Maternal and Child Health Services Title V Block Grant

New Mexico

FY 2018 Application/ FY 2016 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

SUSANA MARTINEZ, GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

LYNN GALLAGHER, CABINET SECRETARY

July 13, 2017

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

Dear Ms. Marquardt,

The New Mexico Department of Health is pleased to submit the Title V Maternal and Child Health Block Grant report for Federal Fiscal Year 2016 and application for Federal Fiscal Year 2018.

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

Sincerely,

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I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

I.E. Application/Annual Report Executive Summary

Application/Annual Report Executive Summary Background

New Mexico (NM) has completely transitioned from the previous block grant cycle (FFY2011-2015) to the new cycle (FFY2016-2020). New Mexico's selected priorities have not changed since the 2015 Needs Assessment update. This reporting year (FFY2016) we have added baseline data on our unique State Performance Measures (SPMs) and Evidence-Informed Strategy Measures (ESMs). The SPMs are measures developed by the state Title V program to address the unique MCH needs of the state. ESMs are strategy measures that will be used to gauge our progress towards impacting the National Performance Measures (NPMs). Each population domain workgroup has selected an ESM as a complement to a specific strategy designed to impact the priorities and NPMs that NM has selected. A renewed focus on health equity and family-consumer partnerships has strengthened the Title V program.

Maternal Health 2016

The Maternal Health Program (MHP), through its involvement with the Collaborative Innovation and Improvement Network (CoIIN) and Title V, has taken the lead on the strategy to improve Perinatal Regionalization in the state. The Maternal Child Health Epidemiology program is working with the state's Bureau of Vital Records and Health Statistics to analyze infant birth and death files to ascertain if women with high-risk pregnancies are delivering in facilities with appropriate levels of care. New Mexico is utilizing the Level of Care Assessment Tool (LoCATe) that categorizes a hospital's level of care. The strategy of gathering baseline data from NM birth hospitals was near completion as of the end of the fiscal year. The MHP- continues to partner with our public health offices, University of New Mexico (UNM), private practitioners, the New Mexico Midwives Association (NMMA), the NM chapter of the American College of Nurse Midwives, the New Mexico Perinatal Collaborative (NMPNC), and institutions throughout NM to form agreements with providers or provider sites to provide timely and adequate care to pregnant, birthing, and post-partum women in NM. Additionally, MHP has partnered with the NMPNC to address maternal/obstetric hemorrhage.

Maternal Health 2018 Application Year Plan

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

Perinatal/Infant Health 2016

Promotion of Safe Sleep and Breastfeeding initiation and duration remain the top priorities in perinatal/infant health. NM Title V and the Children Youth and Families Department Home Visiting Program are collaborating with Cribs for Kids to make Safe Sleep Material available to home visiting clients. Safe Sleep continued to be a priority selected in the Infant Mortality (IM) CoIIN for 2016.

NM Pregnancy Risk Assessment Monitoring Survey (PRAMS) and the Breastfeeding Taskforce collaborated on the workplace breastfeeding initiative. The longitudinal follow-up to PRAMS to measure breastfeeding duration commenced in June, 2016 and we should have data to measure by July, 2017. Women, Infants, and Children (WIC) provided all pregnant and breastfeeding participants with encouragement, education, and support to breastfeed, providing group breastfeeding support sessions and individual counseling to all pregnant and breastfeeding mothers.

Perinatal/Infant 2018 Application Year Plan

Moving into the 2018 application year, perinatal and infant health will continue to focus on breastfeeding and safe sleep. One major strategy with regards to breastfeeding is to compare baby-friendly designated hospitals or regions with prevalence of baby-friendly indicators in PRAMS. The safe sleep strategies with the goal of integrating breastfeeding and safe sleep messaging will continue with planned collaborations with CYFD and various home visiting programs in New Mexico.

Child Health 2016

Developmental Screening and Child Maltreatment are the priorities in Child Health. The Child Health Program (CHP) continued to present trainings on the use of the developmental screening tools to early learning and childcare providers. To maintain work around developmental screening after the end of the Early Childhood Comprehensive Systems (ECCS) grant, the CHP convened a train-the-trainer event, for an additional 25 trainers, on developmental screening tools.

The J. Paul Taylor Early Childhood Task Force (JPT) continued its work of addressing both public and private partners in decreasing child maltreatment. NM Title V continues to remain on active on the JPT. The Title V Director, Child Health staff and Public Health/Health Promotions staff all are active participants at the meetings.

Child Health 2018 Application Year Plan

To increase the percentage of children receiving a developmental screening, four strategies will be implemented. The first is to expand developmental screening activities in early care and education and increase appropriate referrals among medical homes, early intervention services, child care programs, and families. The second is to engage pediatric providers, other child health providers, infant mental health consultants, home visitors, and other related professionals in local communities to improve linkages and referrals. The third is to utilize and promote training to early care and education professionals who serve young children. Lastly, the fourth strategy is to promote public awareness of child development.

To decrease abuse and maltreatment of children, there are three strategies to be implemented. The first is to identify the most vulnerable families and neighborhoods utilizing “mapping” of data bases to overlay risk factors for identifying areas of highest need (concentrated disadvantaged). The second is to develop policy recommendations based on community engagement and leverage resources to expand the home visitation system to provide services for all families identified as most vulnerable. The third is to expand and fund home visitation services for children and families with three or more identifiable risk factors, including those referred by Protective Services. DOH does not fund home visitation services but Title V staff work with the JPT task force members and other stakeholders.

Adolescent Health 2016

Adolescent health priorities for 2016 were to reduce teen birth rates and increase adolescent well visits.

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

New Mexico participated in the Adolescent and Young Adult Health (AYAH) CoIIN collaborative to increase comprehensive well exams among adolescents and young adults. The AYAH CoIIN brought together Title V, the Office of School and Adolescent Health (OSAH), and various partners to increase well exams among adolescents.

The AYAH CoIIN implemented a strategy of school-based health centers to expand services and supports for Medicaid eligible youth and to promote the conversion of sports physicals into comprehensive well exams.

Adolescent Health 2018 Application Year Plan

The state Title V program will continue to collaborate with FHB/FPP to implement a statewide, comprehensive, and coordinated plan focusing on teen pregnancy prevention/reduction, and to assure continued delivery of safety net family planning services through the strategic alignment of contraceptive services and outreach to schools in counties of high teen birth rates. NM Title V continues to support the implementation of two evidence-based teen pregnancy prevention programs: Teen Outreach Program (TOP) and Project AIM (Adult Identifying Mentoring). TOP is implemented in six counties at eight sites statewide by seven different organizations.

The AYAH CoIIN has ended; however, over the next year the OSAH and Title V will continue the efforts already in place by continuing to meet with partners in the AYAH CoIIN including other states who participated in the CoIIN. Primarily, the partnership with Centennial Care Managed Care Organizations will continue to expand marketing on how to deliver youth friendly services.

Children with Special Health Care Needs (CSHCN) 2016

The Children with Special Health Care Needs (CSHCN) domain priority areas of focus in the previous cycle were: increasing numbers of CSHCN who receive care in a Medical Home and ensuring successful transitions to adult healthcare.

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

CYSHCN Social Workers provide service coordination and transition planning to youth aged 14-21 using the "CMS Youth Transition Plan." Staff will search for available avenues of obtaining health care insurance for clients aging out of the Program. CMS social workers will continue to receive training and support around transition planning with youth, as needs arise. The new data system, CACTUS, has integrated the transition assessment and includes a care plan that is being co-developed with the social worker and the youth to highlight areas to assist with a successful transition.

CYSHCN 2018 Application Year Plan

For medical home, the primary focus is to improve the system of care for CYSHCN. To do this, CMS will continue to provide leadership around care coordination and family centered, culturally competent care. CMS is planning on participating in an Action Learning Collaborative that will implement evidence based strategies to strengthen Medical Homes.

To increase the amount of services available for CSHCN to make transitions to adult care, several strategies will be implemented. We will continue to collaborate with the Transition Task Force to implement policy and practice recommendations for pediatric practices and collaborate with Got Transition to provide technical assistance to pediatric providers in developing transition policy.

Cross-Cutting/Life-Course 2016

Cross-Cutting/Life-Couse priorities continue to be oral health among the maternal and child population and adequate

insurance coverage for children.

A total of **6,928** 3rd graders re**ceived a dental sealant in FY 16**. The data on this comes from both the Office of Oral Health (OOH) and Medicaid (**1,862 OOH and 4,282** Medicaid enrollees). The OOH contractors are required to provide dental sealant for 3rd graders.

Title V is collaborating with the University of New Mexico on the New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The project focuses on maternal and infant oral health. The project has commenced and will partner with at least one program impacting targeted pregnant women such as WIC, Healthy Start, or home visiting program, with broad geographic reach that will incorporate targeted oral health messages into routine business activities.

2018 Application Year Plan

Title V will continue to collaborate with the OOH to provide preventive dental services. Title V will also collaborate with the University of New Mexico on the newly developed New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The New Mexico Perinatal and Infant Oral Health Quality Improvement Project will continue to integrate an evidence-based model of inter-professional oral care into primary care delivered to pregnant women and newborns across New Mexico. The Title V Director and the Maternal Health program manager serve on the Advisory Board for the Oral Health Quality Improvement Project.

Family/Consumer Partnership

Family involvement is a strength in New Mexico; the state benefits from having the national headquarters of Family Voices based in Albuquerque, as well as the Family-to-Family (F2F) program through Parents Reaching Out, EPICS which focuses on Native American families who have children with special needs, and the strong family advocacy component of the Center for Development and Disabilities (CDD) at the University of New Mexico, among many others.

II. Components of the Application/Annual Report

II.A. Overview of the State

POPULATION:

New Mexico (NM) is the fifth largest state in the United States by geographic area but is 36th in population size, with its 2,080,328 people scattered across vast, open spaces (US Census, 2015). NM is demographically a "majority-minority" state where minority groups constitute a majority of the population. According to the University of New Mexico (UNM) Bureau of Business and Economic Research, NM's total population in 2015 was 48% Hispanic, 39% non-Hispanic White, 9% American Indian, 2% African American/Black, and 2% Asian and Pacific Islander (compared, respectively, to the US percentages of 17% Hispanic, 64% non-Hispanic White, 1% American Indian/Alaska Native, 13% Black/African American, and 6% Asian/Pacific Islander). In terms of age distribution, 24% of the NM population was younger than the age of 18, 35% of the population is ages 18-44, and 41% of the population is over the age of 44.

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

POVERTY:

Up to 55% of NM children live in poverty. In the majority of geographic areas, between 18 and 40% of children experience ongoing poverty. New Mexico is one of the four poorest states in the nation, with a median household income of $44,963 compared to of US median of $53,889. According to 2011-2015 American Community Survey estimates, 439,983 New Mexicans are living in poverty, including 30% of NM's children and 12% of people 65 years and older. Fourteen percent (14%) of all families and 30% of families with a female head of household had incomes below the poverty level.
http://quickfacts.census.gov/qfd/states/35000.html

The "children in poverty" rate based on household income in 2015 ranked NM as the second poorest state in the nation, with 29% of children living in poverty (compared to 21% nationally); over 20% of New Mexicans lived below the poverty level in 2010-2015 (compared to 16% nationally). Twenty-five percent of all families and 40% of single-parent families had incomes below the poverty level (Annie E. Casey Foundation, 2014). Over half (52%) of NM births are to unmarried women, as measured by marital status on the birth certificate, but this does not account for paternity, co-habitation or long-term, co-parenting families. http://datacenter.kidscount.org/data/tables/7-births-to-unmarried-women?loc=33&loct=2#detailed/2/33/false/868,867,133,38,35/any/257,258

Nearly 86% of the NM population graduated from high school (2011-2015 ACS Survey). Eight percent of teens ages 16-19 were not in school and not high school graduates, ranking NM as one of the worst in the nation in this indicator (Annie E. Casey Foundation, Kids Count). In 2011-2012, 16% of NM kids 2-17 years were reported by a parent as having a diagnosis of autism, developmental delays, depression or anxiety ADD/ADHD or behavioral problems. That estimate increased from 14% in 2007. New Mexico struggles to provide comprehensive, wrap-around services to children and adolescents.

ACCESS TO HEALTHCARE:

Many factors limit access to health care in NM, including provider shortages, lack of affordable insurance, and

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

Due to the ACA and Medicaid expansion, more New Mexicans are insured than ever before, which should help increase access somewhat, although having insurance does not guarantee access to a healthcare provider. Immediately after ACA implementation, the state's uninsured rate was down to 12.8% (in 2015), compared to 20.2% in 2013. In many ways, NM has been a leader in finding innovative ways to improve access to care: promoting the use of midwives and birthing centers; use of community health workers and social workers as care coordinators; utilizing telehealth for training and provider access; and flying pediatric specialists to rural areas to staff one-day specialty clinics for children with chronic medical conditions such as asthma, cerebral palsy, epilepsy, diabetes and congenital heart conditions. NM ranks second in the nation, along with Florida, for the highest percentage of children without health insurance. Through an aggressive outreach and enrollment campaign, the number of children eligible for and enrolled in the State Children's Health Insurance Program (SCHIP) and Medicaid are increasing steadily and enrollment is at an all-time high.

NM Medicaid provides many health care services for children under a federal Medicaid policy which requires that children received Early Periodic Screening, Diagnostic, and Treatment (EPSDT). This policy includes preventive health services, maintenance health services and treatment of medical conditions. It also includes mental health or behavioral health services. Enrollment of children 0-18 years in Medicaid of SCHIP increased significantly between 2007 and 2011, prior to ACA implementation http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-mexico.html As of March 2017, New Mexico has enrolled 787,110 individuals in Medicaid and CHIP — a net increase of 72.17% since the first Marketplace Open Enrollment Period and related Medicaid program changes (expansion) in October 2013. The majority of new enrollees were in the Adult Expansion category.

NMDOH STATE PRIORITIES:

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

Obesity:

Childhood obesity means that children are developing unhealthy eating and physical activity habits and sedentary tendencies early in life, making it more difficult for them to lead healthy lifestyles as adults. Obese children are more likely to become obese adults and to suffer from chronic diseases such as heart disease, cancer, and diabetes. Obesity is associated with food insecurity, and the NMDOH and Human Service Department (HSD) are collaborating to understand more about this problem and how to address it in New Mexico. The Title V Director has also been working with WIC on a collaboration with the Roadrunner Food Bank and NM State University to teach healthy eating and cooking habits to WIC clients in public health offices. When they attend the classes the participants also leave with produce provided by the food bank. In 2015, 11.8% of kindergarteners and 18.9% of 3rd graders were obese. American Indian students are still significantly more likely to experience obesity than any other racial or ethnic group.

By third grade, half (50.4%) of American Indian students are either overweight or obese, followed by Hispanics (36.4%). There appears to be a downward trend in obesity prevalence among 3rd grade students; rates have decreased by 16.3% from 2010 to 2015, going from 22.6% to 18.9%.

Smoking:

Cigarette smoking is the number one modifiable health risk in the United States, and its contribution to infant mortality is well-documented. In New Mexico, we estimate that we could reduce infant deaths by up to 30% if we eliminated maternal smoking all together. Cigarette smoking declined among all NM adults from 21.5% (2011) to 17.1% (2015), and from 20.5% to 19.5% among women of childbearing age (18-49 years) for the same period. (NM Behavioral Risk Factor Surveillance System). Among women giving live birth who reported smoking in the three months before pregnancy in 2012-2014 (35.6%), significantly more than half (71.1%) quit during pregnancy. The prevalence of smoking during pregnancy decreased moderately from 9.7% in 2000 to 7.3% in 2014 (NM Pregnancy Risk Assessment Monitoring System). By maternal race-ethnicity, non-Hispanic White women (11.6%) were significantly more likely to smoke during pregnancy compared to Hispanic (5.3%) and Native American women (6.3%) giving birth in NM (2014).

Drug and Alcohol use:

In 2015, NM had the 8th highest drug overdose death rate in the nation. In 2015, NM's age-adjusted drug overdose death rate was 23.5 per 100,000 persons. That year, 493 New Mexicans died of drug overdose. Between 1999 and 2015, the overdose death rated in NM increased by 62.0%. Prescription opioids have driven the increase in overdose death rates since 2006. Excessive alcohol use (i.e., binge drinking) is the fourth leading preventable cause of death in the US. NM has the highest alcohol-related death rate in the US and NM's rate is nearly twice the US rate. The majority of alcohol-related deaths involve working-age adults. Among women with live birth drinking during pregnancy increased from 5.2% in 2000 to 6.3% in 2014 (NM PRAMS). New Mexico, like many parts of the country experienced a sky-rocketing (about 9 times) increase in neonatal abstinence syndrome (NAS) diagnosis in infants born between 2000 and 2015. Just between 2009 and 2015, the statewide rate increased by more than two-fold from 3.8 to 10.3.

	NAS Diagnosis in infants per 1000 live births				
Year	2011	2012	2013	2014	2015
Rate	6.1	7.6	8.8	9.4	10.3

Diabetes:

Effectively managing chronic conditions, including diabetes and high blood pressure, helps adults stay out of the hospital. People at risk for developing diabetes include those with pre-diabetes; those who are obese, currently smoke, or have a family history of diabetes; and women who have had gestational diabetes. In 2015 American Indians in NM had the highest rate of deaths due to diabetes, three times higher than that of Whites. For every 100,000 American Indians there were 73 deaths due to diabetes, compared to 22 deaths due to diabetes for every 100,000 Whites. The Children's Medical Services Program (NM's CYSHCN Program) developed two pilot projects in 2014 to address the issue of diabetes in children and adolescents. In Roswell CMS partnered with the child health improvement program at UNM/ENVISION to provide coaching on the use of motivational interviewing to CMS social workers to help them work with identified families and PCP's. In Santa Fe a partnership developed with the local hospital's diabetes educator, the CMS nutritionist, and CMS social workers, along with a community farm, to provide education, support and access to fruits and vegetables to children with diabetes. Both pilots showed positive outcomes. With loss of staffing the projects were discontinued; however, currently on the PHD Leadership level there is renewed interest in reviving and expanding at least one of these pilot programs into other regions.

Oral Health:

Tooth decay is the most common chronic disease among children, 5 times more common than asthma and 7 times more common than hay fever among 5 to 17 year olds. Access to oral health care in NM continues to be largely inaccessible to individuals who are uninsured and are low-income. Tooth decay and other oral diseases are due to several factors including a lack of understanding of the importance of oral health to general health, poor oral hygiene, poor nutritional habits, and general lack of access to care in rural NM. American Indians and Hispanics

have the highest rate of tooth decay among all populations. Hispanic and American Indians are less likely to have a dental visit. Less than half of the adults with an annual income of less than $15,000 have had a dental visit within the past year. Every county in New Mexico except one is a dental practice shortage area as well as a medical practice shortage area. The Legislative Finance Committee has estimated that the state needs an additional 153 dentists, the great majority of whom are needed in rural, underserved parts of the state.

NM Medicaid provides full dental services for children and limited for adults. In 2012, 40% of adults reported having six or more teeth extracted. Less than 50% of new mothers have had their teeth cleaned. NM has made great strides in its efforts to screen and treat preschool children for dental caries through the many Head Start sites. This work has been strengthened by recent efforts to fluoridate city water in Bernalillo County, NM's largest metropolitan area. In addition, Title V programs and the Epidemiology and Response Division are working together to resume an oral health surveillance system, including a survey of third graders receiving sealants on permanent molars. Many dentists are not trained in how to provide services to children and youth with intellectual and cognitive disabilities, resulting in an even greater gap in services. The University of New Mexico School of Medicine's Department of Dental Medicine received some funds to create additional educational and clinical opportunities for UNM's special needs dental clinic. The five-year grant from the U.S. Health Resources and Services Administration will provide a special needs coordinator to oversee the academic program and direct patient care experiences for dental residents enrolled in UNM's dental residency program. Discussions are underway between the Residency Program and the Center for Development and Disability (CDD) at UNM to have residents participate in CDD programs for children with intellectual and cognitive disabilities, including possibly participating in the Center's Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program.

Teen Births:

In 2015, there were 25,730 births to NM resident mothers. NM's age-specific fertility rate (typically called 'birth rate' for teens) has declined markedly in the past ten years but remains higher than the national rate. The 2015 NM rate for 15-19-year-old females was 34.2 per 1,000, compared to the 2015 US rate of 22.0 of 1,000 (NCHS, 2016).

Disparities persist for Hispanic and American Indian teens. In 2015 American Indian teens had the highest birth rates in NM (41.9/1000) followed by Hispanic teens (40.1/1000). Hispanics constitute almost half of NM's 15-19-year-old female population, and their share of teen births is higher, representing almost 70% of the births in this age group. Black/African American females ages 15 to 19 gave birth at 24.8 per 1,000; White females ages 15 to 19 gave birth at 19.1 per 1,000. Using the majority population (White) as the reference group, Hispanic teens have 2.1 more births and American Indian teens have 2.2 births to every White birth (NM-Indicator Based Information System [IBIS], 2014 births).

Higher proportions of young, unmarried, American Indian, and Hispanic women, and those with high school education or less, had unintended pregnancies resulting in live birth. Teen mothers were the most likely to report a mistimed or unwanted pregnancy (77.9% of 15-17 year olds and 71% of 18-19 year olds). Among all women with live births who were not trying to get pregnant, 51.9% were using a method of contraception to prevent pregnancy. The three most common reasons for *not* utilizing contraception were: not minding a pregnancy; thinking a pregnancy could not occur when it did; and having a husband, boyfriend or partner who did not want to use birth control (NM Pregnancy Risk Assessment Monitoring System [PRAMS], 2014 births).

The NM Legislative Finance Committee (LFC) conducted research on teen pregnancy in NM in late 2014 and summarized this in a report released in May, 2015. A follow-up LFC report came out in fall of 2016. Recommendations of the original report included developing a new formula for distributing general fund allocations to school based health centers to prioritize centers with the greatest needs; pursuing public-private partnership opportunities to implement best practices related to the most effective forms of contraception among teens at high risk of becoming parents; and a collaboration between DOH and HSD to develop a plan to increase knowledge and provide technical assistance to safety net providers regarding the most effective forms of contraception as recommended by the CDC.

Since this report came out DOH/FHB has responded to the recommendations in several ways. We applied for and were given a two-year grant from the Brindle Foundation to fund a social media campaign; this campaign aims to educate NM teens about contraceptive options and how to access these options. Response rates so far have been higher than expected. In addition, FHB staff are participating in the LARC statewide working group, a coalition of stakeholders working on increasing access to LARCs through provider training and education. Three pilot sites are

currently in the process of holding provider trainings, including Lea County, which has the state's highest teen birth rates.

ACA/Health Care Reform:

Although the ACA brought several welcome changes to NM, including Medicaid expansion for low-income adults and a 24% decrease in the uninsured rate from 2013 to 2014, there are signs that things are still unsettled and that we may start to see regression or reversal of these trends in the near future. A recent community survey commissioned by the Con Alma Foundation found that 61 percent of people interviewed felt their health care coverage was unaffordable, despite the subsidies available on the Health Insurance Exchange. With even higher insurance costs expected in 2017, and rumors of Medicaid expansion being cut on the federal level and possible block grants for Medicaid, it is likely that the uninsured rates may increase again as New Mexicans lose their insurance coverage or find it increasingly unaffordable to maintain coverage. If this occurs safety net programs like CMS could see an increase in children who are newly eligible for CMS coverage for medical care especially for YSHCN ages 18-21 who might no longer have access to Medicaid. The 2016 state revenue projections were much lower than previously expected; therefore, Medicaid was not fully funded and provider rates were decreased in August of 2016. The state budget for FY18 has still not been finalized as of this writing (May 2017), so much remains uncertain at this point. In December 2015, 76% of children in New Mexico were enrolled in Medicaid, and an estimated 787,110 New Mexico residents are covered by Medicaid as of March 2017, approximately a third of the entire state population.

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

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

The NM Medical Insurance Pool (NMMIP) continues as a safety net for those with high cost medical conditions who are not eligible for other insurance or who choose not to buy insurance on the Exchange during open enrollment. Currently the state provides the carriers with tax credits to offset their losses from the Pool. During the 2017 Legislative session a bill was proposed that would have changed the funding structure of the High Risk Pool and eliminated the tax credits, but the bill did not get out of committee in either chamber. The DOH continues to rely on the Pool to insure CYSHCN and those with HIV who are not eligible for Medicaid or any other insurance programs.

Although the percentage of uninsured in NM has decreased from 20.2% in 2013 to 8.9% as of December 2016 (OSI email communication), it is not clear that this number can be reduced much further as there will always be those who do not qualify for assistance, the undocumented, and those who choose not to purchase insurance. If predicted cuts to Medicaid occur on the federal level, the uninsured rates in NM are expected to increase again, especially for the newly insured "expansion" population of low-income adults.

INPUT and NEEDS ASSESSMENT PROCESS:

The Title V Director and other FHB staff continually seek feedback from our partners around the state, including

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

CURRENT and EMERGING ISSUES:

Public Health Changes:

In late 2014 a visioning meeting was held with public health/DOH leadership from around the state to begin envisioning new roles and opportunities for public health in the coming decade. These discussions are ongoing, especially in relation to what services should be offered in the public health offices. In addition, NM DOH/PHD received public health accreditation in 2015, a huge accomplishment! The Public Health Division continues its work on "transformation of public health" although the changes have slowed somewhat as leadership is cautious about potential funding cuts on both the state and federal levels and the Department is currently in a hiring freeze for any state funded positions. The emphasis is on interagency and interdepartmental work (for example, Bureaus working together and Bureaus working with Regions), rather than independent work taking place in "silos", which was the more prevalent model in the past.

Data improvements:

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

CHALLENGES:

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

Insurance coverage for all New Mexicans remains a significant challenge. NM has a large population of immigrants, many of whom are undocumented or reside in mixed-status families. Insurance coverage for the undocumented is a major challenge, as the undocumented are not eligible for subsidies to buy insurance on the Health Insurance Exchange, and even on the open market we found there was only one insurance carrier that was accepting applications from undocumented clients. Currently the only affordable insurance coverage for the undocumented is through the Low Income Premium Plan, which is part of the NM Medical Insurance Pool (High Risk Pool). However, it is unclear how long the Pool will continue to exist; the Board members have frequent discussions about whether or not the Pool should continue and if so, for how long. Since all the carriers in NM follow the same open enrollment

period as the HIX, even for off-exchange plans, the only way the uninsured can obtain insurance outside of the open enrollment period is through the high-risk pool. The Pool, at least for now, continues to be the safety net for coverage of critically ill people who are not eligible for other coverage. Title V, Children's Medical Services' funds are used to procure insurance for children with chronic conditions who are not eligible for any other coverage. The DOH Secretary has asked NM Medicaid to analyze whether it would be possible to provide insurance for these children through the Medicaid program utilizing the MCOs.

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

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

Needs Assessment Annual Update

MCH Population by Domain Group:

Maternal and Women's Health

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

The New Mexico Department of Health continues its partnership and leadership with the New Mexico Perinatal Collaborative (NMPC). The Title V Director currently serves as Vice President of the NMPC. The collaborative has prioritized improving access to long-acting reversible contraceptives for women immediately after delivery (IPP LARC). This aligns with the Title V priority of addressing teen pregnancy prevention in NM and with well-woman care and reproductive life planning among all women of childbearing age. Title V also collaborates with UNM faculty and the NMPC on addressing Neonatal Abstinence Syndrome (NAS). The NMPC is working to develop and disseminate NAS diagnosis and treatment protocols for birthing facilities across the state and train hospital providers and staff. Additionally, the collaborative is seeking to reduce maternal mortality and morbidity from postpartum hemorrhage complications, a leading cause of preventable maternal mortality. There were 163 hospitalizations due to complications of maternal hemorrhage in NM in 2014. NM Title V team members are also renewing partnerships with the March of Dimes, which has a new national, regional and local structure aligning more closely with ASTHO infant mortality objectives, particularly addressing prematurity. In addition, the Maternal Health Program leads a maternal mortality review process, which is currently working with NM Vital Records, University of New Mexico Obstetrics and MCH Epidemiology staff to review several years of maternal deaths before asking a larger committee to review aggregate case findings for 2016 deaths.

Infant Health

New Mexico’s infant mortality rate decreased from 6.9 infant deaths per thousand live births in 2012 to 5.1 in 2015. The decrease between 2012 and 2015 rates was initially attributed to fewer infant deaths among Hispanic mothers within the neonatal period (0-28 days), but there were also changing definitions and certification of live births among some facilities (pulse v. breathing) and this is still being explored as a possible contributor to the change in rates. For the past five years, perinatal conditions, including low birth weight and preterm birth, accounted for more than half of all infant deaths in NM.

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

Neonatal abstinence syndrome (NAS) persists as an epidemic problem throughout New Mexico. In 2015, New Mexico's opiate overdose death rate remained one of the highest in the nation (8th overall) with a rate of 25.3 per 100,000 population. The state has organized in a cross-sector manner to address the continuing problem. As one measure, Governor Martinez signed 2016 legislation authorizing licensed prescribers to write standing orders to prescribe, dispense, or distribute naloxone to community-based overdose prevention and education program staff, first responders, and individuals at risk of experiencing or witnessing an opioid-related overdose.

