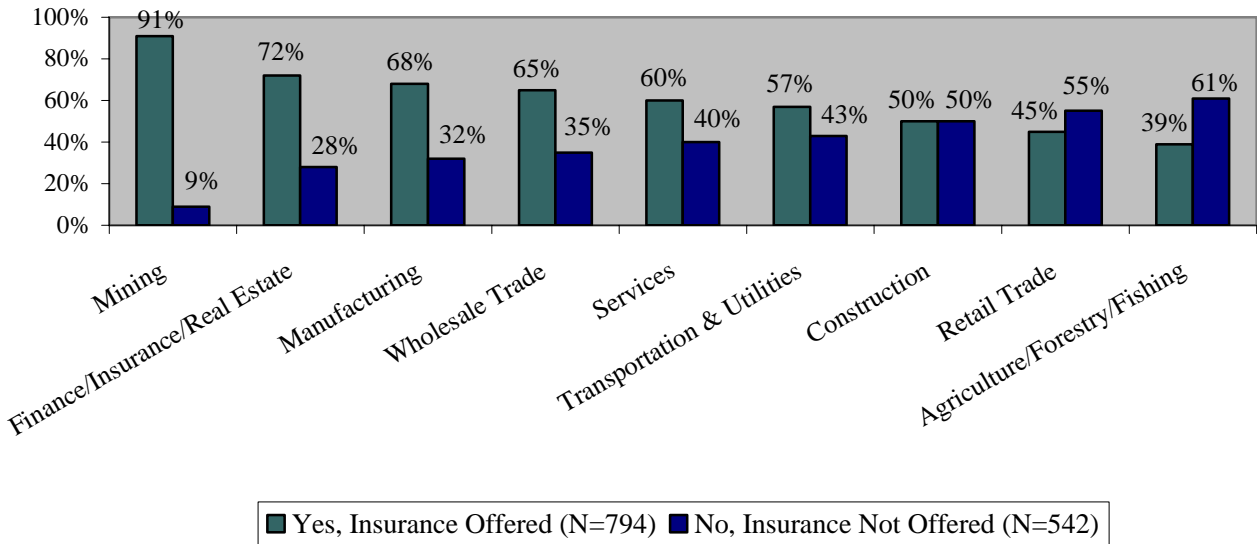
Employers faced a variety of barriers when it came to offering health plans, but the primary obstacle was cost. Eighty-one percent of respondents said, “It is too expensive” or “I can’t afford it.” Cost is a crucial factor in the decision whether or not to offer insurance and enroll in an insurance plan in New Mexico. The second most common reason given was a lack of interest/participation by employees, though this was mentioned by only 10% of the employers who did not offer insurance.

**Health Insurance Rates Among Employers,
by Number of Employees**



■ Yes, Insurance Offered (N=794) ■ No, Insurance Not Offered (N=542)

Health Insurance Coverage Rates Among Employers By Industry Category



In order to address the number of uninsured in New Mexico, a partnership formed which includes the HSD and various public and private stakeholders, to plan and implement ***Insure New Mexico!*** These efforts have enabled New Mexico to work with employers and entities from the health insurance market to develop viable coverage options targeting the uninsured.

GOAL 1: Provide Small Employers More Options for Affordable Health Insurance.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Implement the Small Employer Insurance Program (SEIP). <ol style="list-style-type: none"> a) Develop benefit plan and premium rates. b) Implement Administrative Services Only (ASO) agreement. c) Implement counseling and enrollment system for groups. d) Complete database design for billing and enrollment. e) Utilize New Mexico Medical Insurance Pool and State Coverage Insurance (SCI) program to cover all employees of any given employer. f) Begin SEIP marketing campaign including advertising and website. 2. Continue outreach by the New Mexico Health Insurance Alliance (NMHIA), in collaboration with 	<ol style="list-style-type: none"> 1. More than 500 individuals insured through SEIP. 2. Number of employers participating in State Coverage Insurance Program. 3. More than 6,000 individuals insured through NMHIA. 4. More than 3,600 inquiries received at the NMHIA. 5. More than 37% of children with court-ordered medical support covered by private insurance. 6. More than 87% of NM employers with 21 to 50 employees offering insurance. 7. More than 75% of NM employers with 11 to 20 employees offering insurance.

<p>state agencies, to educate groups and individuals about insurance options to help with retention and initial purchase of insurance coverage.</p> <ol style="list-style-type: none"> 3. Increase Child Support Enforcement field office outreach to small employers regarding their rights and responsibilities in providing coverage for dependents of employees. 4. Submit <i>Insure New Mexico!</i> recommendations to the Governor for 2007 legislative session. <ol style="list-style-type: none"> a) Phase in the requirement by FY08 that companies doing business with the state must offer health insurance benefits to their New Mexico employees. b) Require that state workers enrolling in GSD/RMD’s program for FY 08 provide proof of health coverage from another entity and collect data on employees that do not show proof of other insurance. c) Provide Medicaid for Adults – Ask for a two-year phased in program to provide Medicaid for adults. d) Expand the State Coverage Insurance (SCI) program to extend coverage to adults between 200 and 300% of the federal poverty level. e) Analyze the benefits and cost of various models for providing coverage for all New Mexicans using a stakeholder committee. 5. Conduct outreach to local public entities that are statutorily permitted to participate in General Services Department/Risk Management Division’s health insurance program but do not currently offer insurance for their employees. 	
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GOAL 2: Provide New Mexicans More Opportunities for Affordable Health Insurance.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Increase medical support order to increase the number of children receiving insurance through non-custodial parents’ employer-sponsored insurance. 2. Implement the Premium Assistance Program (PAP) for non-Medicaid eligible children beginning July 2006, and pregnant women beginning September 2006. 3. Increase Medicaid enrollment of children by increasing outreach statewide, especially through schools, childcare and pre-kindergarten programs. 4. Implement rule changes for children 0-5 and pregnant women increasing income disregards so that more 	<ol style="list-style-type: none"> 1. More than 286,000 New Mexicans age 0-20 insured through Medicaid and State Children’s Health Insurance Program (SCHIP). 2. More than 101,000 children age 0-5 insured through Medicaid and SCHIP. 3. More than 1,550 children insured through PAP. 4. More than 10,000 adults insured through SCI. 5. More than 7,700 pregnant women insured through Medicaid receiving pregnancy-