The Title V program works in partnership with the NMPC and the March of Dimes to develop and expand programs aimed at providing prenatal, maternity and postpartum care for mothers and babies impacted by NAS. The NM Substance Abuse Epidemiology Team works closely with the March of Dimes Program Services Committee and MCH Epidemiology staff to monitor and prevent NAS-affected babies. In addition, community advocates led by Young Women United (YWU), based in Albuquerque, NM, continued a media campaign to encourage pregnant substance-addicted women to seek help without fear of losing their children or facing prosecution/incarceration for their addiction. NM Pregnancy Risk Assessment Monitoring System (PRAMS) staff and YWU leaders developed PRAMS surveillance questions to assess the prevalence of substance use in the preconception/early pregnancy period and have been collecting this data since 2014. Those estimates indicated there that about 6% of women with live birth use marijuana and 4% use prescription painkillers in the month before pregnancy. New Mexico MCH Epidemiology Program applied to participate in a 12-question supplement to PRAMS to assess further behaviors and attitudes about marijuana and pregnancy, as well as breastfeeding. The program was funded and planned to implement the data collection with 2017 births.

Child Health

As in previous years, more New Mexican children live in households with income below federal poverty level (28.5%) than the national average of 21.6%. The children of NM are in the dismal rank of 49th on the KID'S COUNT measures of well-being (early infant birth outcomes, child maltreatment, and poverty or systemic barriers to care) (http://www.aecf.org/m/databook/2016KC_profile_NM.pdf).

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

Increasing developmental screening and deceasing child abuse and maltreatment remain the most important priorities in Child Health. The rate of substantiated victims of child abuse has steadily increased from 9.9 per 1,000 children in 2013 to 21.3 in 2015. Title V is working with the Office of Injury Prevention and the Children Youth and Families Department to address these issues of abuse, neglect, and maltreatment, as feasible.

CSHCN

Children's Medical Services (CMS) continued its established partnership with the MCH Collaborative, convening a panel of twelve experts to assess the Children and Youth with Special Health Care Needs (CYSHCN) population needs. The MCH Collaborative is comprised of CMS, Family Voices, Parents Reaching Out, the Pediatric Pulmonary program at UNM, the UNM Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program, the Developmental Disability Planning Council (DDPC), and the organization Education of Parents of Indian Children with Special Needs (EPICS). The Collaborative comprises program representatives who share the personal dedication and commitment to Title V and has been supportive and innovative. It is a mechanism for CMS to receive feedback from other MCH funded programs and parent organizations representing diverse

backgrounds. The participation of Collaborative partners has enabled all represented to stay current and involved in the Health Care Reform process. CMS receives feedback on gaps in services from various sources including the Newborn Hearing Screening Advisory Council, the Newborn Genetic Screening Advisory Council, the Pediatric Society, CMS social workers, and the CMS Advisory Board which is part of the New Mexico Medical Society.

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

Cross-Cutting

New Mexico Department of Health MCH Epidemiology participation in a Technical Assistance opportunity with the Association of Maternal and Child Health Programs (AMCHP, 2015-2016) on Life Course Indicators reinforced the need to understand the upstream contributors to disadvantage. NM has a colonial history of trauma which manifests in different ways among diverse sectors of our population, including women and infants. Adverse Childhood Experiences and stressful events, which people of color disproportionately bear, must be understood before we can effectively terminate discrimination in healthcare, limited access or utilization of care among minority populations, and the adverse experiences of families living in areas of concentrated disadvantage. Racism and historical trauma can and should be addressed directly and within community conversations to change our course. We propose that perinatal outcomes can and should be experienced more equally if we address the social and cultural situations of families who experience the most challenging conditions. Our recent analysis geocoding births by quartiles of disadvantage showed that among the NM birth population

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

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

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

- Monitoring how ACA is being implemented in NM, with focus on vulnerable children in vulnerable communities
- Focus on equity of ACA implementation: access, process
- Identifying HOT SPOTS: communities of vulnerable children
- Assessing what public use data sets will allow us to measure: where the kids are, who they are, and how to

help their families to access insurance options

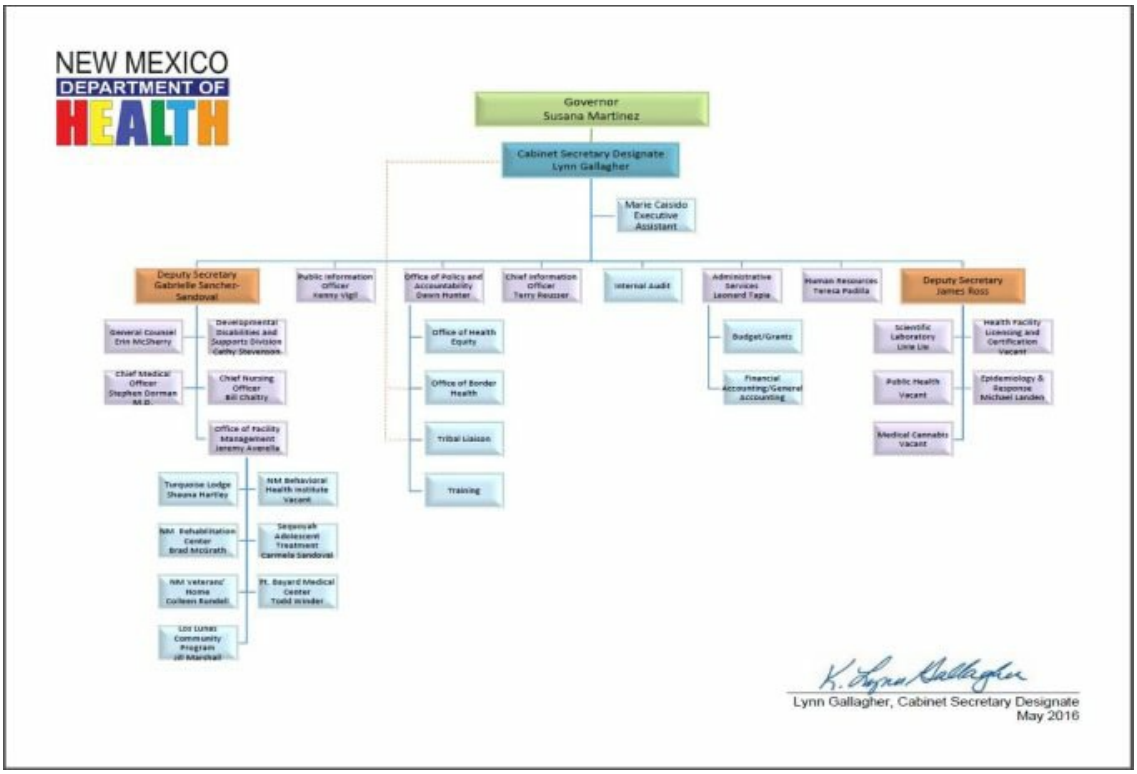
In 2015 there was an increase in the capacity to impact oral health in the child and maternal populations due to a higher level or partnership and collaboration around oral health. Oral health has been a priority in the previous five-year cycle (FFY 2010-FFY 2015). Children of poorer families have 2.5 times more untreated and un-prevented tooth decay. The New Mexico Department of Health oral health survey estimated that 64.6% of New Mew Mexico third graders had caries (the Healthy People 2020 goal is 42%), and 37% had untreated decay (the Healthy People 2020 goal is 20%). A 2014 pregnancy risk assessment monitoring system (PRAMS) survey found that 48.1% of women had their teeth cleaned during pregnancy. The Maternal and Child Health programs are collaborating with the Center for Development and Disability, the College of Nursing and the Dental Medicine Program in University of New Mexico's Health Sciences Center on the New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The goal of this project is to focus on systems building and theory-based clinical change to build a MCH primary care oral health care delivery model with statewide reach.

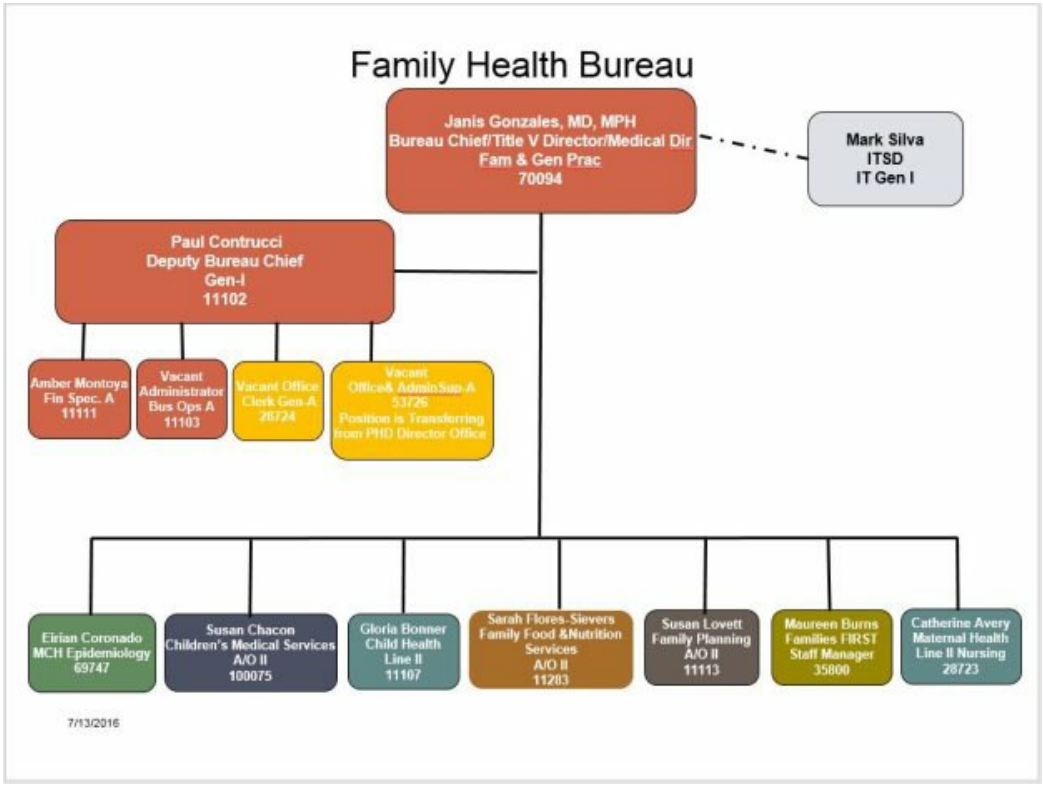
Adolescent Health

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

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

Organizational Structure


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


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

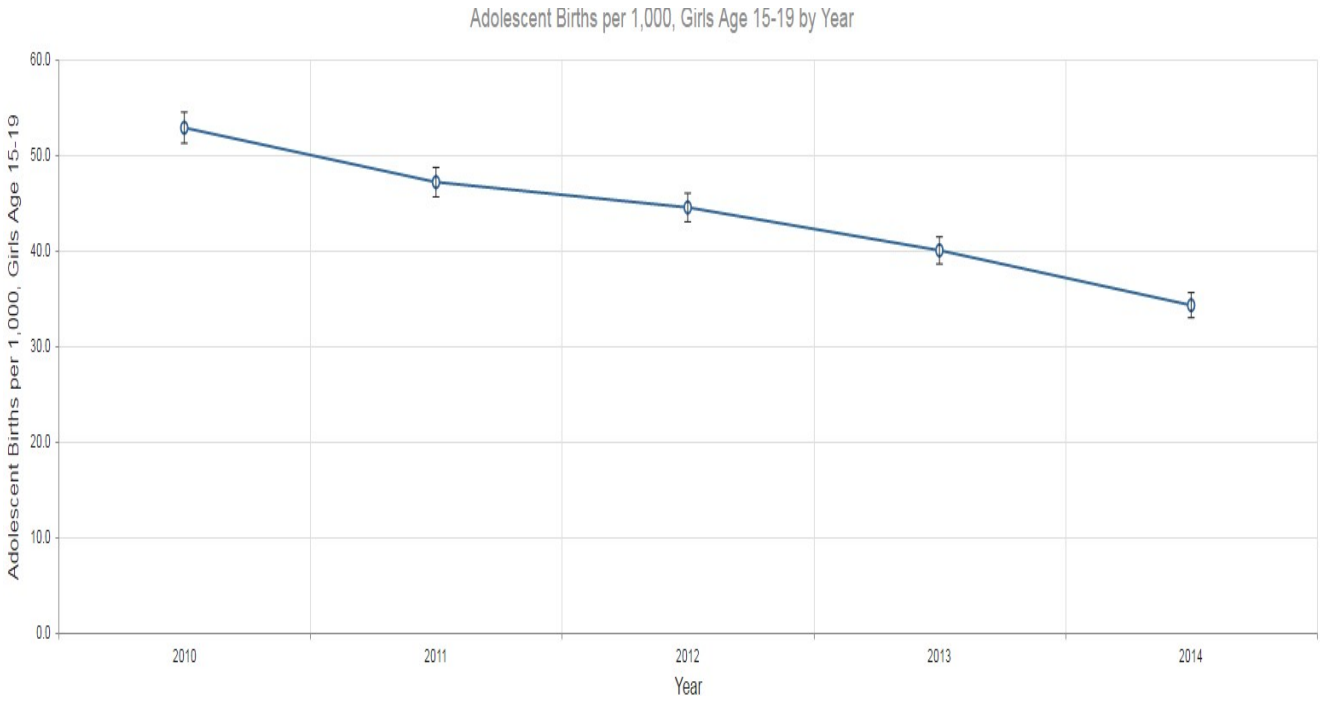
Needs Assessment Annual Update

MCH Population by Domain Group:

Maternal and Women's Health

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

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



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

Infant Health

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

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

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

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

Child Health

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

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

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

CSHCN

Children's Medical Service (CMS) continued its established partnership with the MCH Collaborative to convene a panel of twelve experts to assess the Children and Youth with Special Health Care Needs (CYSHCN) population needs. The MCH Collaborative is comprised of CMS, Family Voices, Parents Reaching Out, the Pediatric Pulmonary program at UNM, the UNM LEND Program, the Developmental Disability Planning Council (DDPC), and the organization Education of Parents of Indian Children with Special Needs (EPICS). The collaborative comprises program representatives who share the personal dedication and commitment to Title V and has been supportive and innovative. It is a mechanism for CMS to receive feedback from other MCH funded programs and parent organizations representing diverse backgrounds. The participation of Collaborative partners has enabled all represented to stay current and involved in the Health Care Reform process. CMS receives feedback on gaps in services from various sources including the Newborn Hearing Screening Advisory Council, the Newborn Genetic Screening Advisory Council, the Pediatric Council, CMS social workers, the CMS Advisory Board which is part of the New Mexico Medical Society.

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Cross-Cutting

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

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

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

As an example, teen birth rates are three times higher in geographies of high social disadvantage compared to those in the lowest quartiles of concentrated disadvantage. This indicates there is a community-related aspect to early child-bearing rather than or in addition to an individual behavior (additional data in attachment 1).

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

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

- Monitoring how ACA is being implemented in NM, with focus on vulnerable children in vulnerable communities
- Focus on equity of ACA implementation: access, process
- Identifying HOT SPOTS: communities of vulnerable children
- Assessing what public use data sets will allow us to measure where the kids are, who they are, and how to help their families to access insurance options

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

Adolescent Health

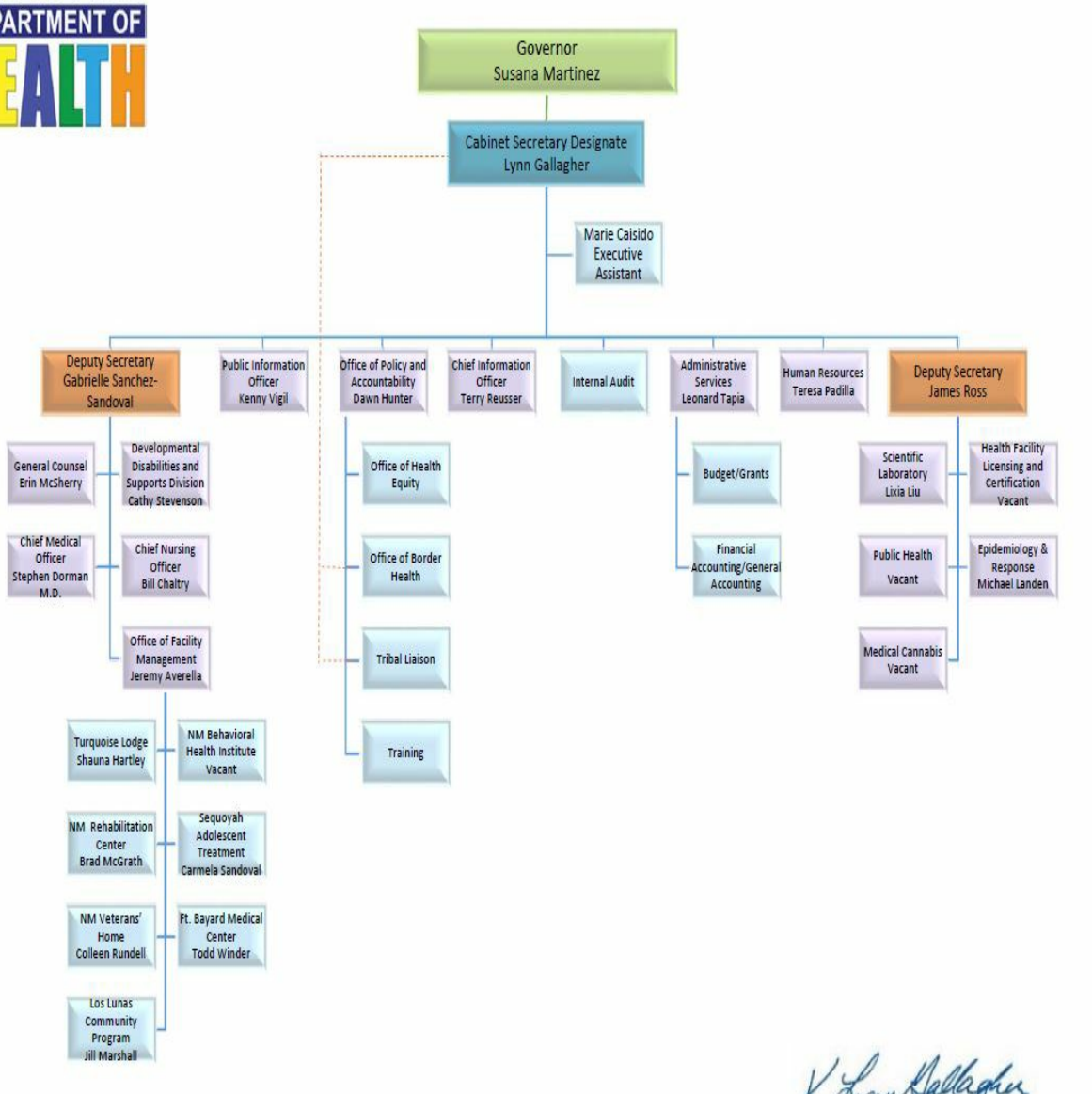
Bullying remains a priority in adolescent health and in the Office of School and Adolescent Health; therefore, there will still be some effort to reduce impact of bullying on adolescents because the programs will continue the efforts that have already been put in place.

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

Organizational Structure

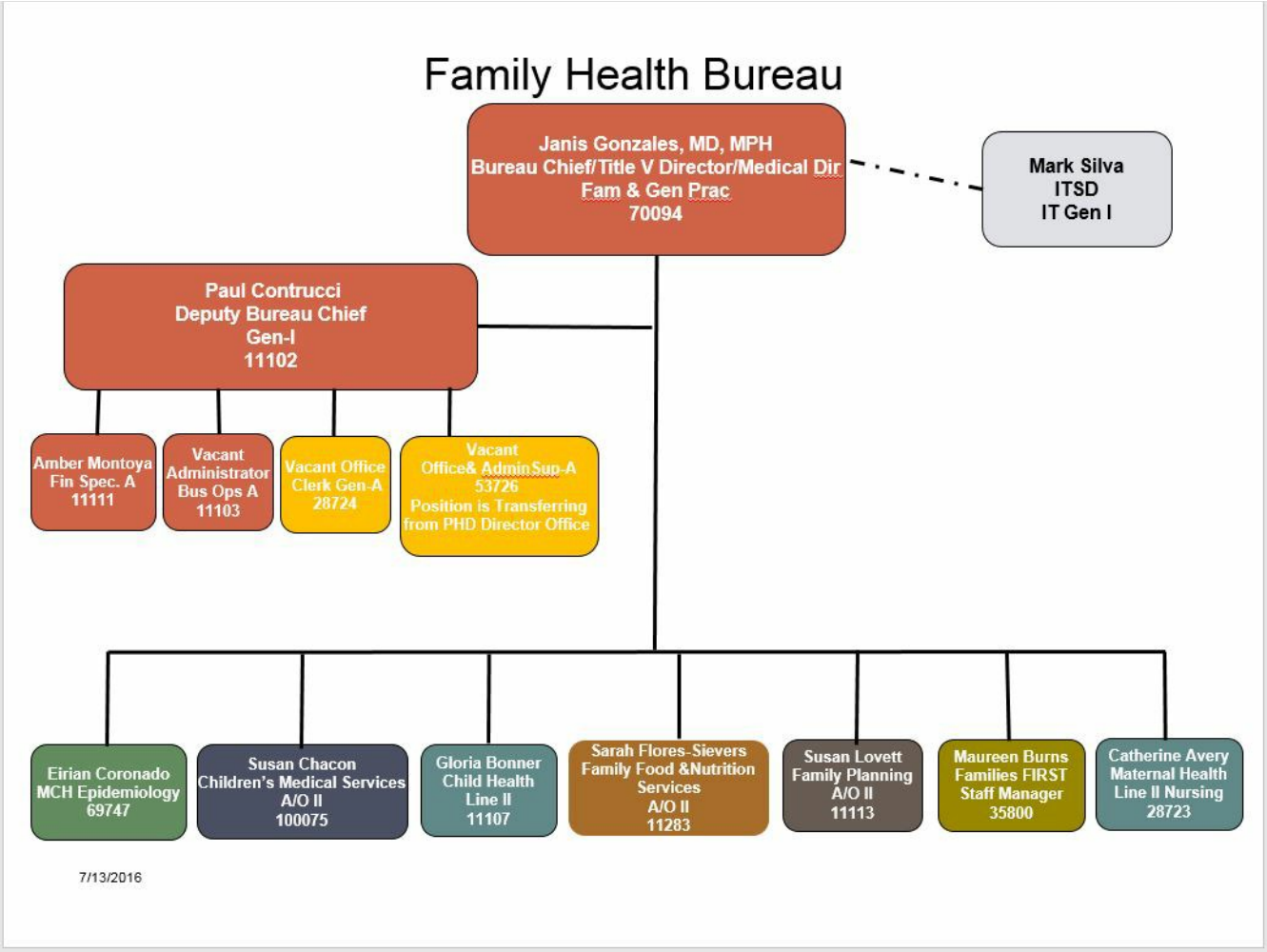
The New Mexico Department of Health experienced a significant change in organizational structure over the past year. The following organization charts are current.

NEW MEXICO DEPARTMENT OF HEALTH



K. Lynn Gallagher

Lynn Gallagher, Cabinet Secretary Designate
May 2016


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

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

II.B.1. Process

Overview

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

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

Framework

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

Data Sources

Each of New Mexico’s six domain work groups had a specific data table constructed from various resources to help the state initially assess strengths and weaknesses. Each indicator in the tables consisted of three data points that allowed each domain work group to compare New Mexico’s past performance or outcome (last four to five years), New Mexico’s current performance or outcome, and a nationwide indicator or outcome estimate. National data sets used in compilation of the data table included: American Community Survey/U.S. Census, Centers for Disease Control and Prevention (CDC) WONDER, CDC Youth Risk Behavior Survey, CDC WISQARS, CDC Sexually Transmitted Diseases Surveillance Special Focus Profiles, CDC Pregnancy Risk Assessment Monitoring System (PRAMS), CDC Breastfeeding Report Card/National Immunization Survey (NIS), CDC Pregnancy Mortality Surveillance System, National Immunization Survey, FBI Crime and Arrests Statistics, U.S. Bureau of Labor Statistics, Child Maltreatment and Foster Care Statistics, Centers of Medicaid and Medicare, National Center for Education Statistics IDEA Data Center, National Highway Traffic Safety Administration, National

Survey of Child Health, FDA Food and Nutrition Program Statistics, Primary Health Care Center Statistics, National Vital Statistics' Mortality data, National MCHB Center for Child Death Review, HRSA Child Health U.S.A., and the National Survey of Children with Special Health Care Needs. New Mexico data sets included: Vital Records and Health Statistics, Juvenile Justice Statistics, Medicaid's Annual EPSDT and Enrollment reports, WIC client participation data, Office of Injury Prevention reports, Behavioral and Substance Abuse data warehouse, School Based Health Center Statistics, Family Planning client data (Title X), NM Child Fatality Review,NM Asthma program, NM PRAMS, NM YRRS, FIT developmental screening (Part C), Emergency Department and Hospitalization data, Safe Kids NM, and Children's Medical Services program data. Additional data sources are described below.

Maternal Health

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

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

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

Infant Health

The infant and maternal health domain groups worked with some crossover during the assessment process, and those shared inputs are described in the attached matrix 'public input'. The primary stakeholder organizations are by definition maternal and infant (or early childhood, 0-3) providers or advocates, so the input points were not usually limited to one domain vs. the other. As described in the needs assessment overview, the process began by engaging internal and external stakeholder over the process of fifteen months in advisory committee meetings, foundation grantee meetings, and statewide gatherings. Active stakeholders included Family Health Bureau programs, the statewide perinatal collaborative, the PRAMS steering committee, Santa Fe, San Juan, Bernalillo and Rio Arriba County Health Councils, perinatal case management and home visiting programs including First Born, Families FIRST, Family Spirit, Tribal Epidemiology Centers, Navajo WIC, and a WK Kellogg foundation consortium of birth to 3 advocacy and service programs (ie Tewa Women United, Envision NM, Share NM, Young Women United and the NM March of Dimes).

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

Child Health

The Child Health Needs Assessment team was led by Gloria Bonner, the Child Health program manager, and included John McPhee, Childhood Injury Prevention Coordinator/Office of Injury Prevention, Crystal Begay, Health Educator/Environmental

Health Epidemiology, and Christopher Whiteside (Title V epidemiologist). The Child Health Needs Assessment domain group began its Needs Assessment by considering the over 200 indicators and health priorities paying close attention to the magnitude and trend of each. The group then narrowed the list to priority areas. The methods used to assess the needs of the child health domain varied between the evaluation of quantitative data and the collection of qualitative data.

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

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

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

CYSHCN

Children's Medical Service (CMS) utilized an established partnership, the MCH Collaborative, to convene a panel of twelve experts to review the Children and Youth with Special Health Care Needs (CYSHCN) data table, which included over 180 data points. The MCH Collaborative is comprised of program representatives from CMS, Family Voices, Parents Reaching Out, the Pediatric Pulmonary program at UNM, the UNM Lend Program, the Developmental Disability Planning Council, and the organization Education of Parents of Indian Children with Special Needs (EPICS) who share the personal dedication and commitment to Title V. The collaborative is a mechanism for CMS to receive feedback from other MCH funded programs and parent organizations representing diverse backgrounds. The participation of Collaborative partners has enabled all represented to stay current and involved in the Health Reform process. CMS receives feedback on gaps in services from various sources including the Newborn Hearing Screening Advisory Council, the Newborn Genetic Screening Advisory Council, the Pediatric Council, CMS social workers, and the CMS Advisory Board which is part of the New Mexico Medical Society.

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

Direct family input is important and critical to the CYSHCN needs assessment. A survey was used to collect additional family/consumer input on the three areas selected by the expert panel. Questions regarding ACA, insurance coverage and gaps was also included. Paper and electronic versions of the surveys were made available to families being served in Children's Medical Services Clinics (CMS) and CMS's partners between March 9, 2015 and May 1, 2015. CMS social workers provided the survey to families after participation in pediatric outreach clinics. CMS staff solicited family input during

two Family Leadership conferences one hosted by the NM Family to Family Health Information Center at PRO and another by the Education of Indian Parents with Special Needs (EPICS) who focus on the needs of Native American families. The survey was available in English and Spanish. Two hundred eighty-one individuals provided feedback on the CYSHCN Needs Assessment (CYSHCN NA) Survey concerning their children's health insurance, quality of medical care, and the ranking of selected health needs. Of those who answered the survey, 22% had a special needs family member that was in transitioning age (teens). Families indicated that for both children and teens with special needs that their top concern was improving the behavioral health care of their children.