<p>children and women are eligible for Medicaid.</p> <ol style="list-style-type: none"> 5. Implement rule change/amend state Medicaid plan to provide Chafee Medicaid to youth emancipating from foster care until age 21. 6. Amend CYFD policy and procedures to include Chafee Medicaid coverage. 7. Collaborate with Indian Health Service (IHS) to address coverage and access issues for Native Americans. 8. In partnership with Navajo Area Director’s Office, work to establish 8 eligibility workers at Shiprock, Gallup and Crownpoint IHS sites to determine eligibility on-site for Medicaid and Food Stamps. 9. Work with Salud! Managed Care Organizations to ensure Native American Salud! Members are included in the Disease Management and Envision Programs. 10. Target schools, including public, tribal and federal, to encourage staff to become certified as presumptive eligibility determiners to provide Medicaid on-site application assistance. 11. Finalize a Medicaid outreach video targeting Native American families. 12. Continue to sponsor radio announcements encouraging Native American families to enroll in Medicaid. 13. Expand outreach to Native Americans in other areas of the state, including Dulce (Jicarilla Apache Nation) and Zuni Pueblo. 14. Coordinate with Governor’s Office to advocate to CMS and congressional delegation for 100% federal matching assistance for Medicaid services to Native Americans. 15. Provide training to Native American Health Councils and IHS to increase awareness of the <i>Insure New Mexico!</i> Council programs. 	<p>related services only.</p> <ol style="list-style-type: none"> 6. More than 350 pregnant women insured through PAP. 7. Percent of youth emancipated from foster care who sign up for Chafee Medicaid coverage. 8. Decrease the percentage of New Mexicans without health insurance to less than 19.4%. 9. Decrease the percentage of NM children without health insurance to less than 8%.
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Chapter Ten: Health Emergency Management

Background and Baseline Data

Public health threats such as outbreaks of infectious disease, forest fires, winter storms and acts of terrorism call for coordinated planning and response efforts across numerous government agencies, private organizations and stakeholder groups at local, state and federal levels. The DOH has provided leadership with the development of health, medical and mortuary response for many years. Coordination of statewide emergency medical and trauma services has been a commitment for more than two decades. Since 1999 and 2002, cooperative agreements with the federal Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) have resulted in substantial improvements in the capacity of the statewide health system to respond to all types of disasters.

Emergency preparedness has been strengthened by the Office of Health Emergency Management in DOH's Epidemiology and Response Division. Special efforts have been made to develop public information materials to emphasize the importance of individual and family preparedness and the responsibility of all New Mexicans to take care of themselves, their loved ones and their communities in the event of a disaster.

Noteworthy accomplishments include:

- Creation of the Public Health Emergency Preparedness Advisory Committee to advise DOH on preparedness planning and develop access to health emergency response services.
- Provision of training opportunities for health care professionals and first responders by the Education and Training Advisory Committee (ETAC), including the University of New Mexico Center for Disaster Medicine, the New Mexico Primary Care Association, New Mexico Hospitals and Health System Association, the Department of Public Safety/Office of Emergency Management.
- Implementation of a full-scale mock-disaster exercise in Santa Teresa, New Mexico to test DOH's emergency preparedness plan and intrastate, interstate and bi-national communication capabilities in the event of a terrorist attack.
- Establishment of the Prepared Community initiative, a statewide, multi-phased educational program emphasizing the role and responsibility of county-based Community Health Councils to promote and establish local health emergency preparedness and response capacity, provide risk communication, support for recovery efforts, public information and identify vulnerable populations during emergencies.
- Creation of the New Mexico Modular Emergency Medical System (NM-MEMS), a local response model addressing medical surge capacity, mass dispensing of medications and supplies, management of mass fatalities, and limited human and material resources likely to occur during a large scale health emergency.

- Development of a Unified Command for Pandemic Influenza Plan including representatives from the New Mexico Emergency Managers Association, the Office of Emergency Management, and DOH.
- Creation of a Native American Preparedness Collaborative to ensure inclusion in city, county and state health emergency preparedness initiatives.
- Development of the NM-Electronic Disease Surveillance System to facilitate the electronic transfer of appropriate information from clinical information systems to DOH.
- Addition of hospitals participating in the Trauma Registry from 0 to 16, and maintenance of three hospital trauma centers. During the same time period, the Trauma System Task Force, with support from Governor Richardson and the Legislature, created the Trauma Fund Authority.

Goal 1: Increase and Fortify Human and Material Resources to Respond to Health Emergencies.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Recruit health professionals for the NM Serves Registry to augment the number of response staff during an emergency. 2. Provide National Incident Management System (NIMS) and Incident Command System (ICS) training to all health-related state employees. 3. Implement the NM Modular Emergency Medical System (NM-MEMS) or a similar system, into all statewide hazard plans, particularly for pandemic influenza events. 4. Implement a system that tracks statewide emergency management training events, drills and exercises. 5. Develop, practice and improve interoperable communications between state and local response systems. 6. Establish a system ensuring that reimbursements to hospitals and trauma centers are shared appropriately with individual doctors and surgeons responsible for trauma care. 	<ol style="list-style-type: none"> 1. Percent of employees that have received NIMS and ICS training. 2. NM-MEMS model adopted by all the counties that exercise their emergency operations plans, health and medical annexes.

Goal 2: New Mexico Communities are Prepared to Respond to a Public Health Emergency.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Ensure that all counties and tribes have medical and mortuary annexes consistent with DOH’s emergency operations plan. 2. Unify procedures, policies, and protocols used by providers, facilities and government entities. 3. Develop and implement a public information and education campaign addressing health risks and providing advice on response strategies to protect their health and safety. 4. Provide training to local school district high school students 	<ol style="list-style-type: none"> 1. Percent of counties and tribes who have tested their public health, medical and mortuary annexes, including their pandemic influenza plan. 2. Number of high school students trained in emergency medical services and community mobilization. 3. Health emergency preparedness measures included in the Public Education

<p>on emergency medical services and community mobilization.</p> <p>5. Adapt “The Prepared Community” training initiative for Native American communities.</p>	<p>Department’s (PED) Health Education Standards and Benchmarks by June 2008.</p>
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Goal 3: New Mexico is Prepared for Pandemic Influenza.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Increase the number of counties and tribes that include pandemic influenza plan in their emergency operations plan. 2. Increase the number of counties and tribes that include a pandemic influenza plan in their emergency operations plan. 3. Increase the number of integrated state and local exercises of pandemic influenza plans. 4. Develop, practice, and improve cooperation with all hazard-response systems statewide. 5. Develop, practice, and improve interoperable communications between the state and local response systems. 6. Continue to coordinate with appropriate state and federal agencies to ensure New Mexico is prepared for the Avian Flu, including planning for timely notification if a positive case of Avian Flu is identified. 7. Conduct presentations/media events to increase awareness of the public on the importance of preparedness for health emergencies, including the avian flu. 	<ol style="list-style-type: none"> 1. Percent of New Mexico counties with Pandemic Influenza Plans that are integrated with the State Plan. 2. Percent of counties/Native American communities who have tested their public health, medical and mortuary annexes, including their pandemic influenza plan. 3. Number of pandemic influenza plan exercises conducted statewide. 4. Number of influenza samples tested in laboratories participating in the NM influenza tracking system (H5N1 tested as indicated).

Goal 4: Improve the Trauma Care System Across New Mexico.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Oversee the New Mexico Trauma Fund Authority. 2. Develop supportive relationships (system building) with and among New Mexico and adjacent-state hospitals that care for people with severe injuries in New Mexico. 3. Oversee the New Mexico Trauma Fund Authority. 4. Develop supportive relationships (system building) with and among New Mexico and adjacent-state hospitals that care for people with severe injuries in New Mexico. 5. Support existing trauma centers and encourage community hospitals to become designated trauma centers. 6. Promote the state trauma registry program, to include increased participation and receipt of data from additional New Mexico hospitals, and adjacent-state hospitals caring for people with severe injuries in New Mexico. 	<ol style="list-style-type: none"> 1. Number of designated trauma centers in New Mexico. 2. Number of hospitals participating in the State Trauma Registry.

Chapter Eleven: Health Care Financing

Background and Baseline Data

The rising costs of health care, greater responsibility for each state to finance health care and the increasing number of uninsured create funding challenges. Any change in the amount of spending in this sector has a substantial impact on the size, composition, and future viability of a state's economy and the health of those residing in the state. Changes in the amount of funding allocated for health education, outreach, prevention and emergency management programs affect the economy and quality of health. Federal programs are under increasing pressure to cut costs and place more financial burden on state, local and private funding sources. Over the next ten years, Medicare and Medicaid funding requirements will become increasingly difficult, and state public and private programs will be progressively more challenged to provide the infrastructure to meet these new requirements. It is expected that a form of "pay for performance" will be instituted so that Medicare and Medicaid payments will be based on performance indicators rather than outcomes.

During New Mexico's 2003 Legislative session, House Bill 955 was passed and signed into law. This bill directed the Legislative Health and Human Services Committee to develop the *Comprehensive Study on Health Care and Health Care Costs in New Mexico*, to determine the level of health care spending and the impact it has on the state's economy.

The study measured health care expenditures and their impacts for the year 2002, providing the state with baselines, creating a data set identifying health care expenditures and their sources. This is expected to improve the state's ability to monitor market trends and provide important information to policy makers and the public. In 2005, the Legislature authorized an update of this health expenditure study for year 2004, including a brief summary of expenditures on the training of health care professionals. This study provides insight into our efforts in addressing the shortage of nurses and other health care professionals.

A preliminary identification of total health care expenditures for 2002 and 2004 is contained in Table A. The New Mexico State University's Department of Economics delivered this preliminary information to the Legislative Finance Committee at their June 2006 meeting. According to the information provided in Table A, expenditures increased by almost 23%, from \$7.8 billion to \$9.6 billion. Public entities provided approximately 75% of the total expenditures.

Health care services are financed by state, federal and private sector monies. The federal programs (Medicare in particular) are under increasing pressure to cut costs and place more of the financial burden on state, local and private funding sources. Current projections by the Social Security and Medicare Boards of Trustees expect the Trust Fund to be insolvent by 2019.

With \$10 billion spent on health care in New Mexico in 2004, it is clear that the health care industry has a significant impact on the state's economy. The complexity of health care delivery, administration and financing requires ongoing evaluation of how administrative and fiscal policy

decisions are made. Changes in health care funding, delivery or administration have a ripple effect on the health care system and the state's economy.