Current initiatives underway are striving to address priority areas identified by the survey. The National CSHCN survey demonstrates a clear need for improvement in providing a medical home for youth with special health care needs in New Mexico, since only 34.9% of CYSHCN in New Mexico receive coordinated, comprehensive care within a medical home, compared to 43% nationally. In New Mexico, over 70% of Hispanic CSHCN, and over 73% of those below the Federal Poverty Level receive coordinated, comprehensive, ongoing care within a Medical Home. This is especially significant given the fact that almost a third of NM children live in poverty and over a third of the NM population speaks a language other than English at home. All this points to the fact that New Mexican children are at higher risk for not receiving coordinated, comprehensive, culturally competent care within a Medical Home compared to U.S. children in general. The New Mexico Pediatric Society's Pediatric Council has been working with the NM Quality Improvement Partnership (ENVISION New Mexico), the FHB/CMS Medical Director, and the Medical Directors of the four state Medicaid managed care plans to develop a consistent set of Patient Centered Medical Home (PCMH) standards. Having this clear and consistent set of standards will encourage physicians to embrace the medical home model and enable practices to more easily make the transition to becoming certified medical homes. With the support of the D70 funding the CMS program has been addressing 4 goals regarding improving the transition/transfer process for youth with special health care needs (YSHCN) in coordination with the Medical Home.1)Increase knowledge, skills and capacity of medical and social work providers statewide to provide effective transition services to YSHCN and their families; 2) Develop sustainable systems to provide support and information to YSHCN and their families during the transition process; 3) Build infrastructure to improve access to accurate, reliable information on Medical Home and transition issues for providers and families; 4) Collaborate with other state agencies and entities to promote policy and/or legislative changes that will improve transition services for YSHCN and their families in New Mexico.

Adolescent Health

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

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

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

perused the published results from the conference to understand how these determinants are impacting adolescent health and assisted in the development of priority areas of focus.

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

Cross-cutting/life-course

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

II.B.2. Findings

II.B.2.a. MCH Population Needs

Infant Health

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

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

Data Table 1.0, 2012-2013

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

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

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

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

Safe Sleep in New Mexico has been an area of significant program and public health investment between the Family Health Bureau and Office of Injury Prevention Epidemiology, a cross-divisional effort since 2011. The two programs have worked together over the past five years to expand awareness around 2011 AAP recommendations for infant sleep safety and to help birthing facilities develop appropriate protocols for safe sleep education during prenatal visits and delivery. The SUID rate for 2008-2013 was .8 deaths per 1,000 (n=134) , and the number of annual deaths decreased from 30 to 16 during that period. The 2014 death review is not complete, but preliminary numbers indicate a return to the more average rate of 20 deaths per year. The SUID (sudden unexpected infant deaths) in New Mexico are unequally distributed by race-ethnicity

and geography with the largest share experienced in the NW quadrant of our state and by Native American families.

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

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

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

Maternal Health

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

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

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

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

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

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

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

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

1. Birth spacing (67%)
2. Postpartum depression (50%)

3. Physical abuse during pregnancy (45%)
4. Non-medically-indicated cesarean sections (45%)
5. Mother's age at child's birth (42%)

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

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

CYSHCN

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

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

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

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

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

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

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

Cross Cutting

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

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

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

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

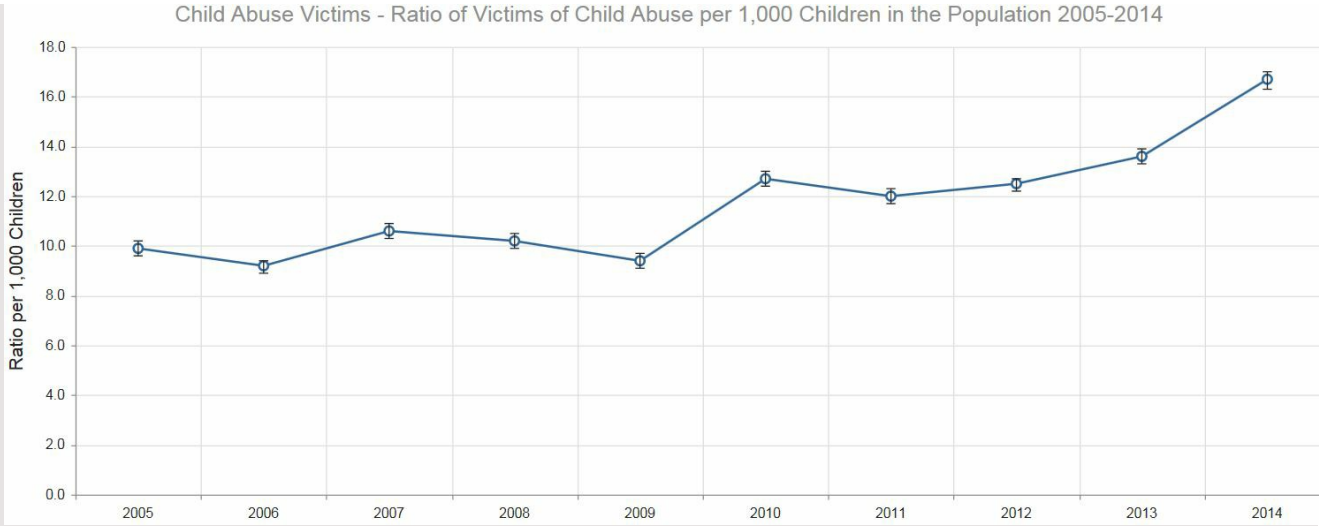
Relating to maternal and women’s health, participants surveyed were asked to rate relative importance of several health needs; the highest need is prenatal care (63%); the lowest, elective C-section (25%). Relating to infant health, the highest need was treatment referrals for infant drug exposure (56%); the lowest Sudden Infant Death (SID) Syndrome/ sudden unexpected infant death (42%). Child abuse rated as highest need (62%) and childhood injuries as lowest (32%) in child/ youth health. When asked about adolescent health, two areas rated equally as the highest concern: adolescent pregnancy prevention and adolescent pregnancy parenting support services (59%). The lowest is adolescent injuries (32%).

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

Child Health

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

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



Adolescent Health

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

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

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

II.B.2.b Title V Program Capacity

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

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

The Secretary of the Department of Health, Retta Ward MPH, is a Cabinet Secretary and reports directly to the Governor. The Deputy Secretaries are Lynn Gallagher, responsible for Programs, and Brad McGrath, responsible for finance and facilities management , including five hospitals and healthcare centers. The Secretary's Office houses the Public Information

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

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

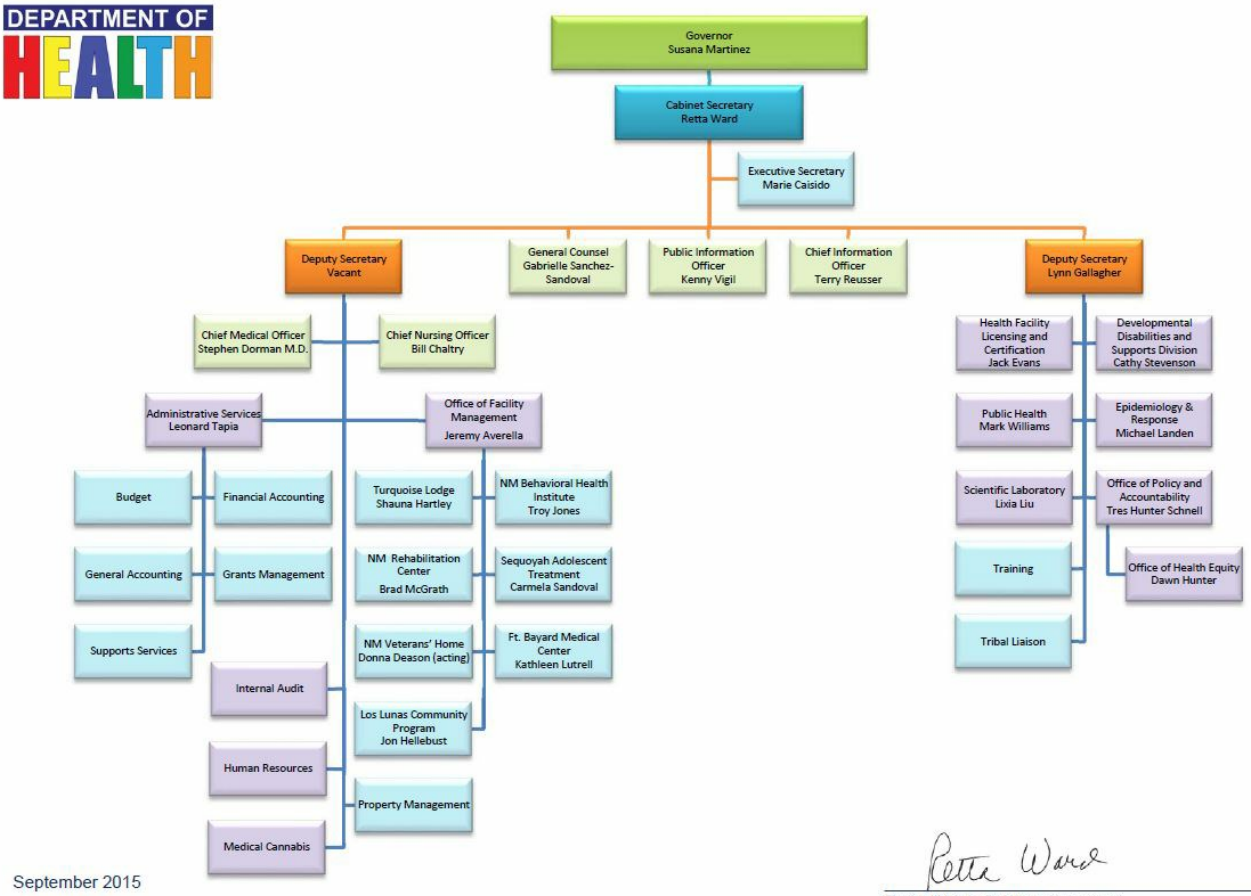
The MCH Epidemiology Program serves the data and information needs of the FHB and its many partners. It has incorporated tl genetic
sreening, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group. The MCH staff, including a position funded by SSDI, aid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

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

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

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

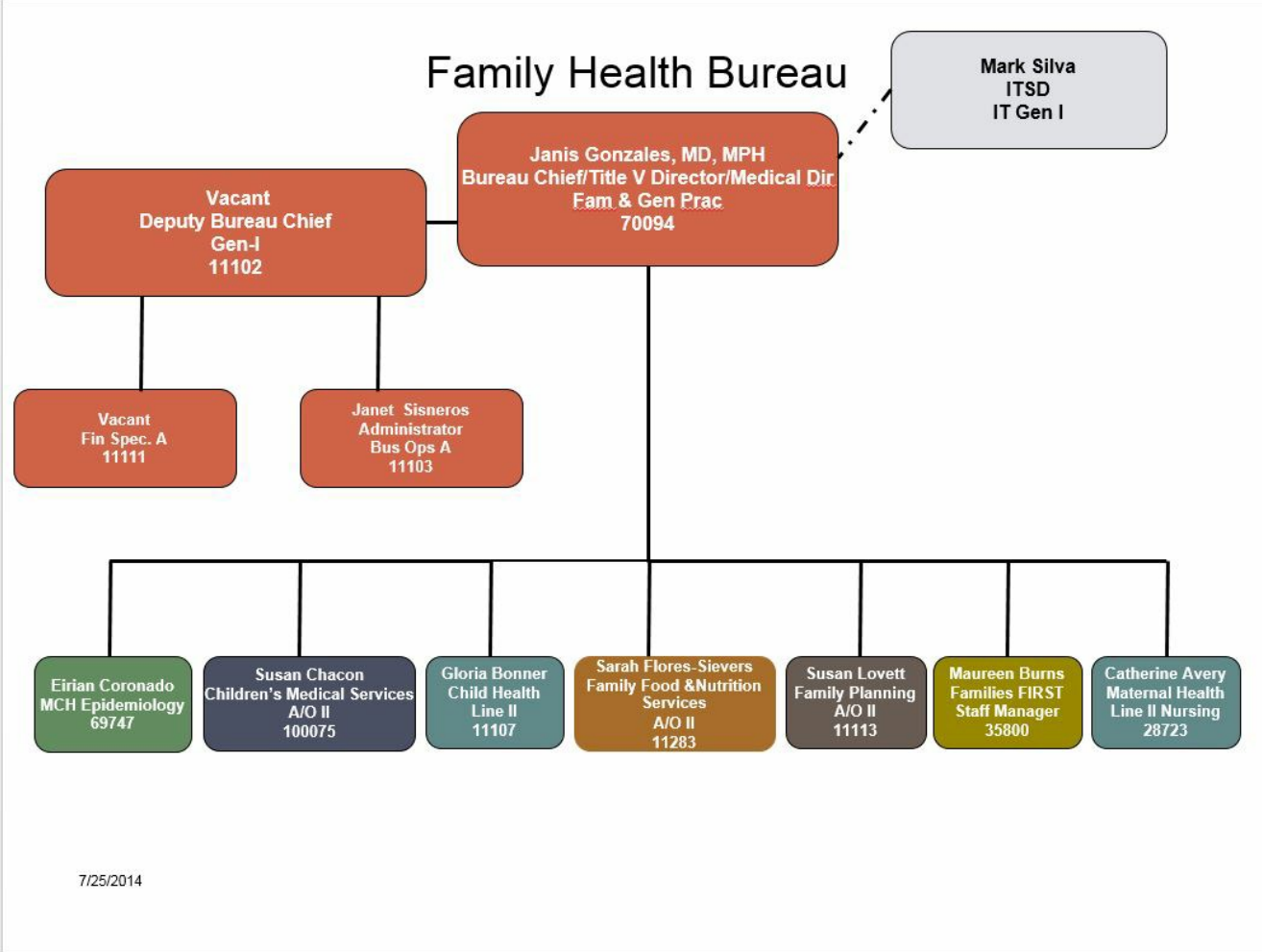
NEW MEXICO DEPARTMENT OF HEALTH



September 2015

Retta Ward

Retta Ward, Cabinet Secretary



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

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

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

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

The Families FIRST Program (FF) provides case management for Medicaid-eligible pregnant women and children 0-3 years. Its goals are to improve birth outcomes, to decrease high-risk pregnancies and identify children with special health care needs for referral to CMS and Early Intervention.

CYSHCN

The New Mexico Title V program for Children and Youth with Special Health Care Needs (CYSHCN) is titled the Children's Medical Services (CMS) that collaborates with partners statewide.

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

State Program Support for Communities:

CYSHCN who are covered by CMS, Medicaid/SCHIP and private insurance can receive clinic services in multidisciplinary CMS/UNM/Presbyterian pediatric specialty outreach clinics, and care coordination by CMS social workers. The number of CMS eligible children with high cost conditions enrolled into the New Mexico Medical Insurance pool increases yearly with an emphasis on meeting unmet orthopedic needs. CMS developed a new relationship UNM pediatric cardiology and in 2015 added 12 cardiology clinics statewide to address unmet needs.

Coordination with Health Components of Community Based Systems:

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

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

Coordination of Health Services with Other Services at Community Level:

Other agencies and community partners include: CYFD/child protective services, Food Stamps, ISD, community organizations providing services to multicultural and immigrant populations, i.e. Somos Un Pueblo Unido, local and statewide family organizations, school systems, some faith based service organizations such as Catholic Charities, and community domestic violence and substance abuse coalitions. Agencies and programs receiving Title V Maternal and Child Health Funding participate in a MCH Collaborative addressing transition, Medical Home and other MCH initiatives. CMS is represented on the Family to Family Health Advisory Board with Parents Reaching Out (PRO). The licensed social workers in CMS are required by statute to engage in eight hours of cultural competence training annually to renew their licenses. The care coordination in CMS is done primarily by social workers, with 2 positions filled by nurses. CMS, located regionally

in the health offices decided in past years to learn and address cultural competency regionally. Working with Hispanic communities of different origins and arrival in New Mexico, pueblos and the Navajo Nation, each region develops its own plan to carry out cultural competence training and delivery of services. While the Public Health Division under which falls the CMS Program focuses on translation for services and has allocated funding reimbursement of bilingual, bicultural staff, each region has its own issues and its own plan to assure clients receive culturally and linguistically competent care.

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

Title V Director's Office

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

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

Maternal & Child Health, Title V Funded Staff

Katie Avery, RN, CNFP is the Maternal Health Manager, responsible for the High Risk Prenatal program, Midwife Licensure and Regulation and the Maternal Health program.The Child Health Manager, Gloria Bonner, is responsible for the Early Childhood Comprehensive Systems (ECCS) Grant, Las Cruces Home visiting contract, and program activities that focus on child health with a focus now on developmental screening. Health Educator, Diane Dennedy-Frank, MSW, assists with segments of the ECCS grant and the child health component of the program including training on Ages and Stages. She also assists the Maternal Health Program Manager with special projects. Amber Montoya Clerk Specialist, provides office support for MCH staff and performs budget operation processes for MCH program.

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

CYSHCN Children's Medical Services

Ms. Susan Chacon, LISW is the Title V CYSHCN Director. Ms. Chacon has 10 years of program management within the

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

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

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

Maternal & Child Health Epidemiology

The Maternal & Child Health Epidemiology program coordinates the Title V Block Grant &Needs Assessment, the State Systems Development Initiative (SSDI) grant, and the Pregnancy Risk Assessment Monitoring System (PRAMS), including a CDC-Kellogg Foundation collaboration to over-sample Native American women in New Mexico. Currently, there are four epidemiologists, a data manager, two data collection staff and a program clerk. Eirian Coronado, MA, MPH candidate, coordinates the PRAMS survey and is the Program Manager. Chris Whiteside MPH, coordinates the Title V grant & Needs Assessment. He also coordinates and leads New Mexico in the Collaborative Improvement and Innovation Network to prevent infant mortality. Garry Kelley, MPH provides advanced analytic support for the CMS and WIC programs. Glenda Hubbard, MPH,RN, is the PRAMS analyst and SSDI data linkage project director. Dorin Sisneros is a data manager and provide fiscal oversight to the program. Oralia Flores and Nicole Hernandez provide data collection, data entry and general program support.The CMS program works in collaboration with the MCH Epidemiology program in data collection & analysis of the newborn screening program.

The Family Planning Program (FPP):

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

Other Workforce capacity:

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

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

Maternal Child Health partnerships with internal and external stakeholders played a key role in the needs assessment process. These groups were involved in the selection of the state’s priorities, informing staff of gaps in services, identifying health issues, and providing feedback on the five year needs assessment priorities as well as quality of services rendered

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

II.C. State Selected Priorities

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

Priorities Identified in the initial Five-Year Needs Assessment

The identification of state priorities began with a comprehensive list of possible priorities as health indicators that were selected by our population domain teams either through community meetings, existing community and health assessments or from those compiled by our epidemiology team. The Needs Assessment team presented those final indicators both in the large meetings and in small work groups, organized into teams, according to the mandated population domain groups: infant, maternal, child, children and youth with special health care needs, adolescents and cross-cutting/life course. The domain group teams were given prioritization ranking tools to assist the Needs Assessment analysis.

In our ongoing Needs Assessment, we systematically collected and examined information to identify and prioritize health problems in the MCH population. We started by collecting data and creating a list of over 800 health indicators organized by domain group from nearly 50 data sources. The indicator sets included risk factors, resiliency factors, and mortality and morbidity factors. Each domain team explored indicators that had the greatest magnitude or prevalence and appeared to be significant regarding disparities, persistence/trend or impact on population health. Each group used various methods such as surveys and stakeholder meetings to collect qualitative and survey data ultimately used to rank and identify any additional indicators that may be linked to emerging priorities.

The domain groups were given ranking tools to rank and choose the priorities. Some domain group teams used Q-sort with internal stakeholders and others used variations of criteria-based rating. Q-sort is a ranking technique where a panel of stakeholders choose and rank the priorities, and it provides some understanding of subjective viewpoints. Criteria-based rating uses standard criteria to score each priority. Most domain groups used the latter, and each domain group settled on two to three final priorities. The criteria considered were: trend or prevalence, disparities, currently addressed, capacity, and community support for change.

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

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

The executive Needs Assessment team discussed all priorities and utilized the criteria-based ranking method. Other factors that came into the process were political will and having to address the required National Performance

Measures. The executive team recommended and the Title V director accepted the final 13 priorities and determined which of the 13 would be submitted on form 9 of the TVIS.

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

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

Updated Priorities 2015 Report and 2017 Application

The MCH priority need to increase access to resources and increase awareness on bullying prevention was removed and replaced with the MCH priority need to increase and improve access to preventive dental care in pregnant women and children. The change was made after the MCH Title V program was encouraged by state public health leadership to align our MCH efforts with broader state priorities in New Mexico around oral health. Bearing in mind the capacity to collaborate, our MCH oral health efforts from the previous 5-year cycle, and being engaged by public health leadership and academic partners at UNM, the Title V director recommended exploring the possibility of reevaluating our MCH priorities. This required the Title V Needs Assessment workgroup, comprised of MCH programs and partners, to reassess our findings on the 5-year Needs Assessment.

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

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

The increased capacity and the ongoing priority to improve MCH outcomes made oral health a renewed priority that could engage multiple partners and programs. Nevertheless, the Title V director did not want to make a change to

the National Performance Measures selected unless there was a marked decrease in the capacity to impact one of the priorities selected. After carefully reviewing all the MCH priorities, the bullying priority was evaluated even further and the results indicated a significant decrease in the capacity to impact bullying. Bullying remains a priority in adolescent health and in the Office of School and Adolescent Health, therefore there will still be some effort to reduce the impact of bullying on adolescents because the programs will continue the efforts that have already been put in place.

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

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

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

State Performance Measures

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

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

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

- Infant mortality per 1,000 live births
- Perinatal mortality per 1,000 live births plus fetal deaths
- Neonatal mortality per 1,000 live births

Preterm-related mortality per 100,000 live births

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

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

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

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

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

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

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

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

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

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

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

- Maternal mortality rate per 100,000 live births

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

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

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

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

State Performance Measures

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

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

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

Infant mortality per 1,000 live births

Perinatal mortality per 1,000 live births plus fetal deaths

Neonatal mortality per 1,000 live births

Preterm-related mortality per 100,000 live births

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

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

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

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

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

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

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

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

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

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

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

- Maternal mortality rate per 100,000 live births

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

II.F. Five Year State Action Plan

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

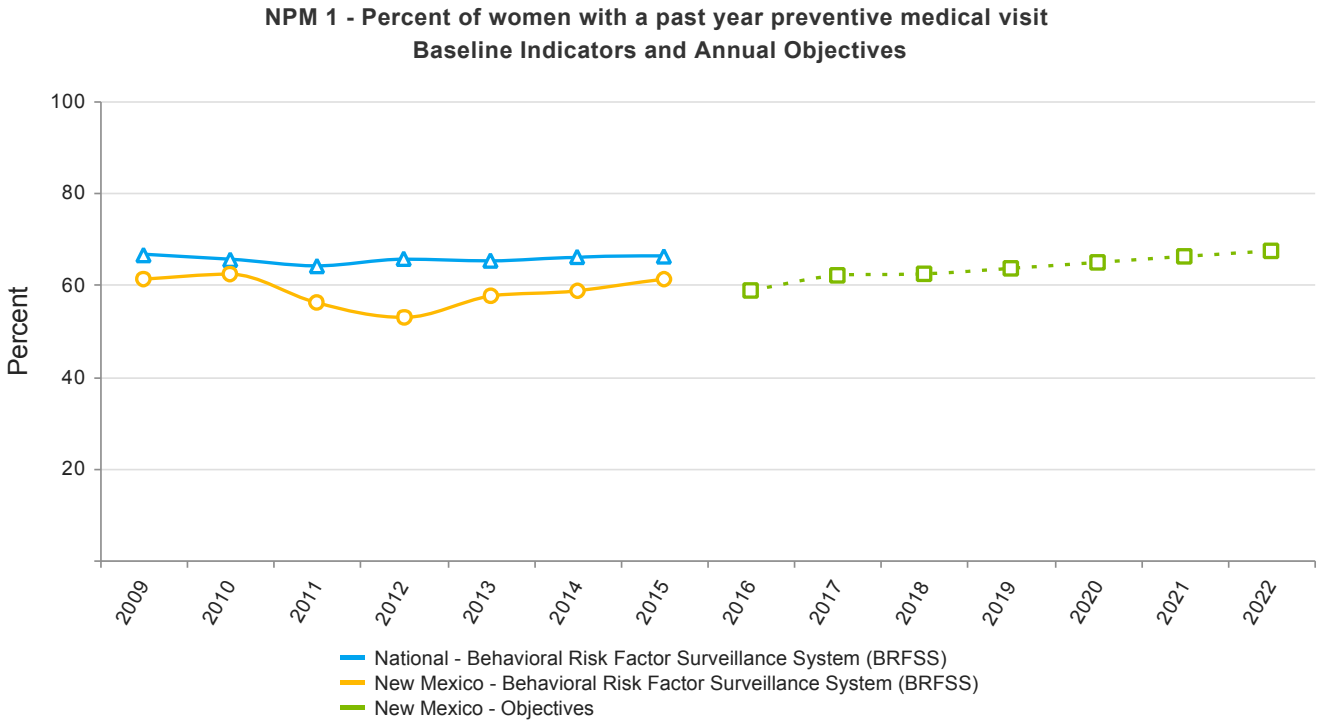
New Mexico has had very little change in the MCH strategies and priorities since the last application/report. In the following report and plan for the upcoming year, each population domain will give a narrative of programmatic activities by each priority area. NM Title V has many partners within the state that collaborate and work on these priorities.

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	181.9	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	25.7	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	8.7 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.2 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.5 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	9.5 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.5 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.1 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	27.3 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	5.1	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	5.2	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	3.5	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	180.4	NPM 1

National Performance Measures



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

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	62.0	62.3	63.5	64.8	66.1	67.3

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Quarterly Midwife Licensure Survey
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	150.0	167.0	167.0	167.0	170.0	170.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	2015
Data Source Year	NM HSD
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	35.0	40.0	40.0	40.0	40.0

State Performance Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	83.0	84.7	86.5	88.2	90.0	90.0

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	31.6	28.8	26.1	23.4	20.7	18.2

State Action Plan Table

State Action Plan Table (New Mexico) - Women/Maternal Health - Entry 1

Priority Need

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

NPM

Percent of women with a past year preventive medical visit

Objectives

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

Strategies

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

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

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

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

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

Add a question on "completion of post-partum visits by clients" to the Quarterly Reporting mandated by NM Licensed Midwives Practice Rule (NMAC16.13)

ESMs	Status
ESM 1.1 - Number of completed postpartum visits by maternal clients followed by Licensed Midwife providers	Active
ESM 1.2 - Number of licensed midwives trained in appropriate medical billing/coding	Active

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SPM

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

Objectives

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

Strategies

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

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

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

Create an interdisciplinary taskforce that will address the adequacy and appropriateness of maternal and neonatal transfer protocols at birth hospitals using the findings of the LoCATe Survey.

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

Well-women Care

In FFY2018, the Maternal Health Program (MHP) will continue to partner with our public health offices, the University of New Mexico (UNM), private practitioners, the NM Midwives Association, the NM chapter of the American College of Nurse Midwives, and birth settings throughout NM to administer provider agreements and/or contracts with providers or provider sites to provide timely and adequate care to pregnant, birthing, and post-partum women in NM. By working to retain providers and promoting public awareness we strive to improve the percentage of women receiving insurance coverage and care in the 1st trimester and throughout pregnancy.

The Maternal Health Program (MHP) manages the High-Risk Prenatal Fund (HRF) which utilizes matched Title V Block Grant (TVBG) funds to provide prenatal care coverage for women who are uninsured and underinsured. Via provider agreements and contracts managed by MHP, in 2016-2017, thirteen provider sites in New Mexico's urban and rural areas and along the US-Mexico border received funding to support prenatal care and delivery services to 1,222 clients. This service serves as a safety net making prenatal care available to maternal clients and optimizing a safer and healthier birth outcome. In FY18, there will be an informal evaluation of per site funding to ensure that allotted funds match the current bundled rate for prenatal care covered by Medicaid. Funds may be redistributed based on this evaluation.

In the past year, a new rural hospital site was added to the covered network to provide support to prenatal providers along the border. A change in availability of public health clinical services for prenatal clients in that area necessitated support of providers in the private sector to maintain access to care for uninsured clients. Over the next year, that area (the southeast region of the state) will continue to be studied to determine whether other provider sites could be recruited as recipients of high-risk prenatal fund monies to improve access issues. It is an area where a county has had higher Infant Mortality (IM) and Pre-Term Birth (PTB) rates than other areas of the state (Lea County, NM: 10.1 pre-term births per 100 vs. state rate of 9.5 preterm births per 100 live births [2015 IBIS data], and infant mortality rate 7.0 per 1,000 vs state rate 5.3 infant deaths per 1,000 live births [2013-2015 Indicator Based Information System (IBIS) data]). Finally, a pilot site's population served by high risk funding will be monitored for whether postpartum services, as an opportunity for well-women care, are made available and completed by clients. This site is in a metropolitan county in the state and in the 2016-17 fiscal year (7/1/16 to 3/31/17) saw 396 clients who received care under Title V High Risk Prenatal Funding. Data on completed well-women visits will also be collected and reported from two other active population-based surveys: the Pregnancy Risk Assessment Monitoring System (PRAMS) on completed post-partum visits, and the Behavioral Risk Factor Surveillance System or BRFSS which collects data on well women visits.

The MHP also serves as the licensing authority for the midwifery workforce in the state. Indirectly, work done in this arm of program function also promotes midwifery care in urban and rural areas of the state. For example, approximately one-third of births in the state are attended by midwives (reported 25,985 live births in 2014; 6,825 or 26% delivered by midwives). This provider workforce contributes to the availability of birthing options for maternal clients in the state including the use of the licensed (or direct-entry) midwives who attend home births, a service that is covered by NM Medicaid under the New Mexico Medicaid Birthing Options Plan. In a partnership capacity, detailed below, the MHP works closely with NM Medicaid and the managed care provider organizations (MCOs) that receive Medicaid monies to recognize midwives as Medicaid-reimbursable providers. MHP continues to receive feedback from licensed midwives in the state that reimbursement delays hamper their ability to practice in rural and metro communities. From workforce data collected at license renewal period from licensed midwives practicing in the state, of 33 midwives who completed the survey, roughly half (18) answered the question on reimbursement issues. Two-thirds of those who answered had issues with reimbursements with six mentioning Medicaid issues, specifically. A number of those who reported that they did not have reimbursement issue said that they didn't serve

Medicaid clients.

To address the above problem, the MHP is working with the Human Services Department/Medicaid Division to develop a formal training for the licensed midwives (LMs) and the MCO's to be held in the fall of 2017. This training will be in a webinar format so that it can be available for later use with the licensed midwife workforce. Coupled with this training plan, MHP will work with Medicaid to revise the Birthing Options Plan (a component of the Medicaid-MCO expanded care services), and incorporate this updated plan into the LM-MCO training planned for Fall 2017.

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

MHP will continue work with NMDOH's Office of Community Health Workers (OCHW) to explore funding sources to expand the doula workforce as well as any legislative initiatives to support continued use and access to doula care for diverse communities and populations. Currently, MHP is engaging with a practicing doula in the metropolitan area of the state to explore options for gaining Medicaid reimbursement for doula care. Certification of doulas will be a requirement by the HSD/Medicaid Division for reimbursement consideration; so, work in the area of incorporating doula/CHW certification into the OCHW function will be crucial to moving doula reimbursement forward.

Perinatal Regionalization

There are three major strategies to promote the availability and accessibility of risk appropriate care for maternal and neonatal populations in the state. First, a comprehensive assessment of neonatal and maternal levels of care was completed in Spring 2017 using the LoCATe survey. The final assessment included 29 birth hospitals in the state as well as 12 out of state hospitals that receive NM resident births. Data analysis with the Centers for Disease Control and Prevention Reproductive Health Division will commence in summer 2017. Once the analysis is completed with CDC assistance, a levels of care key will be provided to our Bureau of Vital Records so that any infant death will be linked to LEVEL OF CARE at a birth facility (as characterized by the birth hospital during the LoCATe survey.) Review of appropriate level of care will be possible with use of this key, and the key will then be an important component to the assessment of maternal and infant mortality review cases. This review work will complement the higher-level work proposed for fall to winter 2017-2018 of a Perinatal Regionalization Taskforce, formed under the NM Perinatal Collaborative, to address whether there is an adequate distribution or network of risk-appropriate levels of care settings in the state and what interventions at the system and/or policy level would be needed to create and sustain such a network.

Secondly, a current assessment of the level of identification, referral and/or care capacity for substance-using mothers and/or neonates with abstinence syndrome at each of NM's birth hospitals is underway and nearing the last 3 months of the second phase of this project funded under an Association of Maternal and Child Health Programs (AMCHP) Birth Outcomes Grant. The clinical-based work team out of the University of New Mexico (2 MDs and a nurse coordinator) contacted each birth hospital and gathered info on current protocols, level of knowledge, and on-site management capabilities (see tables below). Several birth hospitals were selected from the assessment, and specialized on-site training as well as protocol-sharing will be provided by the UNM work team in Summer 2017 via mini-sabbatical format.

Finally, work in the area of maternal morbidity and mortality case review continues in the state. A maternal mortality review (MMR) task force met in July and Oct 2016 and again in March 2017 to assist MHP staff with creation of a re-started MMR Committee. This is a partnership with UNM and other birth hospital clinicians in obstetric, perinatal and

neonatal care, as well as other professional members such as the Office of the Medical Investigator and the New Mexico Hospital Association. The goals of the Committee will be adequate case identification, case review and standardized data collection; review of individual cases with a larger multi-professional review group; and review of aggregate cases to identify regional trends or issues. Eventually, the MMR Committee will be the vehicle to propose strategic public health interventions to address disparities in care by region, race/ethnicity, and access to care, among other categories.

The first formal meeting of this appointed MMR Committee is slated to be held in February 2018 in conjunction with an annual statewide University of New Mexico Women's Health Clinical Update conference held in Albuquerque. At that meeting, an analysis of aggregate cases will be presented to the committee to review trends in causes, timing and demographics on cases in the 2010-2014-time frame. More detailed chart abstraction will be done on 2015 and 2016 cases and presented using a format provided by the CDC. New Mexico is using the Maternal Mortality Review Information Application (MMRIA) for the recording and analysis work at all stages of the MMR process.

Perinatal Regionalization

The Maternal Health Program (MHP), through its involvement with the Collaborative Innovation and Improvement Network (CoIIN), continued to take the lead, in collaboration with Maternal & Child Health Epidemiology staff, on the Risk-Appropriate Care CoIIN Initiative. The strategy of first gathering baseline data from NM birth hospitals (number = 29) on their levels of neonatal and maternal care is nearing completion. Using the Centers for Disease Control and Prevention (CDC) Levels of Care Assessment Tool (LoCATe), 29 in-state birth hospitals and 12 out-of-state hospitals that receive NM resident births were surveyed on their levels of specialty care for those two domain groups as well as their numbers of live births, low birth weight and/or pre-term births, maternal laboring patients not delivered, and fetal and maternal deaths. The goal of achieving 100% reporting was met, and analysis will begin with CDC this summer 2017. Stakeholders involved with this project, such as the New Mexico Hospital Association (NMHA), were instrumental in assisting with the communications to external professional partners. For example, NMHA communicated with its counterpart in Texas to assist with the surveying of El Paso, TX hospitals that receive NM resident births.

The ultimate goal of this CoIIN Risk Appropriate Care Initiative is to ensure that women with high-risk pregnancies, based on medical conditions or at-risk socioeconomic conditions present in pregnancy, are receiving care in facilities that can provide appropriate levels of care. After data analysis is completed, the team will work with the New Mexico Perinatal Collaborative (NMPC) to form a taskforce to create a model of perinatal regionalization that will address patient care needs, transfer protocols, incentive payer models and other necessary components for formulating an appropriate network of birth hospital care in the state. Presenting the survey findings to the NMPC will be the next step in creating the taskforce. Eventually, this model will address how best to create and maintain adequate distribution of services as well as adequate transfer protocols to enhance timely accessibility to risk-appropriate perinatal care.

The NMPNC, now 4 years in existence in the state, has another workgroup that is addressing maternal/obstetric hemorrhage. Members of that group worked with the MHP on re-forming the Maternal Mortality Review Committee (MMRC) at the state level. Legislation was drafted to clarify protections of records and member work. The bill passed both Houses of the state legislature but was subsequently vetoed by the Governor. The re-worked plan is to use the original 1998 rules for conducting MMRC and developing a policy and procedures (P&P) manual following those rules. This P& P Manual will be the guide for the future formal meeting of the state MMRC set for February 2018. A smaller chart abstraction workgroup is starting the abstraction process on 2010-2016 maternal deaths. Analysis on aggregated cases (2010-2014) will be conducted and more in-depth chart abstraction will be done on the individual 2015 and 2016 maternal death cases. Both the aggregate analysis and the individual cases (in a case summary de-identified format) will be presented and reviewed with the MMRC at the first formal meeting.

Since February 2016, the MHP has also been involved in a reproductive health technical workgroup under the US-Mexico Border Health Commission to study maternal mortality occurrence along the border (US and Mexico), compare the maternal mortality review methodology in all involved states, and give recommendations on how to improve outcomes and coordinate all involved systems. A technical report draft was submitted in May 2017.

Prenatal Care

The high-risk prenatal funds provided partially under Title V funding continued to be disbursed to health care sites that service high-risk OB clients who are not eligible for other insurance options including Medicaid. The funds supplement care and support to uninsured and under-insured pregnant clients. In 2016-2017, funds were disbursed to a tertiary care hospital system (3 levels of service at this site), 5 rural outpatient clinics, 2 rural hospital sites, 2 sonogram services and one urban clinic. Another contract with a lab service utilizes the fund to cover prenatal-related

lab services for uninsured clients at ad-hoc sites across the state. Over 1200 patients received services from this funding stream in FY16. With the high-risk fund's provisions, prenatal care access for a high-risk population is optimized, which improves outcomes at delivery. In early 2017, prenatal care services ceased at the one remaining public health (PH) clinic site that continued to serve prenatal clients. With the phasing out of this service, additional funding has been set up in a nearby community hospital setting to cover the services once available through the PH clinic.

The Maternal Health Program (MHP) continues to partner with our public health offices, the University of New Mexico, private practitioners, the NM Medical Society, the NM chapter of the American College of Nurse Midwives, and institutions throughout NM to form agreements with providers or provider sites to provide timely and adequate care to pregnant, birthing, and post-partum women in NM. By working to retain providers and promoting public awareness we hope to improve the percentage of women receiving care in the 1st trimester and throughout pregnancy. Between 2013 and 2015, there was a slight increase in percent of live births whose mother reported receiving prenatal care in the first trimester from 63.0% in 2013 to 65.9% in 2015.

The MHP program manager also participates on a review committee at the Department of Health's Office of Rural and Primary Care. The committee reviews applications for stipend rewards to primary care providers/students (all provider types including midwives) who indicate willingness to serve in rural and underserved areas of the state. The MHP also administers a Birthing Workforce Retention Fund, supplied by state funding, that accepts and reviews applications for awards to NM provider sites to help supplement malpractice insurance policy costs. It works as an incentive to recruit and retain practicing birth providers in the state, especially in the rural areas. Seven awards were disbursed in FY 2016.

In partnership with the Human Services Department/Medicaid Division, MHP will soon be creating a training curriculum and training session for all licensed midwives (also called direct-entry midwives who practice home births) on appropriate and accurate Medicaid billing. This is needed, and has been requested, as the midwives consistently experience claims reimbursement interruptions and delays. Data available from the Pregnancy Risk Assessment Monitoring Survey (PRAMS) reports about 60.0% of births in 2014 had Medicaid as the primary payer source for health care, so this work aids in encouraging the midwives to become Medicaid providers. Approximately 10 years ago, the MHP worked with Medicaid to create a Birthing Options Plan (BOP) to inform clients on the various birthing methods and settings available to them. In this case home birth, as an option detailed in the BOP, allows a client to have their low-risk birth at home utilizing a low intervention approach. The BOP is also used by the state's managed care organizations in their claims billing work, and is offered as an option in the managed care plans. The training plan will also include a component to ensure training with the MCOs to utilize the BOP to its full extent.

Prenatal Care Health Care Coverage

In the past, the Maternal Health Program (MHP) has engaged with its partner Zero to Three (formerly, National Healthy Mothers, Healthy Babies Coalition), to promote *Text4Baby (T4B)* usage in the state, primarily through education and information to clients of the Families First (prenatal case management) Program. A meeting in late May 2016 was conducted with the T4B regional representative who presented on NM user statistics, and what battery of services and messaging is available under T4B. Staff from the Human Services Department, the Department of Children, Youth and Families, and from the University of NM Community Dental Services were present. At the conclusion of the meeting, a plan was formulated to combine efforts from all stakeholders present to potentially utilize T4B's services to promote the work from each of the organizations. To date, continued effort in that area has been minimal. When T4B was taken over by Zero to Three, contact with a regional representative ceased, so continued monitoring of usage in the state has also ceased. One possible avenue to pursue is with HSD/Medicaid and the work to update the Birthing Options Plan. Once updated, information on the BOP could be disseminated via T4B. This will be explored with HSD/Medicaid once the updating BOP work has commenced.

As mentioned previously, but important to note in this section on health care coverage for prenatal clients, the MHP, in its capacity as the licensing authority for midwives in the state, works closely with the midwife community, the Medicaid Division (Human Services Department) and the managed care organizations (MCOs) that insure Medicaid clients to promote the previously mentioned Birthing Options Plan. The Plan is utilized by clients who opt for home or birthing center birth settings, two options where midwives are primary birth providers. Claims and reimbursement issues continue to exist, and the Medicaid Division has taken on the task of updating the Birthing Options Plan and any letter of direction documents needed so that the MCOs can be updated on all aspects of the plan, which, it is expected, will improve timeliness of reimbursement.

Unintended Births

NM has a high rate of unintended births for both teens and all women. These rates were estimated based on weighted data collected by the NM Pregnancy Risk Assessment Monitoring System (PRAMS) for 2004-2014. Unintended births for the years 2004-2014 were those resulting from pregnancies in which women said they did not want to be pregnant then or at any time in the future (unwanted) or they wanted to be pregnant later (mistimed). Starting in 2012, a “not sure what I wanted“ category was included in the survey. For 2012-2014, 50.9% of NM with live birth had an unintended (mistimed or unwanted) pregnancy. This includes 18.5% of women who were unsure what they wanted. Because ambivalence is a primary theme among women with unintended births it makes more sense to include them in the estimate for that v. intended births.

Higher proportions of young, unmarried, American Indian, and Hispanic women, and those with high school education or less had unintended pregnancies. The majority of counties with high unintended birth rates were also counties with high or increased teen birth rates. By implementing strategies to reduce teen birth rates, the unintended birth rate will also be addressed, because teens have the highest unintended birth rate. Seventy-five percent of women under the age of twenty had an unintended pregnancy v. 47.7% of those older than age twenty (NM PRAMS, 2014). Strategies to reduce unintended and teen birth rates include promotion of long-acting reversible contraceptives (LARCs) and provision of clinical services at school outreach sites.

Clinical services are provided in most of the state-funded public health offices across New Mexico and in primary health care clinics that are contracted through the NM Family Planning Program. Between 2010-2015, the use of long-acting reversible contraceptives (LARCs, which include IUDs and Hormonal Implants) increased, from 6% to 13%; during these same years the use of the 3-month injection decreased and the use of the oral contraceptive stayed relatively stable, at 28%. During these same years, the percentage of respondents who are pregnant or seeking pregnancy decreased slightly (from approximately 18% to 13%). In 2015, over 20,000 women of reproductive age received services at a Title X-funded clinic. The most popular method of contraceptive remains the oral contraceptive, followed by the 3-month hormonal injection and the Hormonal Implant. Over 12% of Title X clients report being pregnant or seeking pregnancy.

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

Perinatal/Infant Health

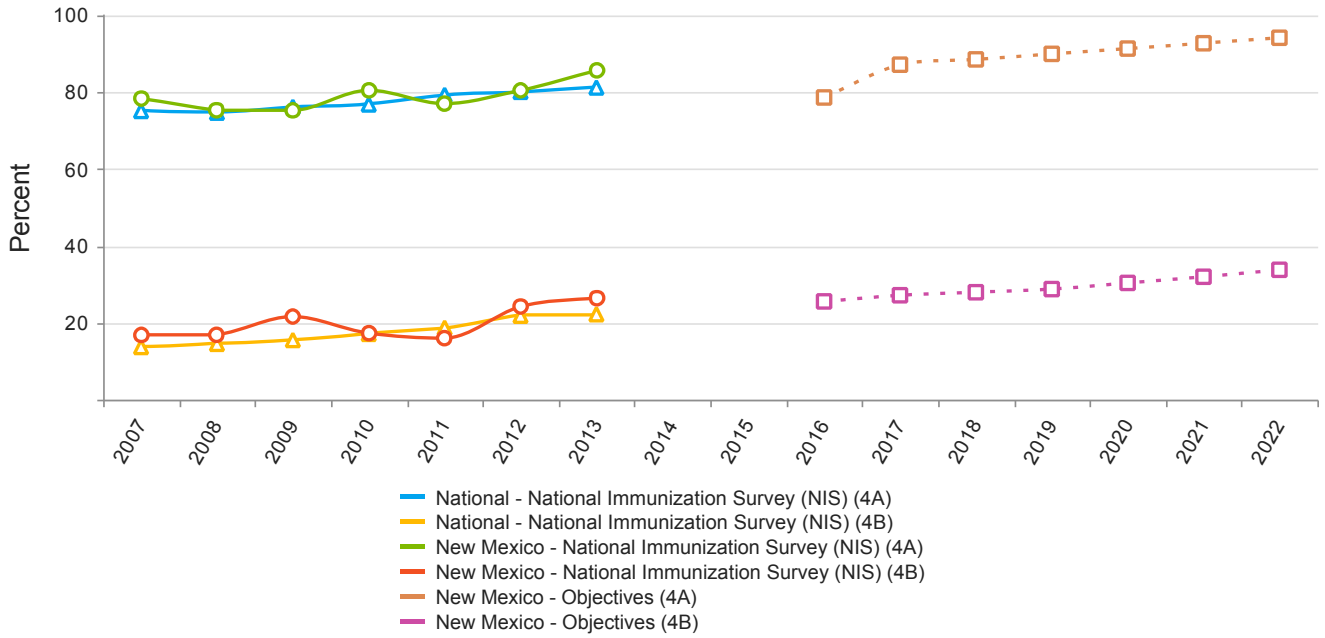
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	1.7	NPM 4
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	46.1	NPM 4

National Performance Measures

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

Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	78.5
Annual Indicator	85.5
Numerator	21,270
Denominator	24,890
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	87.0	88.4	89.8	91.2	92.6	94.0

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	25.6
Annual Indicator	26.6
Numerator	6,319
Denominator	23,784
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.2	28.0	28.8	30.4	32.0	33.8

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	26.4
Numerator	318
Denominator	1,205
Data Source	NM PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.0	31.7	34.3	37.0	39.6	42.2

State Performance Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	83.0	84.7	86.5	88.2	90.0	90.0

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	79.5
Numerator	19,194
Denominator	24,144
Data Source	NM PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.3	81.9	83.5	84.1	85.7	86.5

State Action Plan Table

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

Priority Need

To maintain and increase breastfeeding initiation and duration

NPM

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

Objectives

- Increase the number of NM delivery facilities with Baby-friendly status and corresponding mother/self-reported experience
- Fill measurement gaps to capture breastfeeding duration in NM
- Integrate and define the relationship between SUID/SIDS prevention and breastfeeding promotion
- Establish monitoring and reporting on mother-friendly workplaces and employers in NM

Strategies

- Utilize PRAMS to measure the correspondence between self-reported experience and the facility identification as baby-friendly
- Clearly define and pilot a home visiting curriculum which promotes breastfeeding support while simultaneously promoting safe sleep practices for families and their infants
- Collaborate with the March of Dimes, Children Youth and Families Department, and UNM Envision to co-brand messaging around safe sleep and breastfeeding
- Collaborate with the NM breastfeeding taskforce and the WIC breastfeeding program to monitor anticipated progress in breastfeeding initiation and duration at baby-friendly facilities in NM
- Share data and combine analytic efforts with UNM Envision, the NM Breastfeeding Taskforce and NMDOH to document the return on investment of breastfeeding and supportive workplace policies in NM
- Continue longitudinal data collection and data linkage.

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

NOMs

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

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

State Action Plan Table (New Mexico) - Perinatal/Infant Health - Entry 2

Priority Need

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

SPM

Percent of infants placed to sleep on their backs

Objectives

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

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

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

Strategies

Primary driver: Health care professionals understand, actively endorse and model safe- sleep practices. Convene statewide birthing hospital summit to share best practices and continuing education for hospital staff.

Tie Safe Sleep and Breastfeeding promotion efforts together.

Consult with four regional media companies with an emphasis on American Indian/Native audiences and families of all ethnicities, as well as a bilingual families, regionalized for cultural differences across NM.

Breastfeeding duration/Baby-Friendly Hospitals

a. Longitudinal data collection and data linkage improvement

Data collection for the longitudinal follow-up to Pregnancy Risk Assessment Monitoring System (PRAMS) began in October, 2016. The study is an ongoing survey of PRAMS participants when their child reaches the age of two. The collaboration to develop the survey included expertise from the University of New Mexico, Bureau of Business and Economic Research (BBER), independent epidemiology research consultants and early childhood service and breastfeeding program staff. Data for analysis of 2014 births (with two-year old results) was originally projected to be accessible in May, 2017 but is still pending as of June, 2017, and we anticipate it will be available for analysis by September, 2017 with an update for the final block grant submission. PRAMS infant survey data (2014 births) along with the toddler component results will be used to measure the impact of baby-friendly experiences to early breastfeeding duration and their relationship to ongoing (after 10 weeks) breastfeeding duration. The plans for analysis of breastfeeding duration support Title V priorities and performance measures to monitor breastfeeding duration beyond the early postpartum period at a sub-state geography and sub-population level. This new emerging data gives us an opportunity to monitor breastfeeding at 3 months, 6 months and 12 months by maternal characteristics and health systems-related indicators never available before to New Mexico.

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

The NM Breastfeeding Taskforce (NMBFTF) epidemiologist utilizes the Newborn Genetic Screening breastfeeding data to complete facility-specific report cards for NM birthing hospitals. These report cards are used in conversation with those facilities regarding the progress they are making with breastfeeding rates at discharge. While the information is not public, it is useful for hospitals to have their own data for evaluation of their baby-friendly status and pathways to that status. As stated in other sections of the narrative, early conversations and evaluations of the data revealed inconsistencies with completeness of breastfeeding at discharge and variability in accuracy. Plans for the next period include evaluation of interventions with specific facilities to improve reporting data along with Vital Records data, which is subject to some of the same limitations in terms of known breastfeeding status only at delivery, but which is not subject to missing or inaccurate data in that field. In addition, the NM Breastfeeding Task Force is launching some QI monitoring with Neonatal Intensive Care Units (NICUs). This will be another opportunity to improve reporting through the NBGS and Vital Records among those facilities.

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

Strategies to compare PRAMS surveillance prevalence of baby-friendly indicators with internal reports from specific facilities are planned for 2012-2015 birth data. One strategy we are exploring is to approach birthing hospitals and ask that they request their own data from the Department of Health because Vital Records restrictions do not permit public reporting by facility (nor is facility identifiable on the PRAMS birth extract after 2014). In addition, NM PRAMS updated the phase 8 survey with an addendum asking where women delivered their baby. That may be used to identify populations delivering at specific facilities to provide those facilities with specific feedback, but that data will only be available with the 2017 birth data set. The CDC has not yet released the 2015 NM weighted dataset as of July, 2017, so it is unlikely we would have 2017 data available until late 2019.

d. NM Breastfeeding Taskforce employer/workplace initiative

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

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

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

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

MCH Epidemiology staff participated in the House Memorial 2 (HM2) paid parental leave work group until its conclusion in September, 2016. HM2 was passed in 2015 https://www.nmlegis.gov/Sessions/15%20Regular/final/HM002.PDF to have the Bureau of Business and Economic Research (BBER) at the University of New Mexico to convene a work group to study and recommend parental work leave laws and management of parental paid leave funding in New Mexico. In addition, the work of the HM2 was planned to lead to submission of a 2017 bill to propose the mechanisms and agency roles of preliminary findings presented in October, 2016.

We (Title V stakeholders and MCH Epidemiology) had also planned work with UNM BBER to model simulated breastfeeding outcomes using PRAMS data with work leave indicators. The analysis plan had a target completion date of December, 2016 and a reporting target of May, 2017. These targets were not met, and we are revisiting that analysis as a Title V deliverable for FY18. During the FY17 period we did release PRAMS datasets for analysis to the University of New Mexico Envision program and to the NM BFTF epidemiologist, Heidi Fredine. In addition, the NM PRAMS Principal Investigator/Project Director (PI/PD) Eirian Coronado completed several analyses, reports and presentations to inform NM progress toward achieving breastfeeding duration goals. The focus of these products was primarily on the prevalence and impact of baby-friendly indicators/experiences on breastfeeding duration at 9 weeks. A separate publication in manuscript focused on breastfeeding initiation and duration gains among Native American women in New Mexico. Because Indian Health Service (I.H.S) facilities in New Mexico were the first to achieve baby-friendly designation we expected improvements in breastfeeding initiation and duration with available data in PRAMS (2014). However, the baby-friendly indicators collected only started with 2012 birth data, so baseline measurement is limited in that respect. For FY18 we will have more information to look at overall changes, and with the 2015 dataset we expect to see incremental changes with additional facilities achieving baby-friendly designation.

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

Safe Sleep and Sudden Unexpected Infant Death (SUID) prevention

We have worked to tie safe sleep and breastfeeding messaging together and to improve communication and promote consistent messaging in these areas. In 2016 we initiated communication and plans for strategic development with the DOH Office of Injury Prevention, Children Youth and Families Home Visiting Program, NM Office of the Medical Investigator/CDC SUID registry, Tewa Women United, birthing hospital facilities, Navajo Nation and several home visiting programs to promote breastfeeding while including safe sleep education for NM families. With support of a Graduate Student Epidemiology Program intern, Esther Gotlieb, and National Institute for Child Health and Human Development (NICHD) safe sleep champion, Dr. Mary Overpeck, NM worked on a plan to address the following components, based on plans and accomplishments achieved during the internship (June 2016-August 2016):

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

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

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

The work toward these strategies and goals was expanded to include new partners through Tewa Women United through introduction and inclusion in the Safe Sleep strategy of the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). Several products and presentations were made based on the comprehensive analysis of SUIDs for two different time periods. The results were shared with the Child Fatality Review, Public Health leaders, and with the NM Pediatric Society. However, the environmental scan and the convening of existing partners was not consistent and became inactive for months at a time. Therefore, even though we developed plans for communication and engagement strategies, they are just in the beginning stages, and require development and implementation for FY18.

Although Title V staff and Safe Sleep strategies continued work through the infant mortality CoIIN, an important contract with former Office of Injury Prevention (OIP) manager Robin Swift fell through when she took a full-time position with the University of New Mexico in another discipline. That set back some plans to concretize and implement some strategies for the reporting period. In addition, after several meeting invitations and communications with the CYFD Home Visiting Program, including the federal Maternal, Infant and Early Childhood Home Visiting (MIECHV) we could not establish a strategic direction together, and their staff was engaged in the federal home visiting expansion, making it very challenging to find time for communication. For FY18, bringing the partners to a consistent meeting time has been established and will start officially in June, 2017, in anticipation of full participation by October, 2017. This will include representation from the March of Dimes, select home visiting program staff, NICHD technical assistants, Tewa Women United and at least one managed care organization.

Outline of 2016-2017 analysis plan:

I. Death circumstances of SUID cases reviewed by NM Child Fatality Review team since 2010:

a. Descriptors regarding circumstances by cause of death (age of infant/sleep surface/caretaker relationship at time of death)
b. Cause of death composite for SUID (R99, R95, W75 ICD Codes) overview of sleep-related deaths in NM
c. Cross-tabulations of SUIDs by maternal race/ethnicity, regional of residence and medical characteristics
d. Qualitative and statistical results to identify risks associated with sleep-related deaths in NM.

Outline of communication plan developed in 2016:

II. What we know about SUID
a. National recommendations from AAP, NICHD, and CDC
b. Regional and local efforts (Child Protective Service (CPS) trainings and hospital protocols)

c. National campaign to increase safe sleep
d. Local messaging and cultural adaptability

Engagement strategy plan:

lll. Child Fatality Review and Stakeholders
    a. NM Safe sleep campaign/webinars
    b. Infant mortality CoIIN
    c. March of Dimes program committee
    d. Voices for Children
    e. Federal MIECHV home visiting sites

Breastfeeding promotion activities:

The longitudinal follow up (toddler survey) to Pregnancy Risk Assessment Monitoring System (PRAMS) began with funding procured through the WK Kellogg Foundation in May, 2016. The survey tool was completed and went into field testing in June, 2016- data collection began in October, 2016. The toddler study coordinator/Principal Investigator (PI), Chris Whiteside, met with his advisory committee in 2016 prior to the start of the study operations in October. Eirian Coronado, NM PRAMS PI/Project Director (PD) and Chris Whiteside worked directly with the Women, Infants, and Children (WIC) breastfeeding program managers, University of New Mexico (UNM) professors and Centers for Disease Control (CDC) national breastfeeding experts, as well as the NM Breastfeeding Task Force to develop the survey section relating to breastfeeding, and that section was completed just prior to live data collection in October, 2016.

Newborn genetic screening (NBGS) card data analysis (breastfeeding at hospital discharge) continued as planned. The NM Breastfeeding Taskforce (NMBFTF) epidemiologist utilized the NBGS breastfeeding data to complete a facility-specific report cards to NM birthing hospitals. A primary objective was to improve the use of data obtained from the NBGS reporting and to understand the gaps. The NMBFTF worked with several large facilities to address the information gaps and to institute a follow-up to determine breastfeeding status at six months. In addition, the PRAMS epidemiologists and the NMBFTF staff worked together to assure that questions selected for the Phase 8 PRAMS survey were appropriate and complementary to the data obtained on the NM birth certificate and on the NBGS card. Limitations of the NBGS data identified over the first year were that some hospitals were not filling out the breastfeeding field for all births, and that they may not have recorded whether delivering women attempted to breastfeed, breastfed during the hospital stay, or succeeded at breastfeeding post-discharge, but rather only recorded if they were breastfeeding at discharge.