Table A: Private Health Care Expenditure Estimates*		
PRIVATE	2002	2004
<i>Insurance</i>		
Self-Insured Plans	\$740,824,000	\$630,872,877
Fully-Insured Plans	\$1,056,918,000	\$1,081,905,370
Worker's Compensation	\$88,506,000	N/A
<i>Other Private</i>		
Out-of-Pocket	\$41,641,000	
PhRMA	\$13,400,000	\$36,502,000
UNM Prescription Drug Clinical Trials	\$3,382,534	\$7,762,659
TOTAL	\$1,944,671,534	\$1,757,042,906

* Tables contain preliminary data presented to Legislative Health and Human Services Committee June 2006.

Table A: Public Health Care Expenditures

	Federal	State	County	Private	Total	Federal	State	County	Private	Total
PUBLIC	2002	2004	2002	2004	2002	2004	2002	2004	2002	2004
Medicare	\$2,992,000,000	\$2,645,000,000							\$2,992,000,000	\$2,645,000,000
Medicaid	\$1,294,793,013	\$3,156,309,000	\$429,994,672	\$977,691,000					\$1,724,787,685	\$4,134,000,000
Veteran's Administration	\$194,090,768	\$259,774,407							\$194,090,768	\$259,774,407
Indian Health Service	\$228,280,988	\$30,893,942							\$228,280,988	\$40,921,590
Military Claims and Facilities	\$140,528,874	\$101,125,571							\$140,528,874	\$101,125,571
<i>Grants</i>										
University of New Mexico	\$3,444,891	NA	\$3,229,456						\$6,674,347	N/A
Federally Qualified Health Centers	\$25,395,276	\$31,562,705							\$25,395,276	\$31,562,705
<i>State</i>										
Department of Health	\$83,722,000	\$98,473,100	\$292,735,000	\$354,930,500					\$376,457,000	\$453,403,600
Aging and Long-Term Services Dept.	\$2,799,849	\$6,603,729	\$9,286,943	\$19,514,746					\$12,086,792	\$26,118,475
Children, Youth and Families Dept.	\$1,493,022		\$16,493,804	\$16,949,224					\$17,986,826	\$16,949,224
Dept. of Vocational Rehabilitation	\$996,338	\$1,036,946	\$281,017	\$280,648					\$1,277,355	\$1,317,594
Public Education Dept.			\$5,253,600	\$724,960					\$5,253,600	\$724,960
Corrections Dept.			\$20,908,490	\$24,508,900					\$20,908,490	\$24,508,900
<i>County</i>										
County Indigent Fund					\$23,367,862	\$37,137,343			\$23,367,862	\$37,137,343
Jail Inmate Health Expenditures					\$3,998,462	\$4,127,530			\$3,998,462	\$4,127,530
Other Health Expenditures		\$49,946,956			\$66,698,318	\$16,847,141			\$66,698,318	\$66,794,091
PUBLIC	\$4,967,545,019	\$6,380,726,356	\$778,182,982	\$416,908,978	\$94,064,642	\$58,112,014	\$0	\$0	\$5,839,792,643	\$7,843,465,990
TOTAL PUBLIC & PRIVATE	\$4,967,545,019	\$6,380,726,356	\$778,182,982	\$1,394,599,978	\$94,064,642	\$58,112,014	\$1,944,671,534	\$1,757,070,554	\$7,784,454,177	\$9,600,508,896

Expenditures for Instruction of Health Care Professionals*

Table B provides expenditures for professional health care training from fourteen New Mexico institutions during the 2004-2005 academic year.

Table B - Institution Totals 2004-2005

<u>Institution</u>	<u>2004-2005</u>
Clovis Community College	\$572,900
Dona Ana Community College	\$1,938,081
Eastern NM University	\$224,297
NM Junior College	\$656,884
NMSU - Carlsbad	\$407,386
NMSU - Las Cruces	\$5,797,124
NMSU - Alamogordo	\$411,747
NMSU -Grants	\$49,141
Northern NM College	\$513,776
San Juan College	\$1,716,605
Central NM Community College	\$3,393,518
UNM	\$39,195,220
Western NM College	\$1,279,418
Total	\$56,156,097

*Tables contain preliminary data presented to Legislative Health and Human Services Committee June 2006.

Table C reports the amount spent by program type. The nursing program receives by far the greatest amount of attention, followed by Pharmacy and Medical.

Table C - Program Totals 2004-2005

<u>Program</u>	<u>2004-2005</u>
Communication Disorders	\$1,109,800
Counseling	\$765,026
Dental	\$1,074,840
EMS	\$116,454
Health and Public Service	\$163,753
Health and Social Services	\$365,000
Health Occupations	\$568,266
Health Sciences	\$824,750
Medical	\$2,8115,200
Medical Laboratory	\$664,956
Medical Records Specialist	\$70,770
Nursing	\$12,694,886
Nursing Asst	\$490,465
Occupational Therapy	\$874,608
Pharmacy	\$3,734,197
Physical Therapy	\$797,344
Physicians Asst	\$322,100
Radiological Technology	\$813,463
Respiratory Therapy	\$626,441
Social Work	\$1,734,103
Sonography	\$229,675
Total	\$56,156,097

Chapter Twelve: Long-Term Care

Background and Baseline Data

The aging population and the increased prevalence of disability in New Mexico is a significant issue that places additional demands on the State's long-term service system. New Mexico will need to prepare for the rising number of people requiring long-term services. The State faces challenges including the need for increased access, community-based service options, the rising costs of long-term services and health care, health care quality and budget management.

The US Census Bureau projects that New Mexico's 65 and older population will more than double by 2030, ranking it 4th in the nation. By this time, older New Mexicans are expected to outnumber those under age 18. The Census Bureau also predicts that the 80+ population will increase from 51,000 in 2000 to 97,000 in 2025. As the aging population increases, so will frailty, illness, and dementia as well as the demand for comprehensive, coordinated services.