With funding from the WK Kellogg Foundation, a NM Breastfeeding data advisory group worked to increase breastfeeding duration, starting in 2015. The group was convened formally until August, 2016 through Envision New Mexico, a pediatric quality improvement organization which brought together stakeholders from Young Women United, Nuestra Salud, NM PRAMS, NM Breastfeeding Taskforce, March of Dimes, UNM Robert Wood Johnson Foundation (RWJF) Center for Health Policy, and pediatric specialists. The team conducted a scan of existing breastfeeding data sources including PRAMS, NM Vital Records, the National Immunization Survey, and the National Survey of Children's Health. The group also collected and analyzed both quantitative and qualitative data and conducted community conversations through the leadership of the NM Breastfeeding Task Force. The RWJF Center for Health Policy led the analytic gaps/scan assessment of available breastfeeding data sources in New Mexico.

In July, 2016 a Community Advisory Board (CAB) was established with additional WK Kellogg funds to explore strategies to incorporate a Quality Improvement plan building on initial (Envision-led) findings from community conversations, population survey sources and gaps analysis.

Regarding the strategy of utilizing PRAMS to measure correspondence between self-reported experiences and facilities identified as baby-friendly, we conducted analysis in 2016 to compare self-reported baby-friendly experiences (by indicator and aggregate) in PRAMS by region and maternal characteristics. This was a descriptive snapshot of trends in breastfeeding from 2000-2014 and the baby-friendly indicators reported by new NM moms in 2012-2014 https://nmhealth.org/data/view/newsletter/1939/. Although the analysis included baby-friendly indicators by region of residence, there was no one-to-one correspondence with birthing facilities; we did not obtain permission from the NM Vital Records to make this match, and that will be pursued in the plans for FY18. The short time-period is one limitation, as baby-friendly indicators in PRAMS are only available for 2012-2014 birth analysis, and there was no available surveillance to measure those changes prior to that period. However, we did analyze breastfeeding initiation and duration changes over time, and the increasing trends are associated with systems and policy changes between 2000 and 2014.

The next strategy in place is to collaborate with the NM Breastfeeding Taskforce and the WIC breastfeeding program to monitor anticipated progress in breastfeeding initiation and duration. The NM Breastfeeding Taskforce employer/workplace initiative and Association of State and Territorial Health Officials (ASTHO) Breastfeeding Learning Community continued in the reporting period. One component of the learning community required all WIC staff and breastfeeding peer counselors to participate in the DOH/ASTHO Breastfeeding Friendly Workplace Initiative one-hour webinar 'The Business Case for Breastfeeding'. WIC partnered with the NM Breastfeeding Task Force to sponsor the 23rd Annual Breastfeeding Conference in March 2017, which focused on the biophysics of breastfeeding, human milk banking, marijuana research and breast cancer research regarding breastfeeding. Over 350 health care professionals attended, with about 77% from NM (including all WIC Nutrition staff), and 23% from other states. WIC continues to train all new WIC staff on breastfeeding through a full 2-day workshop within 6-12 months of hire. All WIC Nutritionists continue to attend an advanced 4-day Lactation Training presented by the Childbirth and Postpartum Professional Association (CAPPA) Program after one year of hire. And this past fiscal year, WIC initiated use of a series of web-based trainings on normal baby behavior related to feeding and sleep issues, which was required and completed by all WIC Nutritionists and Breastfeeding Peer Counselors.

WIC staff participated in the ongoing design and development of a new data collection system with Texas and Louisiana WIC Programs to improve breastfeeding services to WIC participants and to improve data reporting capability. The new data system, focusing on collection of prenatal and breastfeeding data, reporting requirements, breast pump/supplies inventory system, and inclusion of peer counselor-client contacts into the system is scheduled for roll-out to NM WIC clinics in the summer of 2018.

WIC expanded the Breastfeeding Peer Counselor (BPC) program to 65 active BPCs providing one-on-one services to WIC participants in 60 WIC sites/communities, including the following activities:

- Working closely with tribal WIC Programs by sharing resources and training their BPCs.
- Expanding BPC Breastfeeding Support Groups to new rural communities statewide.
- Expanding Hospital BPC Project into 9 hospitals statewide: six (6) in Northern NM, two (2) in Southeastern NM, and one (1) in Southwestern NM.
- Pending hospitals for BPC placement, there were two identified in Southeastern NM, one (1) in Southwestern NM, and one (1) in Northern NM.
- Forming partnerships and collaboration with NMDOH Office of Border Health to meet the lactation educational needs of community programs along the border of NM, TX, and Mexico.
- Forming partnerships and collaboration with Graduation Reality and Dual-Roll Skills (GRADS) (high school/teen parent program) to meet lactation education and lactation assistance needs for Teen Parents.
- Forming partnerships and collaboration with NM Kids and Community Health Worker programs to meet lactation education for Community Health Workers working with families.

The next strategy is to share data and combine analytic efforts with Envision NM-UNM, the NM Breastfeeding Task Force, and NMDOH to document the return on investments of breastfeeding-supportive work policies in NM. NM PRAMS and the Breastfeeding Taskforce collaborated on the workplace breastfeeding initiative. We developed some research questions in collaboration with the House Memorial 2 (HM2) Parental Leave Working Group to estimate the economic impact of breastfeeding in NM. We planned to explore the following questions: If we had 6 months of paid maternity, how much would we estimate that breastfeeding duration would increase? Comparing duration rates for employed mothers and unemployed mothers—how does paid maternity leave impact duration? What are businesses doing to comply with the federal regulations for nursing in the workplace? How do employee reports differ from management reports in that regard?

We worked with the HM2 Parental Leave Working Group to formulate some of these questions and to explore data

gaps. We need to answer those and other policy-related questions. The House Memorial requested that the University of New Mexico's Bureau of Business and Economic Research (BBER) convene a parental paid leave working group to develop recommendations for the establishment of a parental paid leave program and a publicly managed parenting workers' leave fund. The work group was facilitated by the Southwest Women's Law Center (SWLC) and met bi-monthly until September, 2016. There were various strategies used to address the outcomes related to breastfeeding duration. One of those was the establishment of the right to work during pregnancy. While there are some federal legal protections in place, SWLC collected qualitative data from focus groups showing a need for more accommodations; this included stories from women who have experienced discrimination in the workplace because of their pregnancy. A preliminary HM2 report was presented to the legislature on October 1, 2016. To contribute to this workgroup, NM PRAMS developed analysis plans to examine the impact of maternity leave policies on the outcome of breastfeeding initiation and early duration. Analysis was not completed within the reporting period, but the goal remains in the FY18 plans.

A major strategy implemented was to co-brand messaging around safe sleep and breastfeeding. March of Dimes, Children, Youth and Families Department (CYFD), WIC and Title V coordinated to bring safe sleep education to WIC staff at the statewide Breastfeeding Task Force in the Spring of 2015 to balance messages from Notre Dame Professor and Researcher, James McKenna. This was the first activity where Title V and WIC staff collaboratively and proactively countered the push for co-sleeping (i.e. bed sharing) since our statewide webinars with DOH and community partners held in 2015. WIC breastfeeding staff were required to attend a session on the American Academy of Pediatrics (AAP) safe sleep recommendations during the NMBFTF breastfeeding summit, as a requirement of their attendance, and the information was well received.

WIC developed and aired TV commercials to educate and support businesses and mothers concerning NM’s Breastfeeding Worksite law. The three TV commercials provide a link to the NM Breastfeeding Task Force website for more information and for access to Worksite Liaisons who can provide outreach education and technical support.

Safe Sleep/SUID prevention

Home visiting curriculum which promotes breastfeeding support while promoting safe sleep practices for families and their infants has been clearly defined and will soon be piloted. The MCH Epidemiology program, Child Health Program, and the Children, Youth and Families Department Home Visiting Program established an agreement to partner with Cribs for Kids to make cribs and safe sleep training materials available to home visiting clients, statewide in 2015. The Cribs for Kids agreement was not implemented, though funds were made available to CYFD in August, 2016. A change in leadership and transitions in early childhood priorities delayed the agreement, and we re-established initial goals in a cross-agency team meeting in March, 2016. At that point we broadened the scope to include poverty, economic and social risk factors associated not just with unsafe sleep but with other adverse early childhood outcomes. During the period, though, we were not able to convene cross-agency partners regularly, and the staff turn-over/re-direction of duties in the Office of Injury Prevention at DOH made it very challenging to plan around this strategy. While the memorial to create a statewide cross-sector safe sleep/Sudden Unexpected Infant Death (SUID) prevention strategy failed to pass the legislature in 2015 and 2016, the March of Dimes, NMDOH and CYFD are committed to establishing that work, given resources including staff or contract time. To get that process started, the MCH Epidemiology and National Institute for Child Health and Human Development (NICHD) safe sleep champion, Mary Overpeck, developed a graduate epidemiology internship. To support the development of a strategic plan, MCH Epidemiology submitted a proposal to host a graduate student epidemiology program intern to support analysis of sudden unexpected infant death data collected in the national child death registry for New Mexico. We were matched with a graduate student from Tulane University in May, 2016 and outlined the following to complete by August, 2016:

Deliverables for internship: status- 2016:

5/23-5/27	Review SUID and ASSB classification literature - the literature review was completed during the stated timeframe
	NM PRAMS dataset overview, safe sleep and former data products
5/31-6/3	Meet with Office of Medical Investigator -complete
	Meet with Office of Injury Prevention- complete
6/6-6/10	Complete preliminary data analysis from SUID registry/CDR- complete
6/12-6/17	Work on select PRAMS surveillance sleep-related indicators
6/20-6/24	Present preliminary SUID analysis to internal stakeholders
6/27-7/1	Meet with partner programs (Young Women United, home visiting, Families FIRST)
7/5-7/8	Communicate with St Vincent hospital and Hospital Association re: past education and current protocols: this was not completed as remains a pending item in the Fy18 plans.
7/11-7/15	Complete phase 2 of SUID analysis with demographics and risk factors: This was completed in August, 2016 and presented to the Child Fatality review SUID panel- complete
7/18-7/22	Articulate PRAMS safe sleep analysis and Geographic Information system (GIS) mapping (multivariate or logistic models)
7/25-7/29	Prepare communications products from SUID data and complete data tables for paper
8/1-8/5	Work on combined breastfeeding and safe sleep Title V and Collabirative Improvement & Innovation Network (CoIIN) recommendations

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

To meet the objective of ensuring that infant caregivers in NM have the knowledge, skills, and self-efficacy to practice “safe for every sleep”, the statewide birthing hospital summit utilizing Cribs for Kids national staff and Dr. Michael Goodstein was held in October, 2014 (not 2016) with birthing hospital teams from all regions of New Mexico. The evaluation of the training and information shared by Dr. Goodstein and Judith Rainey indicated good reception by hospital staff; however, the short-term and long-term outcomes were not measured. We were not able to host another event during this reporting period as there were no available federal funds or staff to plan that after the departure of Robin Swift, who was the co-lead on the Infant Mortality (IM) CoIIN safe sleep strategy. This strategy is too specific in light of recent developments and media around baby boxes. While there is not enough evidence to support the use of boxes as cribs, the boxes are being made available free of charge through Indian Health Services and through federal Home Visiting programs in New Mexico. In addition, while we appreciate Cribs for Kids and the tremendous work of Dr. Michael Goodstein, we do not know that we will convene a hospital summit specifically with either entity. We are proposing a reframing/replacement of this strategy in the FY18 plans.

The DOH Office of Injury Prevention successfully trained over 50 CYFD and DOH staff on train-the-trainer safe sleep promotion and evidence-based strategies in December, 2015. The training was intended to give home visiting, perinatal case management and social work staff tools for teaching safe sleep to family clients throughout the state.

Although a pilot with Tewa Women United YVK doula program did not occur during the reporting year, the conversations on return on investment for doula services in New Mexico did bring Title V and doula program staff to the table for strategic planning. In addition, through the PRAMS steering committee several data reports and briefs were discussed to plan media and outreach to families through the communication expertise of Young Women United. While all the components of strategy 3 are important, we are revising that strategy to be more cohesive and less disjointed. Therefore, rather than specifying a number of trainings or specifying the type of pilot or intervention we want to test, we are proposing a more comprehensive cross-agency strategic planning for the FY18 plans.

Completed safe sleep activities in 2015 or 2016:

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

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

Ongoing strategies:

Engage new members SUID child fatality review committee and SUID registry: this is a barrier to effective planning. MCH Epidemiology reached out to several organizations including WIC, but this is a short-coming to address in the FY18 plans.

Completed Policies that support/facilitate safe sleep practices in FFY2016**:**

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

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

Ongoing

Hospital engagement and follow up to 2014 birthing facility trainings- there were staffing shortages, and the focus on hospitals, while important, has broadened to home visiting and perinatal case management.

Ongoing
Implement small tests of change:

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

2. Assess grandparent receptivity to implementing/advising on safe sleep practices replicating the 1,000 Grandmothers curriculum or by testing local intervention of grandparent safe sleep infant care curriculum: The NM contact Dave Baldrich did present to the IM CoIIN. There has been no follow up.

3. Work with Tribal Epidemiology Centers and tribal doula or home visiting programs to develop culturally resonant safe sleep education: The discussions were mainly supplanted by capacity building and technical assistance to the TECs by Title V/PRAMS. Nevertheless, Dave Baldrich did consult with and present the 1,000 Grandmothers curriculum to the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC).

Our final strategy was to consult with four regional media companies with an emphasis on American Indian/Native audiences and families of all ethnicities, as well as bilingual families, regionalized for cultural differences across NM. We planned to develop a media campaign to raise public awareness on the AAP safe sleep recommendations and most current evidence-based practices for breastfeeding promotion and safe sleep. Funding for this effort was not available during the reporting period, and the plans were not addressed due to the staffing shortages mentioned

above. Although some communications activities were planned for the graduate internship in 2016 it was not feasible to develop partnerships to strategize across programs or agencies.

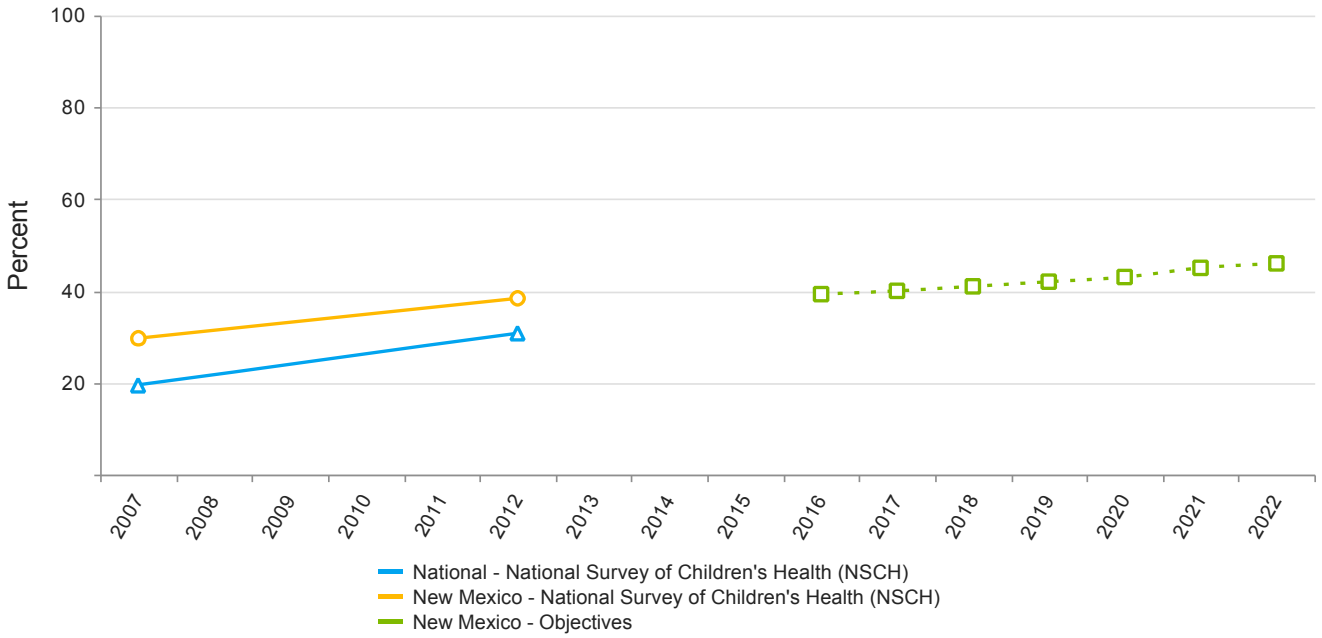
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	81.4 %	NPM 6

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	39.3
Annual Indicator	38.3
Numerator	54,323
Denominator	141,890
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	40.0	41.0	42.0	43.0	45.0	46.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Child Health Program
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	300.0	325.0	350.0	375.0	400.0	425.0

State Performance Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.9	15.1	14.3	13.5	12.7	11.9

State Action Plan Table

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

Priority Need
To increase the percentage of children receiving a developmental screen

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

Objectives
The percent of children receiving a parent-completed developmental screen will increase by 1% annually, as reported by the National Survey of Children's Health

Strategies
Expand developmental screening activities in early care and education, link training and increase appropriate referrals when needed among medical homes, early intervention services, child care programs, and families.
Engage pediatric providers, other child health providers, infant mental health consultants, home visitors, and other related professionals in local communities to improve linkages and referrals
Utilize and promote training to early care and education professional who serve young children.
Promote public awareness of child development.
Capture and document developmental and behavioral health screening and referral activities across early care and education, health, and early intervention systems.

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

NOMs

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

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

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

Priority Need

To decrease abuse and maltreatment of children

SPM

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

Objectives

Reduce incidence of child abuse and neglect

Provide most vulnerable families and neighborhoods with family support services

Strategies

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

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

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

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

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

Developmental Screening

During FY18, the Child Health Program (CHP) will continue to encourage community-based programs with Ages and Stages Questionnaire (ASQ) trainers (as mentioned in the FY16 report) to provide training around the state to early childhood providers, including medical professionals, home visitors, early care and education providers, and early interventionists. The program will have a new health educator who, hopefully, will also be trained as an ASQ trainer.

The 2017 updated report, *Improving Developmental Care for Young Children and their Families in New Mexico: Where are We Now? What Should We Do Next?* (https://nmhealth.org/about/phd/fhb/mch/publications/), builds out new recommendations in several areas related to developmental screening. It has been observed that medical providers need expanded guidance from NM HSD on screening of young children, especially Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT). The CHP plans for the new health educator to work with the Medicaid program at the Human Services Department (HSD) to provide training to NM practitioners and social service providers to become more familiar with EPSDT requirements.

Child Maltreatment

Title V staff will continue its relationship with the New Mexico- Child Abuse Prevention Partnership(NM-CAPP). The NM-CAPP is a consortium of stakeholders throughout the state, each with their own mission relating to child abuse prevention coming together to eliminate child abuse. The individual strengths and programs of the member stakeholders are augmented by their affiliation with other like-minded organizations. The collaboration of NM-CAPP with these stakeholder organizations provides a structured, unified, diverse and comprehensive approach to the prevention of child abuse.

NM-CAPP projects include:

- Identifying the most vulnerable families and neighborhoods utilizing “mapping” data bases which purposely overlay risk factors to determine the locations of the most need.

- Targeting low income neighborhoods for new and renovated housing projects, including both government subsidized rentals and home ownership programs that generate candidates via participation in free job training and income management programs. Lack of secure housing is a principal source of family stress.

- Targeting low income neighborhoods for both fresh food delivery and community garden development to help minimize the issues of high cost and lack of accessibility. Lack of sufficient and nutritious food is a principal source of family stress.

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

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

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

- Incorporating Adverse Childhood Experiences (ACE) questions into EPSDT screens and seeking Medicaid reimbursement for identified treatment needs.
- Standardizing and uniformly applying EPSDT screening.
- Convening county and tribal health councils to monitor local needs and resources and identify gaps in services.
- Developing policy recommendations based on local input and community engagement.

Developmental Screening

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

From October 2009 – May 2016, the Child Health Program presented trainings to early childhood providers in the use of developmental screening tools, Ages & Stages Questionnaire (ASQ) and ASQ: Social Emotional (ASQ:SE). Over those years, 56 separate training events were held with 1,087 attending, representing approximately 181 organizations from around the state of NM.

With the ending of both Project LAUNCH in 2014 and the Early Childhood Comprehensive Systems (ECCS) grant in 2016, and the retirement of the primary trainer in 2016, a new plan to sustain the work was needed. To maintain work around developmental screening training, build capacity in early childhood-serving organizations around the state, and continue to promote appropriate developmental and behavioral screening and referral for young children, a cadre of 25 new trainers from local community-based or county entities were selected to attend a 3-day ASQ Training of Trainers Seminar (TOT) in May 2016. The TOT was funded by the ECCS grant with contributions from the Children, Youth & Families Department/Office of Child Development and the Brindle Foundation, a small family foundation based in Santa Fe, NM with a focus on early childhood.

Each participant organization received a training manual with a thumb drive of all handouts. Additionally, ASQ-3 and ASQ:SE-2 kits in both English and Spanish were provided for the participants. In return for the free (to participants) training and materials, the participants and their supervisors agreed to annually provide trainings for other community-based programs and medical practices. For this year, there have been 266 early childhood professionals and medical providers trained to administer and score developmental screening instruments during 11 training events. Our goal is to continue to build the number of providers who are trained to properly use ASQ developmental screening tools.

After 13 years, funding for the New Mexico ECCS grant ended July 31, 2016. The ECCS State Team, a public/private partnership, was very active for those 13 years and they determined they would continue to meet and work on issues of concern. In June 2016, a survey was taken of State Team members regarding priorities for future work. The top three areas identified were: developmental screening, family engagement, and early childhood mental health. Due to a shared focus around early childhood development and promotion, the state teams for ECCS and Act Early joined together as the ECCS-Act Early State Team. The new team has been working on the following activities to enhance early childhood system building and demonstrate improved outcomes in population-based children's health and family well-being indicators:

1. Revising the 2006 report, *Improving Developmental Care for Young Children and their Families in New Mexico* and building out recommendations, including action steps with activity targets to implement strategies that can be accomplished in a one to five-year time frame; and recognize progress and successes made to date.
2. Developing and implementing strategies to:
    a. Support and engage parents in monitoring their child's development, building on promotional materials already developed through ECCS and Learn the Signs-Act Early;
    b. Ensure that children receive developmental/behavioral screenings that are early and regular, with

appropriate referral and follow-up, through partnership with key stakeholders.

3. Providing educational materials to parents and early childhood development providers related to developmental milestones, developmental and behavioral screening, and early intervention opportunities, and promoting training for the appropriate administration and scoring of developmental screening tools, which contributes to improved health outcomes for young children by identifying developmental and social-emotional delays early.
4. Expanding the of use of media, including social media and websites, to educate parents, medical providers, early child care practitioners, and the general public about developmental promotion, early detection, and linkage with services.

Child Maltreatment

One of the key groups addressing this issue is the J. Paul Taylor Early Childhood Task Force (JPT). The JPT is a legislatively authorized group of public and private partners tasked with:

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

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

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

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

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

The New Mexico Child Abuse Prevention Partnership (NM-CAPP) also works on child maltreatment. This group of stakeholders provides public awareness regarding child abuse using public service announcements, statewide advertising campaigns and fundraising activities.

NM-CAPP Accomplishments for 2016:

•Planned, developed and hosted a summit for all our stakeholders to brainstorm child abuse prevention strategies, identify programs that are working, identify community assets, and to look at roles and relationships of stakeholders with each other;

•Planned and hosted Precious Gems Gala for Awareness and Fundraising;

•Planned and coordinated 2 5Ks to build child abuse prevention awareness;

•Mentored three other cities to have 5K's to begin building statewide awareness about child abuse prevention and provided seed money to these cities for their events;

•Provided funding and helped in the planning of a documentary called "Everyone's Business: Protecting Our Children", a public awareness and education media campaign;

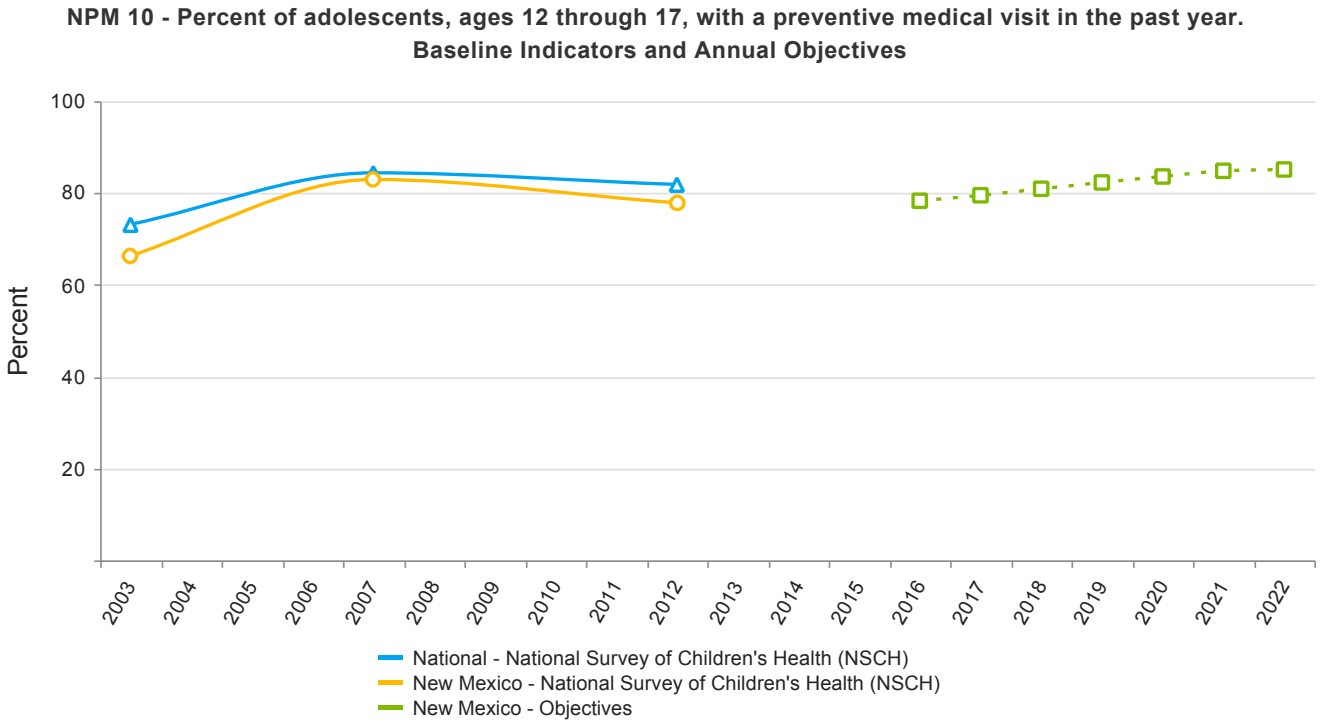
•Completed 25 talks around the state to help increase awareness of child abuse and to address prevention strategies;

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	43.0	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	13.7	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.9	NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	58.0 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	81.4 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	32.9 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	26.6 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	31.8 %	NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	68.9 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	66.7 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	54.3 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	85.9 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	72.5 %	NPM 10

National Performance Measures



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	78.2
Annual Indicator	77.7
Numerator	130,533
Denominator	168,106
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.4	80.8	82.2	83.5	84.7	85.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	128
Data Source	AYAH CoIIN site clinic visit clinic data.
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	25.0	25.0	25.0	25.0	25.0

State Performance Measures

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	31.6	28.8	26.1	23.4	20.7	18.2

State Action Plan Table

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

Priority Need

To improve access and quality of comprehensive well exams for adolescents

NPM

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

Objectives

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

Strategies

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

Increase health literacy education for adolescents age 10-24.

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

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

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

Improve Access and Utilization of Preventive Services

Improve State- and Systems-Level Policies and Practices

ESMs	Status
ESM 10.1 - The number of policies/or practices implemented at a clinical system, that helps improve access to or quality of the adolescent well visit.	Active
ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter	Inactive
ESM 10.3 - Percentage of Well visits ages 10-25 for Medicaid patients	Active

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children in excellent or very good health
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

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

Priority Need

To reduce birth rates among teens 15-19

SPM

Teen Birth Rate, Girls ages 15 to 19 years

Objectives

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

Strategies

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

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

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

Adolescent Well Visit

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

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

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

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

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

The “Youth Health Literacy: A toolkit to strengthen health literacy” was developed by the NM Department of Health (NMDOH) in partnership with Envision Your Future and youth from across the state of NM. The purpose of the toolkit is to provide fun and meaningful activities for youth about healthcare. The toolkit provides an opportunity to engage with youth in discussions that will help improve their understanding and skills necessary to support self-care and well-being. This toolkit draws from a variety of sources and focuses on the following six concepts:

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

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

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

NM AYAH CoIIN members will meet regularly and identify next steps to continue efforts to promote and assess

the quality of AYAH preventive care and youth-friendly environment/services in NM. Additionally, the AYAH CoIIN members will continue to work with, learn from and share information with our national partners.