- The fastest growth rate among the aging population is those 85 and older. Elders in this age group have different health needs from those of younger, more active elders.
- Almost 30% of New Mexicans, age 60 and older, are Hispanic; 5% are Native American; 1.3% are African American; and less than 1% are Asian.
- More than 30,000 New Mexicans are suffering from Alzheimer's disease or related disorders.
- More than 13,000 New Mexicans age 65 and older suffer from depression.

The rising costs of long-term services and health care has a significant impact in New Mexico because of the State's high percentage of elderly residents or individuals living with a disability who are at or below the Federal Poverty Level.

- More than 30% of New Mexicans with disabilities live in poverty.
- Almost 25,000 grandparents are solely responsible for their grandchildren; over 17% of these families are living in poverty.
- In New Mexico, 13.2% of the age 60 and older population live at or below the 2000 census Federal Poverty Level; 46% of the Native American population and 28% of the Hispanic population age 60 and older live in poverty.

To empower the elderly and individuals living with a disability to live independently, productively and with dignity, we must continue the movement towards home- and community-based services and away from institutional care. The State needs multi-faceted programs and services that assist individuals in maintaining health and independence, enable those with functional limitations to maintain their level of independence and respond to frail elders while preserving their independence and right to age in place.

Governor Richardson and the Legislature approved the Aging and Long-Term Services Department Act of 2004 (NMSA 1978 9-23-1 to 9-23-12) to address the needs of the increasing elderly and disabled populations, thus establishing a seamless, comprehensive, efficient, cost-effective home- and community-based long-term care system. Some quick facts are as follows:

- Existing home and community-based services, including home delivered meals, homemakers and respite care, are limited and fragmented.
- Caregivers who enable individuals to remain in their own homes are critical, but support systems for these caregivers are limited.
- As the population ages, per capita hospital and nursing home care expenditures will continue to rise. Per capita health care spending is 3.5 times greater for the elderly than for those younger than 65.
- New Mexico’s Medicaid system is responsible for addressing the increasing demand for long-term care services. The NM Medicaid system spends about two-thirds of its long-term care dollars for home- and community-based care; the system also pays for 80% of the state’s nursing home care.

GOAL 1: Respond to the Needs of New Mexico’s Population of Elderly and Persons with Disabilities.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Increase the number of eligible individuals receiving home and community-based services through the Disabled & Elderly and the Developmental Disabilities Waiver Program. 2. Expand services to new populations to include persons with brain injury. 3. Improve coordination of long-term services and those offered by the New Mexico Behavioral Health Collaborative. 4. Increased outreach, education and navigation assistance to Hispanic, Native American and underserved populations. 	<ol style="list-style-type: none"> 1. Number of waiver allocations annually. 2. Number of individuals with brain injury who are identified and enrolled in <i>Mi Via</i> by the end of the first implementation year. 3. Statewide availability of behavioral health services for the elderly and persons with disabilities. 4. Number of Hispanic, Native American and underserved populations receiving culturally appropriate services either in home and community based settings or in nursing facilities depending upon the consumer’s choice.

GOAL 2: Increased Independence, Choice and Control: Develop a Self-Directed Service Delivery System.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Implement <i>Mi Via</i>, the New Mexico Self Directed Waiver. 2. Expand implementation of Cultural Change in Nursing Homes. 	<ol style="list-style-type: none"> 1. <i>Mi Via</i> Self-Directed Waiver is implemented. 2. Consumer-directed services incorporated in institutional settings.

GOAL 3: Allocate a Majority of Expenditures Toward Home- and Community-Based Services as Opposed to Institutional Services, such as Nursing Homes.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Invest in non-Medicaid Long-term Services. 2. Increase availability of transportation to elders and persons with disabilities. 3. Increase housing options to elders and individuals living with a disability. 	<ol style="list-style-type: none"> 1. Availability of non-Medicaid services. 2. Availability of transportation for elders and persons with disability that leverage all local transportation resources. 3. Track and monitor the need for affordable housing.

GOAL 4: Prevent abuse, neglect and exploitation of vulnerable populations. Eliminate fraud and abuse of public programs so that services are maintained for those who need them.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Provide advocacy for adults at risk of abuse and/or neglect in the settings in which they are receiving services. 	<ol style="list-style-type: none"> 1. Number of abuse and neglect of elderly and persons with disabilities in all service settings. 2. Number of referrals investigated and when appropriate, prosecution of perpetrators.

GOAL 5: Promote the Respect, Dignity and Inclusion of all New Mexico’s Seniors and Persons Living with a Disability by Supporting a Meaningful and Enriched Quality of Life.

Activities	Performance Measures by 2008
<ol style="list-style-type: none"> 1. Affirm with seniors and persons living with a disability the use of language that is respectful and accepted. 2. Facilitate opportunities for meaningful and self-rewarding experiences, as defined by the individual. 3. Promote public awareness of aging and disabilities that facilitates the ability to actively participate in community life. 	<ol style="list-style-type: none"> 1. Number of elders and persons with disabilities who are valued as contributing members of their communities.