Teen Births

The state Title V program collaborates with the Family Health Bureau's Family Planning Program to implement activities related to reducing teen pregnancy in New Mexico. In 2016 FHB/FPP worked with 46 Public Health Offices (PHOs), including 4 PHO outreach sites, and 18 primary care clinics and school-based health centers (SBHCs) through Contracts and Provider Agreements to provide reproductive health services to 17,252 unduplicated clients: 14,826 females and 2,426 males. Statewide activities include clinical services with on-site provision of methods including the most effective (implants, IUDs) or moderately effective (i.e., injectables, oral pills, or ring) methods of contraception sterilization services and community-based education for teen pregnancy prevention. The long-term program impacts related to Title V are to reduce teen pregnancy and unintended pregnancy. Teen birth rates continue to decline in NM and nationwide; we believe both clinical services and educational programming have contributed to the decline. Per the 2016 Family Planning Annual Report, 299 teens under the age of 18 years and 579 teens and young adults under the age of 20 years used a most effective contraceptive method (IUD or implant); 23% of females under the age of 20 years used a most effective method and 38% used a moderately effective method.

FHB/FPP continues to support the implementation of two evidence-based teen pregnancy prevention programs: Teen Outreach Program (TOP) and Project AIM (Adult Identifying Mentoring). TOP is implemented in six counties at eight sites statewide by seven different organizations. Project AIM is an evidence-based Positive Youth Development program for ages 11-14 designed to reduce sexual activity by providing youth with the motivation to make safer choices. The population-based strategies used for teen pregnancy prevention are service-learning programs, adult-teen communication programs, and comprehensive sex education. FHB/FPP works with community organizations and provides technical assistance and oversight to ensure curricula are implemented with fidelity. The parents, guardians, and community members who completed the adult-teen communication curriculum, *From Playground to Prom*, will contribute to teen pregnancy prevention, as adult-teen communication is a strong protective factor.

FHB/FPP also promotes the BrdsNBz text messaging service statewide. Teens text "NMTeen" to 66746 to opt into the service. A teen can then text a question and a trained health educator will respond within 24 hours; however, responses are usually received in real-time. BrdsNBz combines health education and personalized text messaging to meet the public health needs of New Mexicans. This social media system offers teens free, confidential, and accurate answers to sexual health questions in either English or Spanish.

The state Title V program will continue to collaborate with FHB/FPP to implement a statewide, comprehensive, and coordinated plan for teen contraceptive access and pregnancy prevention/reduction, especially with regards to preventing unwanted pregnancies. Components of the plan will include:

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

2. Increase outreach to schools in San Juan, San Miguel, Luna, and Eddy counties, which have the highest teen birth rates;

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

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

5. Provide training for clinic staff within and outside DOH (including through telehealth & the use of an onsite mentor);

6. Provide reproductive life plan messaging by DOH agencies;

7. Increase teen's knowledge of contraceptive options through targeted use of social media

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

Adolescent Well Visits

The Office of School and Adolescent Health (OSAH) used a Positive Youth Development Approach (PYD) to promote youth health promotion (primary prevention) & leadership through peer-to-peer education and youth-adult partnership in FY16. OSAH was 1 of 5 states selected by the National Adolescent & Young Adult Health Information Center to develop a NM Adolescent & Young Adult CoIIN Team. The goal is to increase the number of youth & young adults who receive preventative health care. Key drivers are 1) Health Literacy; 2) Training for Providers; 3) Adolescent Comprehensive Well Exams (ACWE), also referred to as EPSDT; 4) Young Adult Preventative Care; and 5) Youth/Young Adults view health as an asset.

Some of our accomplishments for 2016 include:

1. Engaged youth/young adult to create messaging and promote youth health literacy and preventative health visit along with a dissemination plan to share information across health systems (i.e., managed care organizations, community health centers, and public health).

2. Partnered with the NM Public Academy for Performing Arts (PAPA) & the NM YouthCHAT actors to create videos promoting the health assessment approach endorsed by the American Academy of Pediatrics entitled HEADS; this approach includes essential elements to complete a comprehensive exam and is currently used in school-based health centers as a tool to promote motivational interviewing with adolescents.

3. Collaborated with the NM YouthCHAT actors and Pegasus Legal Services for Children to create a series of videos about adolescent health rights. The series featured “Carrie the Cool Consent Chick.” The video was part of a program focused on helping young people understand their health rights. The campaign is entitled “Know UR Rights” and in addition to the videos included posters and brochures. The materials are shared broadly, including SBHCs, school health offices and health education classes, and youth-serving organizations.

4. Organized and implemented two group discussions entitled “Web & Wellness Summits,” along with a Positive Youth Development Youth Leadership (PYD-YL) Track at the annual school health conference (2016 Head to Toe (H2T).

5. Worked with a local FQHC/SBHC to demonstrate care coordination for youth transitioning from SBHC to FQHC (from adolescent to young adult) services. Tracked outcomes, challenges/learning, and system needs. The NM AYAH CoIIN partnered with El Centro Family Health, a community health centers (FQHC) currently providing care in Northern NM, as well as sponsorship of 10 SBHCs, to demonstrate care coordination for youth transitioning services from SBHC to the community health center. Efforts are being implemented at two locations: NM Highlands University and the El Centro Clinic in Las Vegas, NM.

Simultaneously, our quality improvement partners, Envision NM, developed and are currently implementing a webinar and telehealth series, Adolescent Health Initiative (AHI), providing practitioners with information on best practices in health care for adolescents in the following core areas:

- Basic Concepts in adolescent health & development
- Effective communication
- Laws, policies & quality standards
- Clinical care of adolescents with specific conditions

Teen Births

Between October 2015 and September 2016, the NM Family Planning Program worked on a two-pronged approach to decrease teen birth rates: through clinical services and through educational programming. NM FPP promotes three population-based strategies: service learning and positive youth development programs, adult/teen communication programs, and comprehensive sex education programs. These strategies complement clinical family planning direct services to prevent teen pregnancy in order to bring about meaningful and measurable reductions in teen births.

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

Educational programming is provided to teens across the state by local non-profits that are contracted with the Family Planning Program. These organizations provide evidence-based educational programs, *Teen Outreach Program* or *TOP and Project AIM*. *TOP* promotes positive youth development with service learning (volunteer work in the community) and curriculum-based activities to decrease teen pregnancy and increase school success. *Project AIM* encourages at-risk youth to imagine a positive future and to discuss how current risk behaviors can be a barrier to a successful adulthood through interactive and small-group activities, group discussions, and role-plays. In FY16, there were 384 teens enrolled in these programs. The NM Family Planning Program promotes the use of *From Playground to Prom* to increase parent-child communication, implemented with parents of the teens who participate in the educational programs. In addition to this structured educational and experiential programming, the NM Family Planning Program provides funds to support the BrdsNBz warm-line text-back service that provides medically accurate, age-appropriate sexual health and sexual behavior answers to teens and parents who text questions. The NM Family Planning Program and its contractors also participate in National Teen Pregnancy Prevention Month, “Let’s Talk” month and the National Day to Prevent Teen Pregnancy.

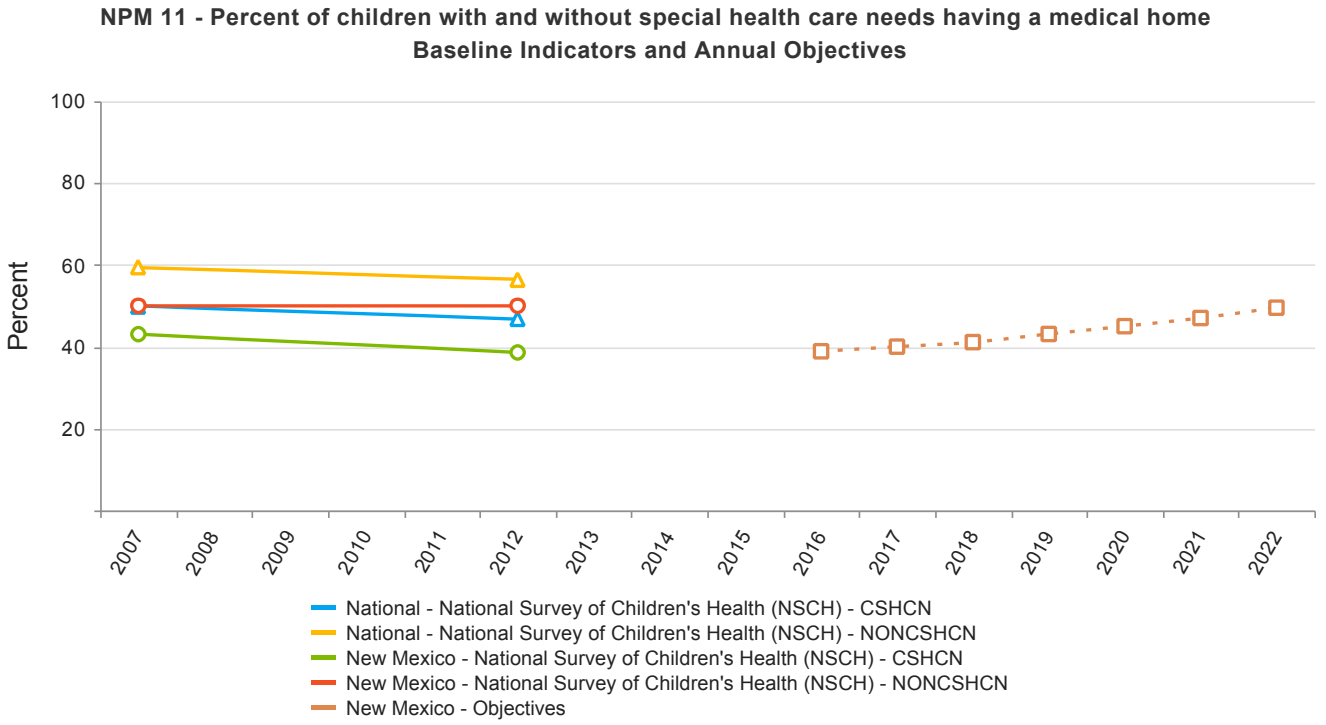
Strategies for teen pregnancy prevention include an increase in the availability of highly- and moderately-effective primary contraceptive methods to teens (through the provision of confidential clinical services and teen-friendly clinical practices and the expansion of family planning services at school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

Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	12.3 %	NPM 11 NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	81.4 %	NPM 11 NPM 12
NOM 22.1 - Percent of children ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)	NIS-2015	70.1 %	NPM 11
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	68.9 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	66.7 %	NPM 11
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	54.3 %	NPM 11
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	85.9 %	NPM 11
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	72.5 %	NPM 11

National Performance Measures



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	38.9
Annual Indicator	38.6
Numerator	34,748
Denominator	90,144
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	40.0	41.1	43.1	45.0	47.0	49.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

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

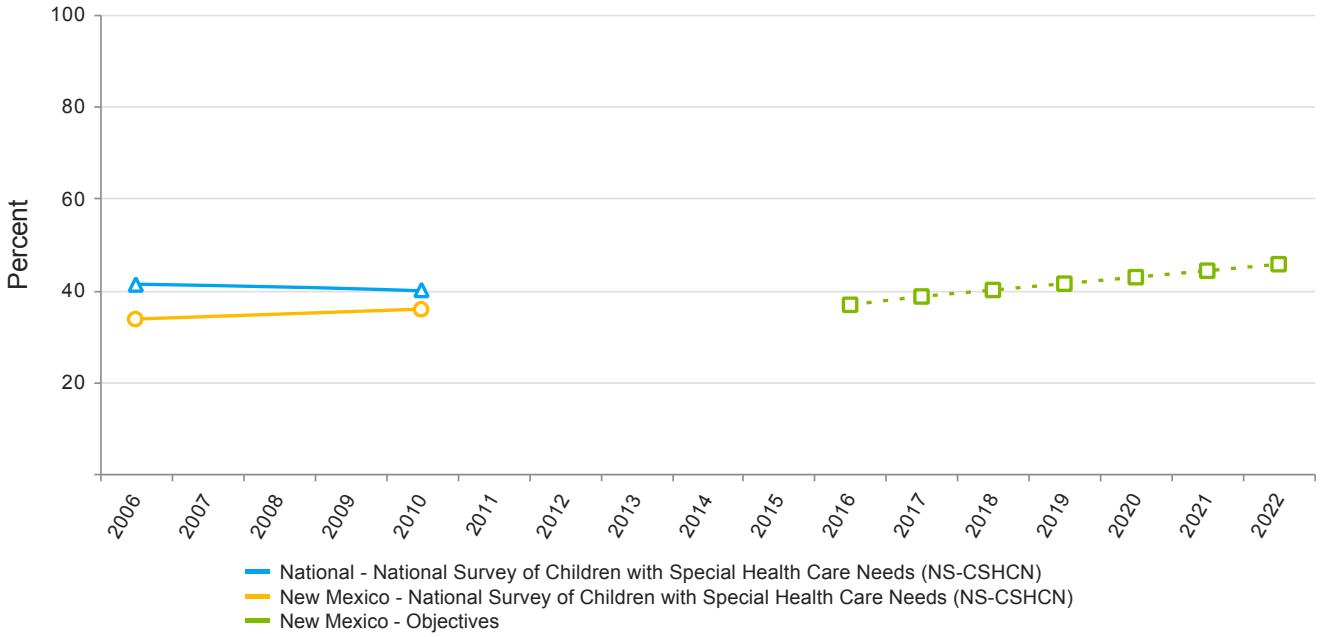
Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	10.0	10.0	10.0	10.0	10.0

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

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



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	36.8
Annual Indicator	35.7
Numerator	9,776
Denominator	27,412
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	38.6	40.0	41.4	42.8	44.2	45.6

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	CMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

ESM 12.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

State Action Plan Table

State Action Plan Table (New Mexico) - Children with Special Health Care Needs - Entry 1

Priority Need

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

NPM

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

Objectives

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

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

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

Strategies

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

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

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

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

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

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

Provide input and recommendations to Medicaid on the Section 1115 Medicaid Waiver Renewal regarding the medical home and the importance of care coordination and diverse family engagement to strengthen the system of care for CYSHCN in the state and promote best practice.

ESMs	Status
ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care and family engagement	Active
ESM 11.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.	Active

NOMs

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

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

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

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

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

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

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

State Action Plan Table (New Mexico) - Children with Special Health Care Needs - Entry 2

Priority Need

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

NPM

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

Objectives

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

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

Strategies

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

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

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

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

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

Provide input and recommendations to Medicaid on the Section 1115 Medicaid Waiver Renewal regarding transition for CYSHCN to strengthen the system of care for CYSHCN in the state and promote best practice.

ESMs	Status
ESM 12.1 - The number of Health Care providers participating in health care transition education and training on the 6 core elements of transition	Active
ESM 12.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 19 - Percent of children in excellent or very good health

Medical Home:

The focus of the state action plan is to improve the system of care for CYSHCN with a focus on Medical Home. CMS will continue to provide leadership around care coordination and family-centered, culturally competent for CYSHCN. CMS employs licensed medical social workers trained in the provision of care coordination for CYSHCN from birth to age 21 in New Mexico, helping to bridge the gaps in the healthcare system and link families to needed services. This coordination of care across settings leads to an integration of services, which decreases health care costs, reduces fragmentation of care, and improves the experience for the patient and family. In rural areas CMS is seen as the only program that addresses the needs of CYSHCN. The CMS program with its revenue source from Medicaid billing will focus efforts on maintaining staffing in all regions of the State and defend the need and value of the work the social workers do in their communities to upper management. With our increased staffing we will be able to resume outreach activities to underserved communities in rural frontier areas and within tribal communities.

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

Although the uninsured rate in NM has dropped significantly with the ACA, over ten percent of New Mexicans remain uninsured. Many, but not all, are undocumented individuals, frequently living in mixed status families. When a child who is medically eligible for CMS has no health insurance, CMS acts as a very limited "insurer," paying for needed medical services related to the eligible condition, and assisting clients in applying for NM's High-Risk Insurance Pool. New Mexico utilizes a high-risk pool to address access to health care for uninsured CYSHCN. The pool is subject to political influences and requires continuous monitoring by the Title V program. In a limited capacity CMS can also be a secondary insurance to help families who have private insurance but meet program medical and financial eligibility guidelines. CMS will continue to monitor the developments at the Federal level regarding "Repeal and Replace" and its impact on insurance coverage for New Mexico children, especially CYSHCN.

CMS social workers and management will continue work to improve three of the core outcomes for all CYSHCN clients. These outcomes are: 1) families partner in decision making and are satisfied with the services they receive; 2) families of CYSHCN have adequate private and/or public insurance and financing to pay for the services they need; and 3) services for CYSCHN are community based and culturally and linguistically competent. Best practice for care coordination of CSHCN involves collaborative patient and family-centered care; for example, the American Academy of Pediatrics (AAP) identifies the following desirable characteristics of coordinated care within a Medical Home: (1) a plan of care is developed by the physician, child, and family in collaboration with other providers and agencies; (2) all pertinent information about medical care and use of services is accessible to the care team while protecting confidentiality; (3)families are linked to support groups and other resources; and (4) the plan of care is coordinated with educational and community organizations to ensure goals of the care plan are addressed.

New Mexico is a largely rural state with almost all pediatric specialists located in Albuquerque at the University of New Mexico Health Sciences Center (UNMHSC) or Presbyterian Hospital, in the central section of the State. High poverty rates and lack of transportation can make accessing specialty care prohibitive for many families outside of

the Albuquerque metro area. In partnership with UNMHSC, CMS will facilitate over 130 multidisciplinary pediatric specialty clinics in rural areas of the State including cleft palate, nephrology, endocrine, pulmonary, neurology, and genetics. Additional clinics have been added including cardiology and GI due to a high need for this type of specialty consultation in the state. In FY18 we will be adding 2 additional neurology clinics in the Southwest due to high need and a lack of pediatric providers. CMS medical social workers follow CYSHCN through the multidisciplinary pediatric specialty outreach clinics, as well as assuring that specialists' recommendations are communicated to the local (community-based) primary care providers.

CMS submitted a proposal to AMCHP to participate in an Action Learning Collaborative (ALC) around implementation of the" Standard for Systems of Care for Children and Youth with Special Health Care Needs" which was accepted and the work has begun. The goals of the ALC are: Develop comprehensive policies and strategies to address specific standard domain areas such as Medical Home, Family Professional Partnership, Transition to Adulthood and others that may be identified as areas of weakness to improve the overall system of care for CYSHCN in New Mexico. The objectives include:

1. Implement strategies to strengthen Medical Homes with a focus on identification of CYSHCN, care coordination, and family centered care with an emphasis on cultural and linguistic access needs.
2. Implement strategies to improve and standardize the transition to adulthood for YSHCN.
3. Enhance strategies to develop and mentor families with CYSHCN reflective of the diverse cultures, languages and ethnicities to become family leaders and partners and represent the voices of families in a leadership capacity across state agencies and other systems of care.

CMS is taking the lead in this ALC and has enlisted several partners including Medicaid, Parents Reaching Out (NMF2F), all 4 Managed Care organizations, and Envision who just completed their Medical Home focus group project. This is a 9-month project and is slated to finish by the end of the calendar year. The ALC also has access to technical assistance from the National Centers on Medical Home and Got Transition as well as AMCHP and NASHP staff, and the team will request assistance as issues arise.

New Mexico has had a Managed Care arrangement for Medicaid clients for many years. Native Americans have always been exempt from participating in Managed Care but all other Medicaid recipients were required to enroll into an MCO. This includes all CYSHCN as well. In January of 2014 the State rolled out significant reform initiatives around Medicaid called Centennial Care which changed the landscape of Managed Care in a dramatic manner. An RFP was issued and 4 carriers were selected; Blue Cross Blue Shield, Presbyterian, Molina and United. The first 3 plans had been existence prior but United was a new option, though they had been working in the State with recipients of the disability waiver programs. Of interest is that the contract between the State Medicaid program and the health plans requires them to contract with the Title V CYSHCN program. A major component of the contract is a requirement that the MCO's implement a comprehensive care coordination process which includes a health risk assessment on every member to identify level of care needs and moves onto a comprehensive needs assessment when a member is identified to have a higher level of care coordination needs.

The Title V CYSCHN program has a long history of providing intensive care coordination for complex, medically involved children. The contracting requirements with the MCO's presented a unique opportunity for NM Title V to develop closer relationships and negotiate how the program and the MCO's can best work together, avoiding duplication and improving the system of care for CYSHCN in the State. The New Mexico F2F was closely involved in this transformation. Gaps continue to occur however around access to specialty care, care coordination for high risk families, financing, need to improve partnership with the F2F to train and utilize family leaders especially representing our diverse cultures and languages in the State, utilization of existing programs for CYSHCN such as Title V and the medically fragile waiver, desire to develop a coordinated approach to identifying CYSHCN in the state, better utilization of EPSDT as a monitoring tool, and dissemination of best practice around youth transition.

Family Engagement/Family Leadership

Parents Reaching Out (PRO) and the NM Title V CYSHCN program are committed to providing support for New Mexico families of children and youth with special health care or education needs, especially those who have challenges accessing current systems. Within our vast and diverse state, our aim is to reach all families, especially those who may be isolated due to language, citizenship status or geographic location. We work with diverse cultural, ethnic, linguistic and populations with varying citizenship status within the state of New Mexico. Specifically, the parents and partners with whom we work reflect New Mexico's demographic makeup, which is majority Hispanic with significant Native American representation. Organizations with whom we partner include ENLACE, Growing in Beauty (Navajo), the Mescalero Apache Early Childhood Program and the Asian Family Resource Center. New Mexico is also a large state which has many rural and border regions.

Barriers that need to be overcome include:

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

CMS will continue its partnership with the lead agency for child welfare, the Children, Youth and Family Department (CYFD). The CYSHCN/Child Protective (CYFD) services pilot project was expanded to all counties in New Mexico. The goal is to provide CYFD staff with an efficient means to improve overall care of children with chronic medical conditions on their caseloads through collaboration with Children's Medical Services (CMS) staff. CMS social workers provide consultation and co-management for this population as they are specially trained in care coordination for children with chronic medical conditions. They know the pediatric subspecialists well and also have close ties to the primary care offices and dental practices in the local communities. CMS social workers continue to work with the clients until they turn 21, which provides continuity for those CYFD clients who are aging out of their system at 19, and also provide intensive work around youth transition in all areas (healthcare, educational and vocational). They can also work with foster families to teach them about the medical needs of the child, how to navigate the specialty healthcare system, and assure a medical and dental home. New efforts are underway statewide to address the needs of children with Neonatal Abstinence syndrome. These children are often jointly managed by CYFD protective services workers and CMS social workers. A training will be developed for social workers from both agencies to address the medical/psychosocial needs of these children and their families.

As noted above New Mexico is also in need of increased family leadership and advocacy, especially with regards to the system of care for CYSHCN. From feedback received by Parents Reaching Out (PRO), the state family-to-family organization, family members have identified multiple barriers in obtaining the necessary information to navigate the complex managed care system. The Title V program will continue to strengthen the existing family networks to be fully prepared, mentored and connected to meaningful opportunities of program and policy partnership and ensure that the four Managed Care Organizations (MCOs) are guided by patient and family voices.

The ECHO™ financing clinic will continue to address health care financing issues and access to care for CYSHCN. The "hub" in this case are experts from Medicaid, the MCO's, the disability community, Title V and others and the "spokes" are care coordinators and families in rural communities who meet in local Public Health offices. This project has been increasingly successful over the past year and there has been an increase in utilization by CMS social

workers and CYFD. PRO has helped outfit CMS offices in Gallup, Roswell and Farmington with equipment so that staff can participate using the “Zoom” technology and staff will be encouraged to present cases and invite families to participate during clinics.

To improve the quality of CMS social worker care coordination for CYSHN and improve integration with the Medical Home, the contract with Envision (ENM), the Child Health Improvement program in the Department of Pediatrics at the University of New Mexico, will be renewed for year 2. In year one of the project Envision held focus groups in five target communities to identify areas of improvement in coordination of are and family engagement. Groups in the target communities were composed of primary care providers, CMS personnel, families and representatives of community organizations that serve CYSHCN. Projected outcomes of the process were:(1) a plan for implementing positive changes in knowledge, attitudes and provider practice in care coordination for CYSHCN by CMS social workers; (2) a plan for implementing significant improvements in patient/family engagement in care consistent with AAP Bright Futures Guidelines for evidenced-based approaches to care coordination; (3) a plan to improve PCP engagement with CMS social workers as part of the care team; and (4) a plan to improve tracking of and follow up for families of CYSHCN receiving care coordination services from CMS. In year two the plan also includes: summarizing the findings of the focus groups and evaluation and offering recommendations for a plan to improve NM rates on core Maternal Child Health Bureau (MCHB) outcomes; defining and implementing quality improvement activities statewide based on these results, which will include an evaluation process; and implementing trainings based on the needs identified through the focus groups. This work will also be integrated into the AMCHP/NASHP ALC which will engage the MCO’s in the overall systems improvement project.

The MCH Epidemiology program will continue its partnership with the Department of Health Asthma Epidemiology program to address unmet needs of children with moderate to severe asthma. The Asthma program provides MCH with a list of children who have been hospitalized or had an ER visit due to asthma from surveillance data. The parents are called and asked a series of questions regarding access to a medical home and other services and offered a referral to CMS for care coordination. The program has been successful linking families to local CMS social workers who assess the family’s needs and ensures that the child has a Medical Home. An evaluation component will be developed in FFY18.

Youth Transition:

Children’s Medical Services will continue to enhance foundational program activities to improve transition for YSHCN. CMS social workers will continue to complete a transition assessment and develop a plan of care for youth starting at age 14. This assessment addresses youth knowledge and ability to manage medical condition, use of health care services, daily living activities, what areas they continue to need assistance with or anticipate needing assistance with, living arrangements, transportation, recreation and social relationships, and future planning for education/training/employment. CMS social workers work with the youth to identify adult providers that will assume care during the transition process and assist in addressing health care financing. NM does participate in ACA Medicaid expansion and this has been very beneficial to YSHCN who are 18 and are now able to move off Medicaid/CHIP and onto the expansion. For youth that are not eligible for Medicaid ACA or private insurance the social workers transition these YSHCN onto the NM High Risk Pool at age 21 after they age out of CMS. The High-Risk Pool offers a low income premium plan where youth can take over their monthly premiums based on a sliding scale fee.

Activities related to assisting youth transition to an adult health care provider can still be challenging in some areas. CMS social workers are used to working with pediatric providers but have been limited in their connection with the adult providers in any meaningful way. The program will continue to working on partnering more closely with the adult providers (either medical home or specialist) through a warm hand off to help bridge the gap between pediatric and

adult providers, improve the transition and transfer process and increase satisfaction of the provider, youth and family with the transfer process. We will continue to focus on training and mentoring in order to increase the level of comfort the social workers feel with this role, as well as identifying additional training needs for providers to help them understand the benefits of partnering with the CMS social worker. Many communities have Family Medicine Physicians as primary care providers, which can ease the transition process. This focus on individual community needs is the basis of a successful transition.

CMS social workers will continue to receive training and support around transition planning with youth. The new data system CACTUS has integrated the transition assessment and includes a care plan that is being co-developed with the social worker and the youth to highlight areas of work that need to be focused on to assist with a successful transition. The plan of care has been modified to identify who has primary responsibility for completing tasks. Arrangements are being made to participate in the Baylor University Transition conference through a live stream as to support the training of the CMS social workers. Regional staff meetings will continue focus on different aspects of transition and social workers earn CEU's towards their social work
license.

The CMS Management team will continue to review the materials from Got Transition and incorporated questions into the transition plan. The CMS statewide program manager attends webinars and trainings that are sponsored by Got Transition and shares this information with the CMS Management team as best practices.

The Action Learning Collaborative with AMCHP/NASHP has as its goal to develop a NM specific tool kit. At our first meeting of stakeholders there was overwhelming consensus that was positive for this activity. Team members will begin to review the 6 Core Elements and other state examples as part of our team meetings to identify components that will be applicable to NM families and providers. The ALC will also begin exploring the use of telehealth as a means for training and consultation to providers. The managed care organizations are required by contract to utilize telehealth to address provider shortages for their networks. Several MCO's have been using telehealth in various capacities for behavioral health and other specialty care visits. The team will explore models that might be able to address provider concerns regarding the acceptance of YSHCN's into their practices. The team is also supportive of making recommendations to Medicaid during the public comment phase for the 1115 waiver renewal process. Transition was identified by the MCO's and Medicaid as an essential component of care that needs to be addressed.

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

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

also part of the annual family leadership conference sponsored by EPICS (Education of Parents of Indian Children with Special Needs) a parent organization that is geared towards Native American families. CMS will continue to provide funding to EPICS as part of parent leadership training and help the program liaison to Native American families in the State. The annual conference attracts over 400 attendees and includes families with CYSCHN from other Tribes across the country as well as New Mexico families. EPICS has started a webinar series on transition as well, and CMS will continue to maintain partnership and collaboration.

During the 2016 Legislative session the Transition Task Force presented to the Senate Disabilities Subcommittee, which was well received. Recommendations include: Training of NM Health Care Providers; performing a gap analysis on resources and supports for families seeking guardianship; improving support (including funding) for family education and involvement in policy development; improving access to health care transition services for immigrant youth; improving payment/reimbursement for transition services; improving interagency communication and collaboration; performing a gap analysis on the need for a complex care clinic; and improving oral health care for youth in transition. It has been difficult to have momentum to move forward on these recommendation dues to severe budget shortfalls and cutbacks to non-profit agency and state agencies. Efforts will continue to move forward as we can on Task Force recommendations. CMS will work to integrate these priorities into the work of the ALC as we develop the tool kit and through recommendation to Medicaid during the public comment period for the 1115 waiver renewal process.