Appendix A

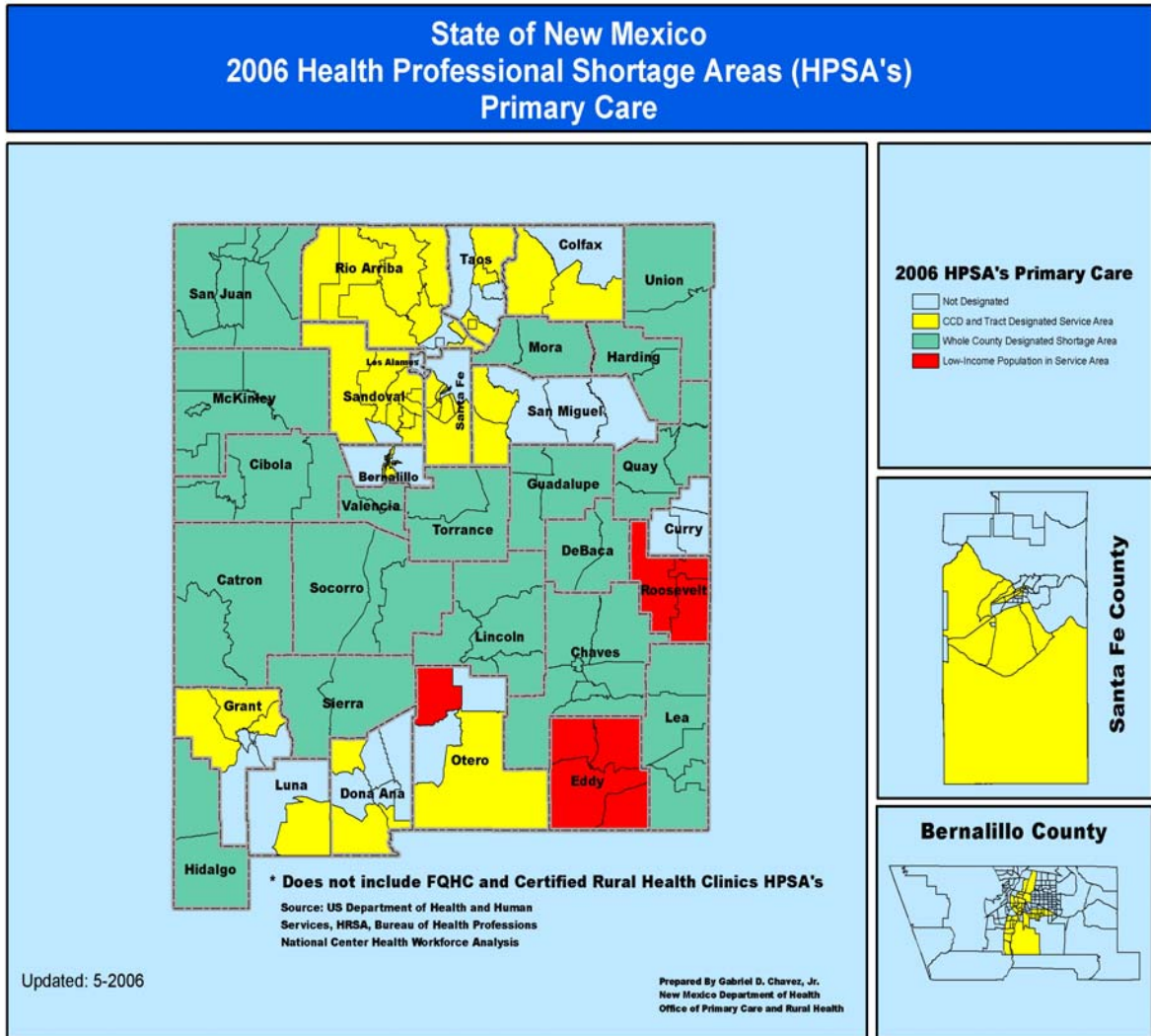
Statistics by Race / Ethnicity in New Mexico

Race	2003 - 2005 Births to Teens Age 15 – 17		2003-2005 No Pneumonia Vaccination Adults Aged 65 & Older (1)		2003-2005 Obesity Among Adults Aged 18 & Older (1)		2005 Overweight Among Youth, Grades 9-12	
	Rate per 1000 females	Disparity Ratio (2)	Rate (3)	Disparity Ratio (2)	2004 Rate (3)	Disparity Ratio (2)	Rate (4)	Disparity Ratio (2)
African-American Black	20.6	1.5	51.2	1.7	N/A		13.2	1.6
American Indian	32.7	2.4	58.8	1.9	33	1.9	17.4	2.1
Asian / Pacific Islander (4)	6.4	N/A	31.8	1.0	N/A		10.5	
Hispanic	56.2	4.2	46.5	1.5	24.5	1.4	24.6	2.3
White	13.4	1.0	30.9	1.0	17.6	1.0	17.7	1.7

Race	2003 – 2005 Pneumonia and Influenza Deaths		2003 – 2005 Alcohol Related Deaths		2003 – 2005 Diabetes Deaths	
	Rate (5,6)	Disparity Ratio (2)	Rate (5, 6)	Disparity Ratio (2)	Rate (5,6)	Disparity Ratio (2)
African-American Black	22.4*	NA	35.4	1.0	45.9	2.0
American Indian	33.5	2.0	106.6	3.0	71.8	3.1
Asian / Pacific Islander (4)	5.5*	NA	20.3	N/A	29.5*	N/A
Hispanic	18.6	1.1	62.8	1.8	48.2	2.1
White	16.5	1.0	45.3	1.3	22.9	1.0

1. Data from the Behavioral Risk Factor Surveillance System. The measure for obesity is BMI, which is based on a person’s height and weight. Obesity is defined as a BMI of 30 or greater.
2. Disparity ratio is calculated by dividing the rate for each group by the best rate among groups with 20 or more cases during the time period.
3. Rate is estimated percent of population with characteristic based on sample response.
4. Data from the 2005 New Mexico Youth Risk and Resiliency Survey.
5. Rate is unstable due to small numbers.
6. Age-adjusted death rates by number of deaths per 100,000 U.S. standard population.