Medical Home:

The focus of the state action plan is to improve the system of care for CYSHCN with a focus on Medical Home. CMS continued to provide leadership in the area of care coordination for CYSHCN. CMS employs medical social workers trained in the provision of care coordination for the special population of CYSHCN. For many years, the CMS medical social workers have provided care coordination for CYSHCN from birth to age 21 in New Mexico, helping to bridge the gaps in the healthcare system and link families to needed services. This coordination of care across settings leads to an integration of services, which decreases health care costs, reduces fragmentation of care, and improves the experience for the patient and family. In rural areas CMS is seen as the only program that addresses the needs of CYSHCN. The CMS program with its revenue source from Medicaid billing has been able to add additional social work positions in high need areas of the State. This includes a Social Work Supervisor in the Northwest region, two social workers in the Southeast and two social workers in the Northeast which is the result of years of advocacy and hard work defending the need and value of the work the social workers do in their communities.

The Patient Protection and Affordable Care Act (ACA) extended Medicaid coverage to over 100,000 uninsured children and adults in NM during the first enrollment period. A significant requirement is to implement initiatives to improve the quality of care to reduce health care costs and improve overall health outcomes. This provides a wonderful opportunity to leverage these requirements to develop a state plan for CSCHN in New Mexico and continue work on the joint goal of assuring each child has a Medical Home. Although the uninsured rate in NM has dropped significantly with the ACA, over ten percent of New Mexicans remain uninsured. This includes undocumented individuals, frequently living in mixed status families. When a child who is medically eligible for CMS has no health insurance, CMS acts as a very limited “insurer,” paying for needed medical services related to the eligible condition and assisting clients in applying for NM’s High Risk Insurance Pool. For high cost clients with no other source of insurance, CMS pays the premiums for the High Risk Pool, giving the client full insurance benefits.

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

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

Having the CMS medical social workers based in public health offices throughout the state, providing family-centered, culturally competent care coordination and case management uniquely strengthens the system of care in NM. CMS social workers interact with the child and family and are sensitive to economic and cultural factors

affecting management in the communities where they provide services. CMS social workers are able to reinforce health care and provider messages and identify and facilitate access to required resources. For example, a youth with cleft palate who is deaf and from the Navajo reservation attends the residential school at the School for the Deaf in Santa Fe, a 4-hour drive from his home. The CMS social workers link the youth with the cleft palate team when in Santa Fe and, when he is home for the summer, with the team in Farmington. Care must be coordinated with the family who lives remotely and the team from the School for the Deaf.

New Mexico is a largely rural state with almost all of the pediatric specialists located in Albuquerque at the University of New Mexico Health Sciences Center (UNMHSC) which is in the central section of the State. High poverty rates, lack of transportation and other socio-economic conditions can make accessing specialty care prohibitive for many families outside of the Albuquerque metro area. In partnership with UNMHSC CMS facilitated over 130 multidisciplinary pediatric specialty clinics in rural areas of the State including cleft palate, nephrology, endocrine, pulmonary, neurology, and genetics. Additional clinics have been added including cardiology and GI due to a high need for this type of specialty consultation in the State

CMS medical social workers followed CYSHCN through the multidisciplinary pediatric specialty outreach clinics, as well as assuring that specialists' recommendations are communicated to the local (community-based) primary care providers. CMS medical social workers assure that these recommendations are understood by families and followed up on, addressing the many barriers faced by CMS families. Families of CYSHCN are frequently stretched to meet the complex medical care responsibilities, leaving many psychosocial issues unaddressed. CMS medical social workers assist families with meeting basic needs such as food, clothing, and shelter, assist families with coordinating medical appointments, arrange for transportation, provide linguistic interpretation and translation of medical reports/recommendations, work with families on immigration issues, and assist clients with applications for Medicaid and other types of medical insurance. Most importantly, CMS medical social workers coordinate the care with the medical home/primary care provider.

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

CMS continued its partnership with the lead agency for child welfare, the Children, Youth and Family Department (CYFD). The CYSHCN/Child Protective (CYFD) services pilot project was expanded to all counties in New Mexico. The goal is to provide CYFD staff with an efficient means to improve overall care of children with chronic medical conditions on their caseloads through collaboration with Children's Medical Services (CMS) staff. Based on Medicaid data we have found that these children and youth have much higher rates of diagnosis for developmental disorders, ADHD, and mental health issues, than the rest of the child Medicaid population.

CMS social workers provided consultation and co-management for this population as they are specially trained in care coordination for children with chronic medical conditions. They know the pediatric subspecialists well and also have close ties to the Primary Care offices and dental practices in the local communities. CMS social workers continued to work with the clients until they turn 21, which provides continuity for those CYFD clients who are aging out of their system at 19, and also provided intensive work around youth transition in all areas (healthcare, educational and vocational). They can also work with foster families to teach them about the medical needs of the child, how to navigate the specialty healthcare system, and assure a medical and dental home.

The work of the New Mexico Pediatric Society's Pediatric Council and NM Quality Improvement Partnership (ENVISION New Mexico), the FHB/CMS Medical Director, and the Medical Directors of the four state Medicaid managed care plans to develop a consistent set of Patient Centered Medical Home (PCMH) standards was discontinued as well as any work related to the SIM grant, which was not funded.

In addition to needing more Medical Homes, New Mexico is also in need of increased family leadership and advocacy, especially with regards to the system of care for CYSHCN. From feedback received by Parents Reaching Out (PRO), the state family-to-family organization, family members have identified multiple barriers in obtaining the necessary information to navigate the complex managed care system. The Title V program continued to strengthen the existing family networks to be fully prepared, mentored and connected to meaningful opportunities of program and policy partnership and ensure that the four Managed Care Organizations (MCOs) are guided by patient and family voices.

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

The Project ECHO CYSHCN Health Care Financing clinics occurs twice a month. Case presentations address gaps in insurance coverage or other barriers such as prior authorizations that prevent CYSHCN receiving the health care they need. Didactic presentations occur with each ECHO clinic which provides a perfect opportunity to promote and educate families and other clinic team members about the Medical home and core components. This platform will also be used to educate participants on the 6 core elements of successful youth transition developed by the Got Transition National Center. This project has been increasingly successful over the past year and there has been an increase in utilization by CMS social workers and CYFD. Deidentified information is presented utilizing Zoom technology and the "hub" experts develop a health care financing plan for the family which the social workers help to implement.

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

To improve the quality of CMS social worker care coordination for Children with Special Healthcare Needs (CYSHCN) and improve integration with the Medical Home CMS developed a contractual partnership with ENVISION (ENM) the Child Health Improvement program in the Department of Pediatrics at the University of New Mexico. CMS social workers live and work in the communities they serve. In this setting they are able to address the significant barriers to the routine follow-up care required by families that encompass transportation, educational, and cultural/linguistic elements. The CMS social workers are a critical resource for CYSHCNs in New Mexico and need to be well integrated into a changing healthcare system.

The project was initiated in the summer of 2016, with a focus on the school-aged population, children ages 5-10. Projected outcomes of the process were:(1) a plan for implementing positive changes in knowledge, attitudes and provider practice in care coordination for CYSHCN by CMS social workers, (2) a plan for implementing significant

improvements in patient/family engagement in care consistent with AAP Bright Futures Guidelines for evidenced-based approaches to care coordination; (3) a plan to improve PCP engagement with CMS social workers as part of the care team, and (4) a plan to improve tracking of and follow up for families of CYSHCN receiving care coordination services.

Five target communities identified by CMS (Farmington, Las Cruces, Roswell, Hobbs, and Las Vegas) used a modified focus group approach called a “World Cafe.” The larger group was divided into smaller groups of 3-5 people addressing the same set of questions. The total time for the focus groups was 90 minutes. Focus groups were recorded and transcribed. Notes from the mingle session were then used to identify themes that impact planning for improved care coordination. Groups in the target communities were composed of primary care providers, CMS personnel, families and representatives of community organizations that serve CYSHCN. This initiative incorporated five Leadership Excellence in Neurodevelopmental Disabilities (LEND) trainees from the UNM Center for Development and Disabilities (CDD) as facilitators and recorders for the focus groups. The results are still being analyzed but preliminary results identified three overwhelming themes: communication/collaboration; information/resources; and CMS identity in the communities. Communication and Collaboration” includes communication and collaboration between agencies or companies or communication with clients, including language barriers.

Many CMS social workers discussed language barriers in healthcare and education settings, specifically regarding Spanish speaking families. Families agreed; one said, “If I could do magic, I would make everyone bilingual. I would make people speak other languages that are not common, like English.” CMS social workers said that even when all parties speak the same language, families still might not understand what doctors are saying, because of terminology. “…Providers [are] not speaking a language which is understood by English speaking families. So my job is to do an interpretation and a translation of what are the needs and what are the services.” Similarly, families also discussed the need for providers to communicate in a way that families understand, taking into consideration language, culture, education, and disability. “…It’s coming down to who the parent or the individual is and coming to a level and taking into consideration some cultural issues, maybe, a problem, learning deficits.”

CMS social workers also commented about the need for increased communication in all settings. They talked about providers not following-up with patients to make sure they are getting recommended services and frustrations regarding communicating with numerous people at the same company. “…They're big business, so they have so many clients or patients, that I don't think they really take the time to follow up and say, ‘Did they go see CMS? Did they go see a specialist?’ until they return [for another visit].”

Families said better communication between team members, healthcare providers, and systems would help improve care of their children. “I think one of the hardest things for us as family members… are doctors don't talk to each other. We are the communicators for everybody. So we have to know our child's history inside and out. We can't let one little tiny detail slip. That is a huge amount of stress to keep track of.” Information and Resources” includes the lack of clear information or resources for clients and support staff to use or reference.

Families also discussed how it is hard to find out what resources are available. “There’s a lot of programs, but they don’t talk about them. You have to find them on your own.” CMS social workers said it is hard to find contact information and the types and availability of resources, because they often change and differ depending on type of client. “…There are providers who close their office, and then new ones pop up, so it's important to always stay on top of what's available currently because it may not be available tomorrow, or maybe it wasn't available yesterday…”

One parent reflected she did not know her daughter’s rights until she found the advocacy group Parents Reaching

Out (PRO). “My daughter is turning 18 in January and I didn’t know my rights until last year, when I got involved with PRO. I wasted all of those years my daughter was in school, because I didn’t know my rights and I wasn’t able to demand what my daughter needed and I can tell you that 95% of families in school go through the same thing, because they just give you a paper, ‘These are your rights.’ But, they don’t explain anything at all.”

Even when families do receive information, they may not know what to do with it. Also, a website may not be user friendly or families may not be able to access the internet. “…and they may mention to a parent, ‘Well, you could look at this site.’ …It’s a resource, but the families don’t know how to do that, or don’t have the materials or the technology to be able to do that.” One parent said that she does have access to the internet, but “if you try to look up the DD waiver in New Mexico Department of Health, I don't find it a very useful or informative website.”

Further, CMS social workers noted there is often misinformation regarding what benefits people can receive. “[For undocumented] immigrants, there are a lot of rumors that go around of things that they might have access to that aren't true. For example, I've had clients thinking they could get the DD waiver and they can't because you need to have a Social Security number to do that.”

CMS social workers and families discussed the wish for transparency. One parent said, “…I would like more transparency in how [DD Waiver] budgets are submitted, reviewed, denied or not, or approved. It is a black box. It is a complete black box. There's no way to get online to look at your [child’s] case, where it is in the process, and what has been approved. CMS Identity” falls under “Information and Resources” and includes comments about how people do not know about CMS or the services it offers.

The MCH Epidemiology program partnered with the Department of Health Asthma Epidemiology program to address unmet needs of children with moderate to severe asthma. The Asthma program provides MCH with a list of children who have been hospitalized or had an ER visit due to asthma from surveillance data. The parents are called and ask a series of questions regarding access to a medical home and other services and offered a referral to CMS for care coordination. The program has been successful linking families to local CMS social workers who assess the family’s needs and prioritizes that the child has a Medical Home.

Two strategies will be eliminated from the State Action plan as the activities have been discontinued by stakeholders.

1. Participate in the SIM grant planning and implementation work groups to develop standard policies and procedures for medical home providers
2. Collaborate with the NM Pediatric Society to address issues of payment of use of Bright Futures with the managed care organizations.

One strategy will be revised.

1. Collaborate with the NM Pediatric Society (add: and Envision NM) to provide training to PC’s and their staff on Bright Futures including information on how to bill for screenings and assessment.

Transition:

Children’s Medical Services has built some foundational activities to improve transition for YSHCN. CMS social workers complete a transition assessment and develop a plan of care for youth starting at age 14. This assessment addresses youth knowledge and ability to manage medical condition, use of health care services, daily living activities, what areas they continue to need assistance with or anticipate needing assistance with, living arrangements, transportation, recreation and social relationships and education/training/employment future planning. CMS social workers work with the youth to identify adult providers that will assume care during the transition process and assist in addressing health care financing. NM did participate in the ACA Medicaid expansion and this has

been very beneficial to YSHCN who are 18 and are now able to move off Medicaid/CHIP and onto the expansion. For youth that are not eligible for Medicaid ACA or private insurance the social workers transition these YSHCN onto the NM High Risk Pool at age 21 after they age out of CMS. The High-Risk Pool offers a low income premium plan where youth can take over their monthly premiums based on a sliding scale fee.

Activities related to assisting youth transition to an adult health care provider can still be challenging in some areas. CMS social workers are used to working with pediatric providers but were limited in their connection with the adult providers in any meaningful way. The program has been working on partnering more closely with the adult providers (either medical home or specialist) through a warm hand off to help bridge the gap between pediatric and adult providers, improve the transition and transfer process and increase satisfaction of the provider, youth and family with the transfer process. This has proven to be successful in a small Northern community where the CMS social worker has relationships with adult providers and is able to do a joint visit with the transitioning youth and the adult provider at the time of transition. This has been less successful than anticipated in other areas, due to difficulty getting buy-in from both the social workers and the adult providers. We continued to focus on training and mentoring in order to increase the level of comfort the social workers feel with this role, as well as additional training needs for providers to help them understand the benefits of partnering with the CMS social worker. Many communities have Family Medicine Physicians as primary care providers which can ease the transition process. This focus on individual community needs is the basis of a successful transition.

CMS social workers continued to receive training and support around transition planning with youth. The new data system, CACTUS, has integrated the transition assessment and includes a care plan that is being co-developed with the social worker and the youth to highlight areas of work that need to be focused on to assist with a successful transition. The plan of care has been modified to identify who has primary responsibility for completing tasks. The CMS Management team reviewed the materials from Got Transition and incorporated questions into the transition plan. The CMS statewide program manager attended webinars and trainings that are sponsored by Got Transition and shared this information with the CMS Management team as best practices.

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

A transition track was supported through funding and professional presentations to continue training families who have CYSHCN at the annual family leadership conference sponsored by Parents Reaching Out (PRO) the NM F2F. Families from throughout New Mexico, and some CMS staff members, attend this conference. Transition training is also part of the annual family leadership conference sponsored by EPICS (Education of Parents of Indian Children with Special Needs) a parent organization that is geared towards Native American families. CMS provided funding to EPICS as part of parent leadership training and helps the program liaison to Native American families in the State. The annual conference attracts over 400 attendees and includes families with CYSCHN from other Tribes across the country as well as New Mexico families.

The Governor's Commission on Disability continued its advocacy around transition education in the schools and funds training of trainers who can go into elementary schools to address disability as part of the human condition and

increase student awareness of disability issues.

A Transition Task Force was legislatively executed through a Joint Memorial in the 2015 Legislature and the work continued into 2016. Stakeholders include: the MCO's, UNM, School of Nursing, National Association of Social Workers, PRO, AAP, several nonprofit organizations representing the Disability community, Medicaid, Indian Health Services and others. The Task Force focused on assessing the fragmentation that exists; identifying strategies to address the barriers to effective health care transition and transfer services, including evidence-based strategies that have been successfully used in other states and through Got Transition; and making recommendations for changes to existing policies, programs and regulatory provisions or recommendations on regarding transition-focused policies, programs or regulatory provisions. The goal of the recommendations attempts to address barriers to effective health care transition for children and youths with special health care needs; and increase the efficiency and effectiveness of services for children and youth with special health care needs as they make the transition from pediatric to adult health care services. The report was submitted to the Governor's Office, the Cabinet Secretaries, the University of New Mexico and the NM Legislature in the Fall of 2015.

During the 2016 Legislative session, the Task Force presented to the Senate Disabilities Subcommittee which was well received. Recommendations include: Training of NM Health Care Providers; perform a gap analysis on resources and supports for families seeking guardianship; improved support including funding for family education and involvement in policy development; access to health care transition services for immigrant youth; improve payment/reimbursement for transition services; improve interagency communication and collaboration; perform a gap analysis on the need for a complex care clinic; improving oral health care for youth in transition and remedy the problem of providers leaving the network. It has been difficult this year to have momentum on moving forward on these recommendations due to severe budget shortfalls and cutback to non-profit agency and state agencies.

CMS has begun to utilize the Project ECHO Health Care Financing clinics to highlight the needs of transitioning youth and elicit feedback on policies and practices that have been effective. The Youth in Transition Learning portal will be promoted widely among the medical community. Transition training for parents and youth at the Family Leadership annual conferences will continue to be included as a deliverable in the contract with PRO and EPICS.

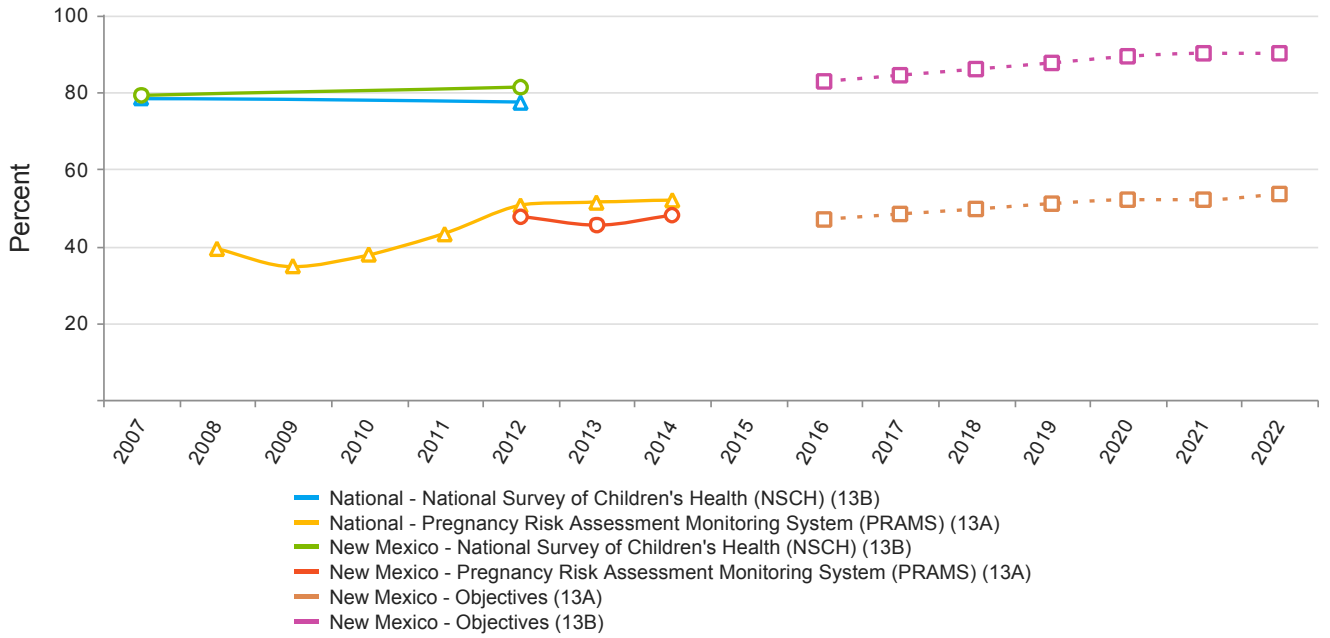
Cross-Cutting/Life Course

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	NSCH-2011_2012	23.9 %	NPM 13
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	12.3 %	NPM 15
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	81.4 %	NPM 13
NOM 21 - Percent of children without health insurance	ACS-2015	4.4 %	NPM 15

National Performance Measures

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



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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	46.9
Annual Indicator	48.1
Numerator	11,379
Denominator	23,671
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	48.3	49.6	51.0	52.0	52.0	53.5

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	82.7
Annual Indicator	81.1
Numerator	389,669
Denominator	480,550
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.3	85.9	87.5	89.2	90.0	90.0

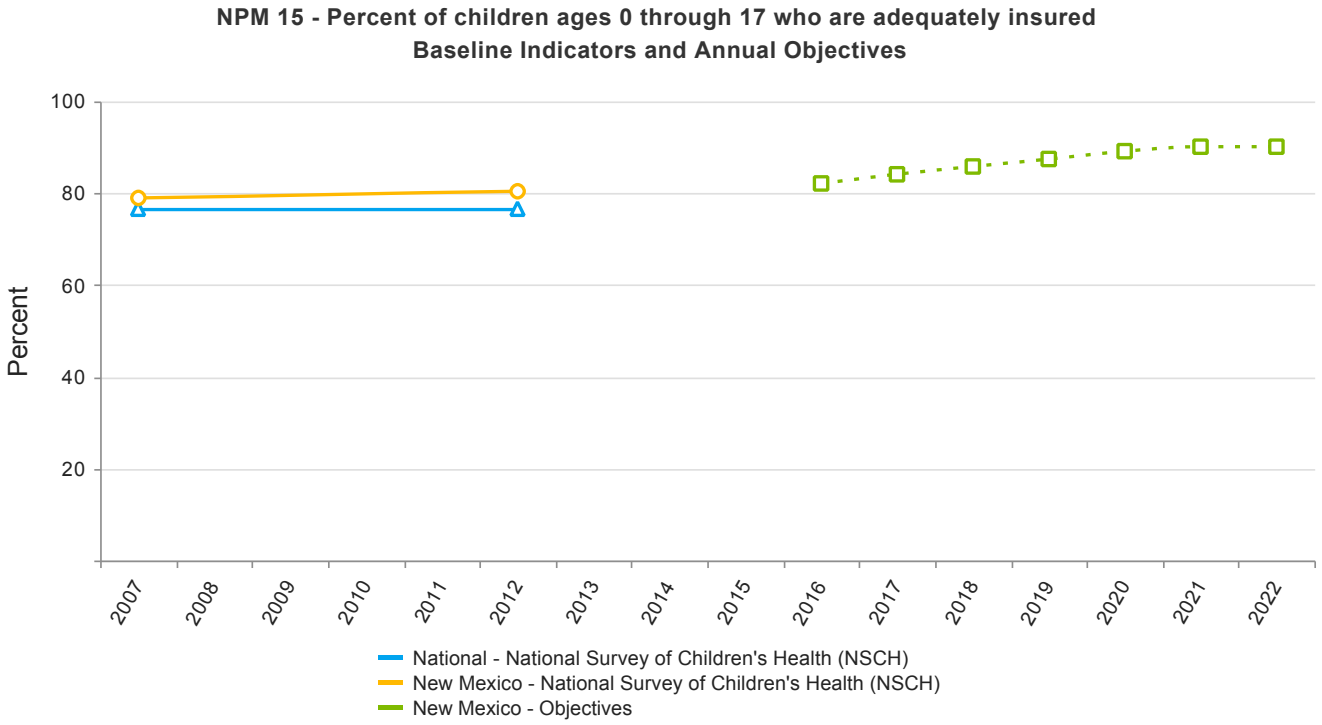
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Office or Oral Health
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	82
Annual Indicator	80.4
Numerator	386,077
Denominator	480,422
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.0	85.7	87.3	89.0	90.0	90.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	MCH Epidemiology
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	38.9
Numerator	14
Denominator	36
Data Source	ACS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	55.0	60.0	65.0	70.0	70.0

State Action Plan Table

State Action Plan Table (New Mexico) - Cross-Cutting/Life Course - Entry 1

Priority Need

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

NPM

Percent of children ages 0 through 17 who are adequately insured

Objectives

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

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

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

Strategies

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

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

Continue to expand and reinstate insurance navigation staff and outreach statewide

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

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

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

ESMs	Status
ESM 15.1 - Develop at least one cross-agency agreement or policy developed to address insurance gaps for prenatal and child coverage.	Active
ESM 15.2 - Percent of children 0-17 previously uninsured at baseline who are insured at period end, among Medicaid-eligible, insurance pool/high risk and private insurance populations.	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
NOM 21 - Percent of children without health insurance

State Action Plan Table (New Mexico) - Cross-Cutting/Life Course - Entry 2

Priority Need

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

NPM

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

Objectives

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

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

Strategies

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

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

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

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

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

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

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

NOMs

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

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

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

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

Access to Care

Border health/cross-cutting priorities

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

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

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

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

Recommendations, solutions and action items

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

We are in the process of expanding the detailed strategies and objectives for the three broad recommendations to reach regionally and culturally or population-specific solutions for year two. The recommendations were originally derived based on needs assessment directed at the US-Mexico border region health systems and stakeholders, but there are many crossovers applicable to other regions and sub-populations. For example, directly evaluating the

experiences of families and clients to confirm or re-direct our efforts is something we are doing statewide with perinatal case management, doula programs and in metro areas, as well as in the border counties. Based on the preliminary efforts, we have found that in addition to navigation of insurance options or most cost-effective healthcare access, women (in particular) may not be aware of options such as home births, which are covered by Medicaid in New Mexico. In addition, barriers to provider reimbursement complicate the solutions to opening these access points. Title V Programs are partnering with the March of Dimes, Young Women United, community-based health councils and the University of New Mexico to assess and strategize for improvements in access to well-woman/interconception care, reproductive life planning, and personal healthcare financing. Many of these partners on December 9, 2015 in a MCH strategic planning session for the Southern part of the state, an event which was hosted by La Clinica de Familia Healthy Start in Las Cruces. That group meets quarterly and crosses all population domains in its representation of programs and outcomes of interest. We also updated plans to hold a statewide summit on prenatal substance use and neonatal abstinence syndrome, an epidemic which leaves every demographic of family unscathed. Along with the Children Youth and Families Department, our agency has plans to address the drivers and poverty-related determinants of risks associated with drug addiction, especially among women of childbearing age.

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

Tribal health/ cross-cutting priorities

1. Improve knowledge about insurance options among Native American families

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

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

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

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

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

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

Oral Health

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

UNM and the Maternal Health program (MHP) will partner with at least one program impacting pregnant women such as WIC, Healthy Start, or a home visiting program with broad geographic reach that will incorporate targeted oral health messages into routine business activities.

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

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

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

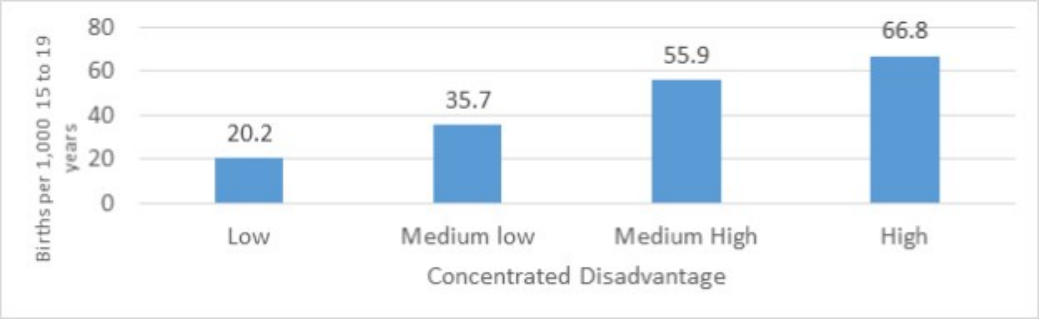
OOH will continue to work very closely with the NM Pediatric Society to educate physicians, as the first contact of children, to promote oral health and increase the use of fluoride varnish and dental case management. OOH has attended the annual NM Dental Association Conference to promote the use of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

Health Equity and Life Course Metrics

The New Mexico Department of Health MCH Epidemiology team participated in a Technical Assistance opportunity (AMCHP, 2015-2016) on Life Course Indicators which reinforced the need to understand the upstream contributors to health disadvantages. NM is a post-colonial state with a population grappling with health inequities due to historical trauma[i][i] and loss of connection to traditional knowledge. Today, Native American and Hispanic communities experience pejorative health conditions and well-being. Historical trauma calls for continuous interventions and dedicated resources towards healing in order to remedy past atrocities and advance health equity among all women, their infants and families. Adverse Childhood Experiences and stress events, which people of color disproportionately bear, must be understood before we can effectively terminate discrimination in healthcare, end limited access to or utilization of care among minority populations, or improve the experiences of families living

in areas of concentrated disadvantage. We, therefore, propose to address the social determinants of perinatal outcomes in order to promote equitable opportunities for achieving health and well-being among families. Racism and historical trauma can be addressed directly and within community conversations to understand birth outcome disparities, given the appropriate data and community engagement resources. Our recent descriptive analysis geocoding births by quartiles of concentrated disadvantage reflects important relationships between socio-economic conditions and birth outcomes. As an example, teen birth rates are three times higher in geographies of high social disadvantage compared to those in the lowest quartiles of concentrated disadvantage. This indicates there is a community-related aspect to early child-bearing rather than, or in addition to individual behaviors (Fig. 1) (additional data in data appendix).