Appendix B



Explanation of 2006 HPSA's Primary Care Legend Above

Not Designated

No primary care health professional shortage.

CCD and Tract Designated Service Area

Census County Divisions are county subdivisions that were delineated by the US Census Bureau for data presentation purposes.

Whole County Designated Shortage Area

The entire county is a shortage area.

Low Income Population in Service Area

May not have a shortage but low income populations may not have access to health care.

Appendix C

The Behavioral Health Purchasing Collaborative is comprised of seventeen state agencies, including:

- Administrative Office of the Courts (AOC)
- Aging and Long-Term Services Department (ALTSD)
- Children, Youth and Families Department (CYFD)
- Corrections Department (CD)
- Department of Finance and Administration (DFA)
- Department of Health (DOH)
- Department of Indian Affairs (DIA)
- Department of Labor (DOL)
- Department of Transportation (DOT)
- Developmental Disabilities Planning Council (DDPC)
- Governor’s Commission on Disability (GCD)
- Health Policy Advisor, Office of the Governor
- Health Policy Commission (HPC)
- Human Services Department (HSD)
- Mortgage Finance Authority (MFA)
- Office of Workforce Development (OWD)
- Public Education Department (PED)

Appendix D

Comprehensive Strategic Health Plan Contributors

Strategic Health Plan Advisory Team

Gayle Adams, Lovelace Health Plan; Beverly Allen-Ananins, Grant County Health Council; Mary Altenberg, Indian Health Service; Debbie Armstrong, Secretary, Aging and Long-Term Services; Betty Barrett, NM Osteopathic Medical Association; Regina Begay-Roanhorse, Department of Indian Affairs; Charlotte Little, Pueblo of San Felipe; Darlene Collins, Collins Consulting; Debra Cyphert, NM Nurses Association; Dan Derksen, UNM Center for Community Partnerships; Bill Doggett DC, American Chiropractic Association; Jeff Dye, NM Hospital & Health Systems Association; Ruby Ann Esquibel, Human Services Department; Jose Frietze, Rio Grande Behavioral Health; John Garcia, Secretary, Department of Veterans Services; Roque Garcia, Rio Grande Behavioral Health; Joie Glenn, NM Association for Home & Hospice Care; Dan Green, Epidemiology and Response Division; DOH, Jerry Harrison, NM Health Resources; Lou Helwig, Department of Veterans Services; Yolanda J. Herrera, Corrections Department; Jo Kinberger, Case Manager; Allison Kozeliski, Board of Nursing; Mike Landen, MD, Epidemiology and Response Division, DOH; Harvey Licht, Office of Primary Care, DOH; Albert Long, Navajo Nation Behavioral Health; Melissa Manlove, First Choice Community Health Center; Barbara McAneny, MD, NM Oncology/Hematology Consultants; Patsy Nelson, Public Health Division, DOH; Mark Oldknow, Children Youth Families Department; Wayne Powell, UNM-Institute for Public Health; Carrie Roberts, NM Nurses Association; David Roddy, Primary Health Care Association; Peter Snow, Presbyterian Healthcare Services; Paul Sowards, Bank of Albuquerque; Anne Sperling, State Association of Health Underwriters; Kristine Suozzi, Public Health Division, DOH; James Toya, Albuquerque Area Indian Health Service; Susie

Trujillo, Grant County Health Council; Michael Trujillo, MD, University of New Mexico; James Tryon MD, NM Medical Society; David A. Vargas, Community Dental Services; Alfredo Vigil, MD, Health Centers of Northern New Mexico; Michelle Welby, Governor's Office; Niki Zeuner, The Wellness Coalition.

Health Disparities Team

Christina Carillo y Padilla, DOH/Public Health; Ron Lujan, MD, Isleta Pueblo; Mary Lewis, DOH/Public Health; Francisco Ronquillo, Public Health; Roxanne Spruce Bly, All Indian Pueblo Health Council; Theta Nyein, DOH/Behavioral Health; Jose S. Martinez, MD, Presbyterian Health Services; Joe Cordova, Pueblo Advocate - organization not specified; Dan Reyna, Border Health Commission; Lily Foster, DOH/Epidemiology & Response; Harold Bailey, Office of African-American Affairs.

Workforce Issues Team

Pat Boyle, Center for Nursing Excellence; Laura McClenny, San Juan County Partnerships; Mary Altenberg, Indian Health Service; Pat Stephens, Albuquerque, CNM; Camille Scielzi, Socorro County Options Education & Prevention Council; Fran Smith, DOH/Public Health Division; Jozi DeLeon, Higher Education Department; Christina Carrillo y Padilla, DOH/Public Health; Yolanda Cordova, DOH/Public Health; Jim Tryon, NM Medical Society; Paul Romero, DOH/Office of Policy and Multicultural Health; Len Malry, Governor's Office of Workforce Development; Donald Hume, Value Options of NM; Jerry Harrison, New Mexico Health Resources; Margaret Glass, Santa Fe Community College; Barbara Hickok, DOH /Public Health; Pam Galbraith, Value Options of NM; Jim Clarkson, Value Options of NM; John Pieper, UNM College of Pharmacy; Jeff Dye, NM Hospital & Health Systems Association.

Oral Health Team

Mary Altenberg, IHS, Jane Batson, Eastern NM University – Roswell; Walt Bolic, Delta Dental; Glenelle Butler NMDHA/ DH Com; Bill Dixon, Aging and Long Term Services; Henry Espinosa, NM Dental; Gregory Grannan, Delta Dental of NM; Carol Hanson, DOH Office of Dental Health; Jerry Harrison, NM Health Resources; Patricio Larragoite, HPC; Buddy Lujan Retired Dentist; Joseph Menapace, NM Dental Association; Ken Padilla, HAD; Barbara Posler, NM Dental Hygienist Association; Wayne Powell, UNM Health Sciences Center; Bill Valentine, Dentist.

Immunization Team

Lance Chilton, MD, UNM; Barbara Carver, UNM; Sonya Andron, DOH/Public Health; Anne Lutz, DOH/Public Health; Anna Pentler, New Mexico Immunization Coalition; Margy Wienbar, DOH; Theresa Tsosie-Robledo, Indian Health Service; Ruby Bishop, AARP; Eileen Goode, NM Primary Care Association.

Teen Pregnancy Team

Ruthie Dearing, CYFD; Karen Taylor, Presbyterian; Johnny Wilson, Planned Parenthood of NM;

Wanicha Coggins, DOH Family Planning Program; Michelle Walela, Zuni Tribe and Native American TANF; Krista Wills, M.D., Presbyterian; Linda Brooks, NM SHARE Collaborative (PED); Brian Serna, DOH Male Involvement Program; Sylvia Ruiz, NM Teen Pregnancy Coalition; Veronica Plaza, DOH-Health Promotion; Lynn Mundt, DOH-Family Planning Program; Eirian Coronado, DOH-FHB MCH Epi; Susan Lovett, DOH-FHB; Linda Brooks, NM SHARE Collaborative (PED); Francisco Ronquillo, DOH; Craig Drury, DOH; Mary Shepherd, DOH - MCH Epi; Debra Belyen, DOH – Roswell; Veronica Harding, New Mexico Community Foundation - Las Cruces.

Suicide Team

Chris O'Donnell, Jason Foundation; Cynthia Gonzales, NM Suicide Intervention Project; Michelle Linn-Gust, NM Suicide Prevention Coalition; Emily Stafford, DOH/Office of School Health; Susan Nelsen, DOH/Office of School Health; Norma Vasquez, DOH/Office of School Health; Amanda Lopez, DOH/Office of School Health; Georgia Castro, DOH/Office of School Health; Molly Brack, Agora Crisis Center; Delia Mendoza, DOH/Office of School Health; Ron Lucero, Public Education Department; Don Maestas, DOH/Behavioral Health Services; Bruce Jacobs, New Mexico State University; Saumitra Sengupta, DOH/Family Health; Kris Carrillo, DOH/Office of School Health; Suzanne Udall, NM Suicide Prevention Coalition; Joann Sartorius, NM Suicide Intervention Project; Darlene Edwards, NM Suicide Survivors; Steve Adelsheim, DOH/Office of School Health; Leslie Kelly, DOH/Office of School Health; Jack Pischner, DOH/Behavioral Health Service; Laura Owen, Albuquerque Public Schools.

Health Emergency Management

Roman Jenks, Eastern New Mexico Medical Center; Jimmy Hestard, Eastern New Mexico Medical Center; John Miller, DOH/Region 2; Fred Shumate, DOH/EMS Region I; Barbara Byrne, DOH/OHEM; Eric Gregory, DOH/IPEMS; Gary Ludi, New Mexico Behavioral Health Institute; Charlene A. Lujan, New Mexico Behavioral Health Institute; Joie Glenn, New Mexico Association for Home & Hospice Care; Wynn Brannin, DOH/OHEM; Deb Boehme, DOH/OHEM; Gayle Kenny, DOH/OHEM; Christina Carrillo y Padilla, DOH /Public Health Division; Maggi Gallaher, DOH/Public Health Division; Jimmy Stoer, Presbyterian Health Care; Joan Murphy, DOH/OHEM; Caryn Relkin, NMHSA; Fred Gallaher, DOH/IPEMS; Tres Schnell, DOH/OHEM.

GLOSSARY OF ACRONYMS

ALTSD	Aging and Long Term Services Division	IHS	Indian Health Service
BMI	Body Mass Index	JPPO	Juvenile Probation and Parole Office
BRFSS	Behavioral Risk Factor Surveillance System	NIMS	National Incident Management System
CATCH	Coordinated Approach to Child Health	NMOHSS	New Mexico Oral Health Surveillance System
CD	Corrections Department	NMSU	New Mexico State University
CDC	Centers for Disease Control (U.S.)	NMTFEH	New Mexico Task Force to End Hunger
CHICs	Community Health Improvement Councils	NMHIA	New Mexico Health Insurance Agency
CMS	Centers for Medicare and Medicaid Services (U.S.)	OWD	Office of Workforce Development
CYFD	Children Youth and Families Division	PA	Premium Assistance Program
DFA	Department of Finance and Administration	PED	Public Education Department
DOH	Department of Health	SBIRT	Screening, Brief Intervention, Referral and Treatment
DOT	Department of Transportation	SCI	State Coverage Insurance Program
EMS	Emergency Medical Services	SCHIP	State Children's Health Insurance Program
ETAC	Education and Training Committee	SIIS	Statewide Immunization Information System
GSD	General Services Division	SEIP	Small Employer Insurance Program
HED	Higher Education Department	RLD	Regulation and Licensing Department
HHS	Health and Human Services Department	RMD	Risk Management Division
NMHIA	New Mexico Health Insurance Alliance	UNM	University of New Mexico
HPSA	Health Professional Shortage Area	UNM-HSC	University of New Mexico's Health Sciences Center
HRSA	Health Resources and Services Administration	VFC	Vaccines for Children
HSD	Health Services Division	VONM	Value Options New Mexico
HPC	Health Policy Commission	WIC	Women, Infant and Children
IAD	Indian Affairs Department	YRRS	Youth Risk and Resiliency Survey
ICS	Incident Command System		

State of New Mexico Comprehensive Strategic Health Plan

2006