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



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

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

language loss due to forced assimilation.

Cross-Cutting/Life Course - Annual Report

MCH Epidemiology and Maternal Health Programs co-lead the activities associated with cross-cutting strategies, which involves participation from Children's Medical Services, WIC, Family Planning and Families FIRST Case Management. The first year of the action plan included the following activities identified through the needs assessment process:

Access to Care

Border health/cross-cutting priorities, 2015-2019

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

Title V Programs in Maternal Health and Maternal Health Epidemiology partnered regularly with US-Mexico area health organizations to continue the work of understanding barriers to health insurance, timely prenatal care and linkages between primary and behavioral/mental health care. Unique challenges persist in access and utilization of health care in the international border region. To address those, we established regular participation in the Dona Ana County Maternal Child Health Coalition in 2015 and 2016. Through the Maternal Child Health Epidemiology program, we continue to share maternal and infant health indicators, solicit input and participate in consumer meetings through the MCH Coalition. Many of these partners met on December 9, 2015 in a MCH strategic planning session for the Southern part of the state, an event which was hosted by La Clinica de Familia Healthy Start in Las Cruces. That group meets quarterly and crosses all population domains in its representation of programs and outcomes of interest.

During the reporting year, we found that not only is insurance coverage changing and unreliable, but some families are still fearful of or unfamiliar with accessing care in the United States even if they have legal citizenship. NM Title V programs are in a position to help communicate insurance options through Public Health Office media outreach and by working with partners in Dona Ana County (which borders Mexico) such as the La Clinica de Familia - First Step Clinic, Memorial Medical Center, La Clinica de Familia Healthy Start, Ben Archer Healthy Start and the Dona Ana County Health and Human Services Health Promotions.

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

The recommendations were originally directed at the US-Mexico border region health systems and stakeholders, but there are many crossovers applicable to other regions and sub-populations. Plans associated with the Tribal Health needs assessment

1. Improve knowledge about insurance options among Native American families

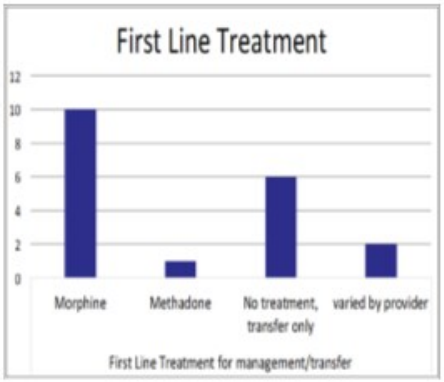
2. Continue to expand and reinstate insurance navigation staff and outreach, statewide

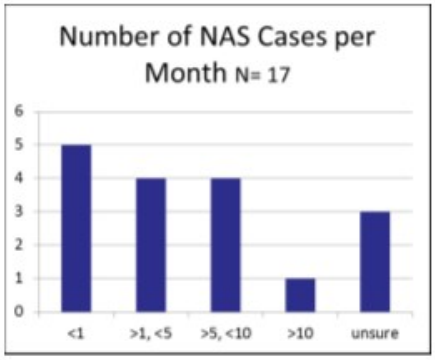
3. Improve State agency (DOH, HSD) collaboration with tribal health entities including but not limited to the Tribal Epidemiology Centers, Indian Health Services, Navajo

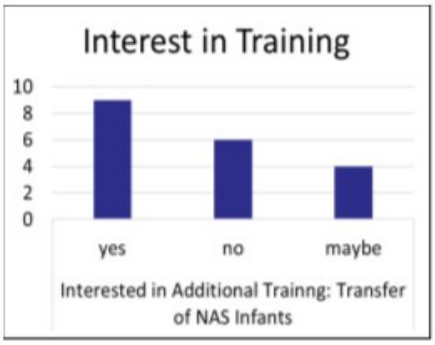
Many or our initial findings regarding Native families or vulnerable families throughout the state are similar to border health challenges with regard to access. The age groups that struggle to maintain adequate levels of insurance are cross-cutting; therefore, the activities have taken on a life-course and life-span framework. As part of our years two and three Title V plans, we established a sampling plan with 26 New Mexico Tribes to conduct a parallel, tribe-specific PRAMS surveillance with Navajo Nation and with the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC), beginning with 2017 birth data collection. Agreements and data sharing plans were signed with both Tribal Epidemiology Centers and the Department of Health in 2016 to assure a long-term, collaborative surveillance plan which builds in capacity sharing, resource/cost sharing, and community participatory research.

Based on the preliminary efforts to address access to healthcare in all maternal populations, we have found that, in addition to confusing navigation of insurance options or difficulty establishing cost-effective healthcare access, women may not be aware of non-traditional options such as home births, which are covered by Medicaid in New Mexico. In addition, barriers to provider reimbursement complicate the solutions to opening these access points. New Mexico's Medicaid Division and the Maternal Health Program created a Birthing Options Plan in 2008 via legislation. This Plan is integrated into the Centennial Care model (NM's state-based Medicaid model) that was introduced through the ACA. In the past year, reimbursement issues and general knowledge and compliance with the tenets of the BOP continued to plague the claims and reimbursement issues across the three groups involved: licensed midwives attending at home births, the MCOs claims staff, and the staff of the state Medicaid Division. To address these issues, a training for all 3 groups is scheduled for Fall 2017. It will be conducted in person but a webinar format will be created so that the training can be viewed at later dates. The plan is to ensure that all LMs attending at NM deliveries take part in the training in person or by video over a 6-month period.

In March 2017, a clinical team from UNM presented at the Annual Meeting of the New Mexico Perinatal Collaborative (NMPC) on a project addressing neonatal abstinence syndrome (NAS) protocols and training for clinical staff in birth hospitals across the state. The project is a 2016-17 effort funded by an AMCHP Birth Outcomes Grant. The goals of the project are: to improve care of infants with NAS around the state; to empower birth hospital sites to keep and treat babies when capable; and to improve the hospital transfer process when necessary. Through a 3-phase process, the work team seeks to target a hospital's needs in the assessment and care of NAS infants and tailor a training program to assist a hospital at whatever capacity they have to address NAS infants born in their facilities. Phase I, assessing needs, is completed; Phase II, training and protocol development is set for summer 2017; and Phase III, sustainable programming and evaluation will be completed in Fall 2017 (see table below for results of the Phase I activity, surveying birth hospitals for their capacity and training needs.)







Health Equity and Life Course Metrics

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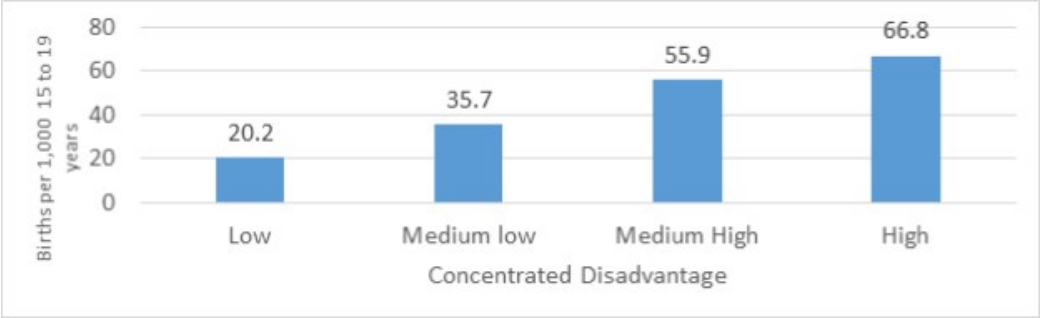

The New Mexico Department of Health (NMDOH) made health equity a priority in the state's strategic plan for fiscal years 2014-2016. The goals are to reduce health disparities due to characteristics such as race/ethnicity, limited English proficiency, disabilities, sexual orientation, gender identity, economic status, and geographic location. New Mexico Title V team members understand the multi-factorial nature of addressing heath inequities with regard to social environment, determinants of health and socioeconomic disadvantage. We have actively engaged with partners in the analysis and policy development to address these determinants at the neighborhood level and within a health and policy systems framework. The Title V team brings together individuals from the NMDOH Family Health

Bureau (MCH Epidemiology, case management, Children's Medical Services, Family Planning/Title X, and WIC, Office of Oral Health, Adolescent Health), community-based organizations, and community members who have experience in maternal and child health and have a passion for reducing adverse health outcomes in the community. The diverse team skills include policy development, community engagement, program evaluation, and data analysis and epidemiology. This team also leads the infant mortality Collaborative Improvement and Innovation Network (CoIIN) for NM, with participation from the New Mexico Public Health Association (NMPHA), the New Mexico Alliance of Health Councils, the NM March of Dimes, the NM Health Equity Partnership, Young Women United, and the Office of African American Affairs. Through the to focus entirely on health equity in birth outcomes over the next year.

Oral Health

In 2015, the University of New Mexico (UNM) received a grant to improve perinatal and infant oral health in New Mexico. This gave birth to the New Mexico Perinatal and Infant Oral Health Quality Improvement Project. The priorities of the UNM oral health project correlated strongly with the Title V Oral Health priority to increase and improve access to preventive dental care in pregnant woman and children. Consequently, a partnership has been formed between UNM and Title V. Title V will collaborate with UNM on common strategies. UNM and the Maternal Health Program (MHP) will partner with at least one program impacting targeted pregnant women such as WIC, Healthy Start, or a home visiting program, with broad geographic reach that will incorporate targeted oral health messages into routine business activities.

From the New Mexico Perinatal and Infant Oral Health Quality Improvement Project Progress and Performance Report, May 2017:

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

As above, from the May 2017 Progress Report, **La Familia Health Center** is a community health center providing medical and dental care in Santa Fe, New Mexico. Founded in 1972, it received a National Health Service Corps grant for a family practice physician and a dentist in 1982, and in 1987 began receiving federal financial support under Section 330 of the Public Health Act of the Department of Health and Human Services. La Familia sees over 20,000 patients annually. Two trainings were conducted at La Familia. The first was on March 1st on "Oral Health Education and Clinical Care Recommendations for Infancy". The second was on March 29th, 2017 on "Nurse Midwife Intake OB Training".

The Office of Oral Health (OOH) will continue collecting 3rd grade data and report the data. OOH data reflects state staff and contractors providing dental sealants to 3rd graders. Medicaid data reflects those Medicaid patients that have received a dental sealant through a Medicaid Provider. OOH will continue its partnership with the NM Primary Care Association to promote the application of both dental sealants and fluoride varnish among the Federally Qualified Health Centers and community clinics in NM. Increasing the use of sealants/varnish by all public providers is critical since they serve urban/frontier NM children. OOH will continue to work very closely with the NM Pediatric Society to educate physicians, as the first contact of children, to promote oral health and increase the use of fluoride varnish and dental case management. OOH has attended the annual NM Dental Association Conference to promote the use of preventive services in the daily practice of private dentists (dental sealants/fluoride varnish).

The Medically Fragile Case Management Program (MFCMP): The MFCMP provides statewide Registered Nurse Case management and service coordination services for approximately 360 children who are medically

fragile and their families via nine satellite offices located throughout the state. A training session for all MFCMP Nurse Case Managers and their Quality Improvement Coordinator was held on April 5, 2017. The Program has committed to introducing oral health into the Individualized Service Plan (ISP) of every child served by the Program.

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

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

Title V Funded Staff:

Title V Director's Office

The Family Health Bureau houses 7 separate programs. The Bureau Chief/Medical Director/Title V Director, Dr. Janis Gonzales, oversees all programs &works with each of the program managers for direct oversight of each program. Dr. Gonzales is Board Certified in Pediatrics and in Hospice &Palliative Medicine, and has a Master's Degree in Public Health. She previously spent 9 years in private practice &then worked in hospice and in Early Childhood Developmental Screening before joining CMS. She also had a daughter with special needs. For the past nine years she has served as Medical Director for the Title V CYSHCN program in New Mexico. She served as the CMS Medical Director for 5 years and as the Family Health Bureau Medical Director for the past 2 years. She was promoted to Bureau Chief and Title V Director in Feb. 2015 and is currently Vice President/President-Elect of the NM Chapter of the AAP. She has a Deputy Bureau Chief, a Bus-Ops specialist and a financial specialist on her Administrative Team.

Maternal & Child Health

Katie Avery, RN, CNFP is the Maternal Health Manager, responsible for the High Risk Prenatal program, Midwife Licensure &Regulation & the Maternal Health program. The Child Health Manager, Gloria Bonner, is responsible for program activities that focus on child health with a focus on improving developmental screening in NM. The program is in the process of hiring a new health educator.

CYSHCN: Children's Medical Services

Ms. Susan Chacon, LISW is the Title V CYSHCN Director. Ms. Chacon has 11 years of program management within the Maternal &Child Health Program. The Title V CYSHCN Director position is the Statewide Program Manager for Children's Medical Services (CMS), under which fall the CYSHCN Program, The Multidisciplinary Specialty Outreach Clinic Program; the Newborn Genetic Screening Program; the Newborn Hearing Screening Program. Dr. Janis Gonzales has been the CMS Medical Director since 2008.

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

Brenda Romero RN is the State Genetics Coordinator and Carla Ortiz RN is the nurse consultant for screening; both have been with the program for over 10 years. Robert Morrison was hired as the Newborn Hearing Screening Coordinator in February 2017. He has a Master's in Public Administration and many years of experience coordinating Public Health programs. Kaye Martin is the clerk specialist and provides administrative support to the Newborn Screening Programs. Michelle Quintana who has also been with the program for over 10 years is the Training and Development Specialist. Mary Lewis is the Financial Specialist and Paul Frey oversees the budget and all grant funding. Adrienne Miera-Branch was hired as the Clinic Coordinator in 2016 and she comes to the program from WIC where she worked for over 15 years. A new position was created through the Zika preparedness funding to support birth defects surveillance and linkage to support services. Susan Merrill was hired into this position early

2017. Ms. Merrill was a CMS Social Work Supervisor in the Northeast Region for over 10 years and has extensive knowledge of community resources and care coordination. The CMS staff in the Public Health offices consist of regional program managers, social work supervisors, social workers, clerks and nutritionists. Fully staffed, CMS has about 90 personnel statewide. The program has had success recently in filling vacant positions and even creating new social work positions in high need areas, which has boosted morale and productivity.

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

Maternal & Child Health Epidemiology

Currently, there are four epidemiologists, a data manager, two data collection staff and a program clerk. Eirian Coronado, MA, MPH candidate, coordinates the PRAMS survey and is the Section Manager. Christopher Whiteside MPH, coordinates the Title V grant & Needs Assessment. Christopher was hired in Sep. 2014. Garry Kelley, MPH provides advanced analytic support for the CMS and WIC programs. He also coordinates and leads New Mexico in the Collaborative Improvement and Innovation Network to prevent infant mortality. Garry was hired in May,2014. Glenda Hubbard, MPH, RN, is the PRAMS analyst and SSDI data linkage project director. Glenda was hired in June, 2015. Dorin Sisneros is a data manager and provides fiscal oversight to the program. Nicole Hernandez, and Theodore Ashford provide survey data collection, data entry and general program support to MCH Epidemiology, CMS, and the ERD Asthma Program. Nicole was hired in June, 2015 and Theodore was hired in January, 2017. The CMS program works in collaboration with the MCH Epidemiology program in data collection & analysis for CMS and the newborn screening program.

The Family Planning Program (FPP):

The Program Manager Susan Lovett in the State Office manages the statewide Family Planning Program including oversight of budget, personnel, and Federal Grant requirements. The Family Planning Medical Director position is currently vacant and is being covered by Peg Ickes RN, Janis Gonzales MD, MPH, and Chris Novak MD, MPH. The Epidemiology position in the program is also currently vacant and is in the process of being reclassified from an Epi O to an Epi A. The FPP has three nurses on staff: Peg Ickes, Susann Curtis and April Neri; however, Susann and April have both gotten other offers so those positions will soon be vacant as well. In addition, they have a financial manager Genevieve Lujan, two health educators, an executive secretary and two accountant auditors. The vacancies are impacting the work but we do hope that we will be able to fill the positions very soon.

II.F.3. Family Consumer Partnership

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

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

Family Organizations are invited to provide input into the CYSHCN Program activities and the Title V Block Grant during scheduled MCH Collaborative meetings.
CMS contracts with and provides funding to family organizations to ensure that families who have children with special needs have input into programming and serve in an advisory role regarding policy. The funding also supports family participation in local, State and National meetings/conferences and provide training for staff/families. Funds from the CMS program support an annual family leadership conference sponsored by EPICS and PRO where over 400 families who have children with special needs gain new skills, support and resources. Contracts were maintained with family organizations PRO and EPICS to support their annual family leadership conferences.

A family consultant was hired to review and critique the newborn hearing screening education material. Susan Chacon, the CMS Program Manager participates as a member of the stakeholder committee for the National Parent and Professional Partnership organization through Family Voices. Contracts were also maintained with Hands & Voices to support the work they do with families who have a child that is deaf or hard of hearing. The contract also funds (2) parents to attend the annual EHDI meeting. EPICS also receives funding to send (2) parents representing the voice of Native American families to the annual EHDI meeting. CMS sponsors a parent to attend the AMCHP annual conference. The partnership with PRO has intensified over the past year due to the success of the Project Echo Financing Clinic that is held bimonthly. PRO received some funding from the Con Alma foundation to help outfit local CMS offices with cameras for the PC’s to improve access for staff and families to participate remotely in the Financing clinics. Family participation in the Medical Home project with Envision was key to obtaining feedback as to the challenges receiving coordinated care in rural areas of the state and in the development of recommendations to improve systems.

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

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

Title V programs have strong ongoing collaborations with partnering agencies, such as Medicaid/Human Services Department and parent advocacy groups. We participated in Action Learning Collaboratives to improve birth outcomes with Dona Ana County Healthy Start/La Clinica de Familia sites, Medicaid's Medical Assistance Division, and CYFD home visiting programs throughout the state. We have partnered with the Las Cruces and Deming Healthy Start Sites for focus groups to gain input from families over the last ten years. Specifically, input has been gathered from clients' families in Healthy Start to understand barriers to prenatal care, address mental health and postpartum depression, to learn about awareness of the need for preconception folic acid, and to help improve services to the MCH population in the US-Mexico border communities and colonias. Healthy Start programs participate in the PRAMS Steering Committee, an Action Learning Collaborative on optimizing healthcare reform and in the statewide perinatal collaborative, initiated in 2013.

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

The NMDOH has held tribal health fairs for the last three years to formalize health promotion, knowledge sharing and collaboration among the majority of American Indian tribes in New Mexico. Throughout the Needs Assessment process, family and consumer partnerships were established through focus groups and surveys. Family/consumer stakeholders are assured a voice in the Needs Assessment process in addition to being given opportunities to give input on the state’s selected priorities.

II.F.4. Health Reform

New Mexico has included Health Reform in the Overview of the State section.

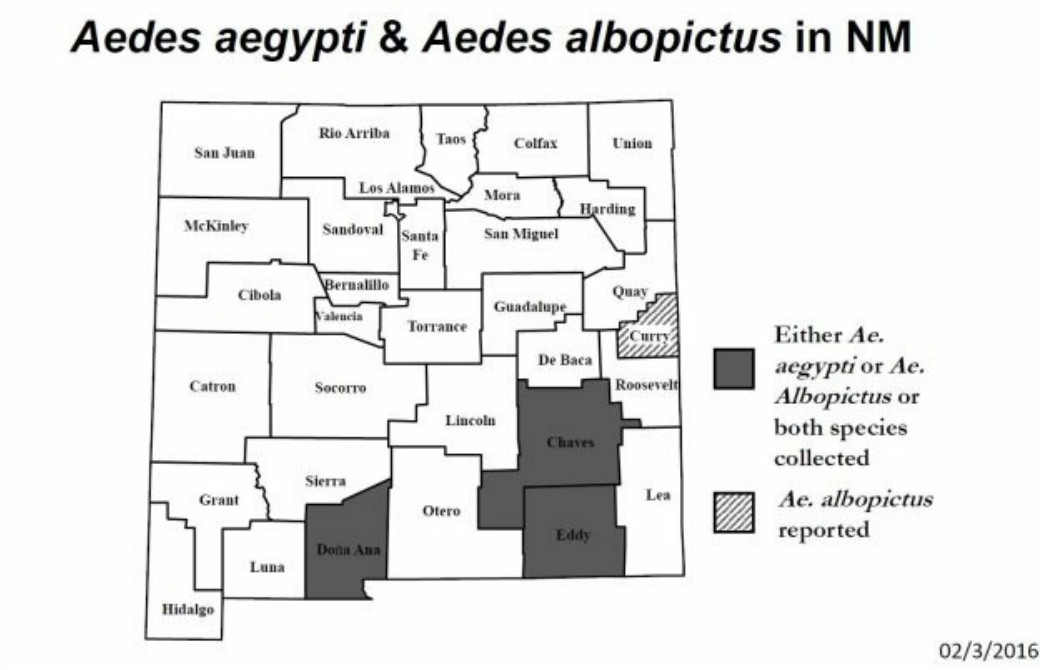
II.F.5. Emerging Issues

Zika Virus

The current Zika outbreak that is happening in many countries and territories is of concern here in New Mexico as well due to the potential impact and risk of adverse maternal outcomes. The two mosquito species in the United States that can transmit Zika virus have been found in some parts of southern New Mexico. If a person gets infected with the virus while in an area with Zika virus transmission and then goes to a part of New Mexico where *Aedes aegypti* or *Ae. albopictus* mosquitoes are present, those mosquitoes could become infected with the virus by biting the infected person and could then spread the infection to other people they bite. The Family Health Bureau is working with others in PHD and DOH (including in the Epidemiology and Response Division and the Bureau of Emergency Management) to develop a state plan for Zika. FHB staff from various programs will be very involved in the outreach to the maternal and child population, especially the outreach to pregnant women. FHB staff also collaborated with the Epidemiology and Response Division's Birth Defects Program on a CDC grant application directed at developing a pregnancy registry for Zika cases. CMS social workers will be intimately involved in the identified infant cases as care coordinators and will make referrals to other agencies (such as Part C) and linkages to Medical Home.

New Mexico does have the mosquito capable of Zika transmission in several of its southern counties bordering Texas and Mexico. In response, the DOH did receive federal funding for Zika emergency preparedness including the development of a pregnancy registry. The DOH Birth Defects program in the Epidemiology Division created a position to address linking families with birth defects into services and assuring a Medical Home. The position is funded out of CDC Birth Defect grants but housed in the CMS program. This position is part of the Department of Health Zika emergency preparedness planning and will play an essential role in coordinating information between prenatal care providers and the Department of Health Birth Defects Surveillance program to improve reporting of microcephaly and other associated birth defects to the DOH.

A primary function of this position will be to link identified infants and their families to essential services including Children’s Medical Services care coordinators, Developmental Disabilities staff including early intervention providers and waiver programs and to close the loop between identification of birth defects and access to needed services and family support. This position will serve on the DOH Core Communication team around Zika emergency preparedness and will be involved in decision making and provide guidance on community needs and issues. As part of a long overdue process to move from a passive birth defects surveillance system to an active birth defects surveillance system CMS is moving to address unmet needs for families with congenital conditions. The DOH is very supportive of this project. In April 2017 Ms. Susan Merrill was hired into this position. Ms. Merrill has been with the CMS program as a social work supervisor for over 10 years and is very skilled as a social worker and knowledgeable of community resources. Over the next year Ms. Merrill will be developing the scope of this program and its activities.



New Mexico has had 10 reported cases of Zika virus disease. Of those, all 10 were in travelers who were infected abroad and diagnosed after they returned home.

Zika Active Surveillance for Birth Defects:

Ms. Susan Merrill was hired as the Birth Defects Coordinator in the CMS program in March, and is developing a system that identifies babies born with a diagnosis that may be related to the Zika Virus. The program is receiving monthly files of babies born with ICD10 birth defects from the Department of Health Epidemiology Birth Defects program. The Birth Defects Coordinator contacts the parents of babies born with an identified diagnosis, first to confirm the diagnosis given by the parent, then to discuss services that they are receiving and/or may need and lastly to discuss travel history and to rule out if the biological mother may have been exposed to the Zika Virus.

Data collection and active surveillance started in January of 2017. Coordination of care and services includes referrals to PH Programs such as WIC and Children's Medical Services, along with outside community agencies such as Early Intervention and/or Home Visiting Programs. Communication is being coordinated with multiple partners such as the Family Infant Toddler Program (which is part of NM DOH, DDSD), Newborn Hearing Screening Program and the Medical Fragile Program. The goal is to assure that children and families living with birth defects have all the services available and appropriate for them.

Neonatal Abstinence Syndrome

Table. Neonatal Abstinence Syndrome (NAS) Rates (per 1,000 live births) by County of Residence of the Mother, New Mexico 2008-2015

County of Residence of the Mother	2008	2009	2010	2011	2012	2013	2014	2015
Bernalillo	5.3	7.2	7.3	9.5	12.7	14.4	12.6	14.2
Catron	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Chaves	1.9	2.9	4.1	3.2	2.1	5.3	4.4	2.1
Cibola	2.3	0.0	0.0	0.0	2.3	0.0	10.1	0.0
Colfax	0.0	0.0	0.0	14.0	0.0	14.7	8.0	7.4
Curry	0.0	0.0	0.0	1.1	1.1	0.0	3.3	2.3
De Baca	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Dona Ana	1.2	0.9	2.1	2.8	2.9	5.0	2.1	6.2
Eddy	1.2	0.0	1.4	3.9	1.3	2.3	4.5	3.3
Grant	4.9	2.7	2.8	6.8	6.2	9.7	16.9	12.5
Guadalupe	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Harding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0.0	0.0	0.0	13.2	0.0	0.0	0.0	39.2
Lea	0.0	0.8	1.0	0.9	0.9	4.2	0.0	3.3
Lincoln	0.0	0.0	0.0	5.1	0.0	5.4	5.7	5.3
Los Alamos	0.0	0.0	0.0	0.0	11.2	6.3	5.8	23.8
Luna	2.3	0.0	0.0	2.8	0.0	0.0	0.0	4.7
McKinley	2.9	0.7	0.8	0.8	2.4	2.6	0.0	1.9
Mora	19.2	0.0	0.0	0.0	0.0	22.7	0.0	0.0
Otero	1.1	2.3	2.3	1.1	1.1	0.0	5.6	7.4
Quay	0.0	0.0	9.2	0.0	8.3	0.0	0.0	0.0
Rio Arriba	8.5	17.5	12.9	29.5	31.1	35.7	64.1	64.6
Roosevelt	0.0	0.0	0.0	0.0	0.0	0.0	3.0	3.8
Sandoval	3.1	4.4	3.2	4.5	4.1	7.9	8.0	6.4
San Juan	1.3	0.0	1.6	1.0	1.6	2.1	1.1	1.1
San Miguel	10.3	3.2	5.8	6.3	0.0	6.3	10.6	3.4
Santa Fe	4.7	2.1	2.0	9.3	20.6	7.6	17.4	20.8
Sierra	0.0	0.0	0.0	34.5	0.0	8.7	26.3	9.3
Socorro	3.9	4.1	11.7	16.8	19.0	36.4	60.7	50.0
Taos	0.0	6.1	6.1	6.1	9.4	24.3	9.6	3.6
Torrance	0.0	0.0	6.1	5.8	0.0	6.8	8.0	11.6
Union	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Valencia	4.0	7.0	9.5	6.5	13.7	13.3	15.6	14.3
New Mexico	3.3	3.8	4.3	6.1	7.6	8.8	9.4	10.3

*NAS cases identified by using the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code 779.5 or the ICD-10-CM code P96.1

Data source: New Mexico Department of Health - Hospital Inpatient Discharge Datasets

New Mexico continues to see a steady rise in prenatal opioid use and neonatal abstinence (withdrawal). In 2012, an estimated 5.9% of women nationwide aged 15 to 44 years used illicit drugs during pregnancy. Marijuana use is most common, followed by prescription opioids and, less commonly, stimulants, heroin, and psychotropic drugs. In New Mexico NAS diagnoses at hospital discharge increased from 1.3 cases per 1,000 live births in 2000 to 8.8 per 1,000 in 2014. In at least two counties the rate is as high as 58 cases per 1,000 live births increasing from 35 per 1,000 in 2013. As a result, New Mexico is trying to understand some of the preconception and prenatal drug use through the PRAMS survey and added questions in the 2013 data collection. The data have not been released by the CDC, but will be available over the next five years for monitoring.

Health care spending for pregnancy complications related to illicit drug use during pregnancy and related neonatal

outcomes has increased from an average of US$39,400 per NAS hospital admission in 2000 to $53,400 in 2009, with 77.6% of these charges attributed to state Medicaid in 2009.The length of stay for NAS averages 16 days and has not significantly changed during this time. According to a recent survey, only about half of neonatal intensive care units (NICUs) in the United States have a written protocol for the diagnosis and management of NAS, which represents an important area for educational improvement.

New Mexico's rate of opiate overdose death leads the nation. The University of New Mexico (UNM) reported a doubling in volume over the last 3 years of women cared for in the Milagro program located in Albuquerque, NM (prenatal care for women with addictions). Over 180 women with opiate addiction delivered babies at UNM last year. In addition, the South and Southwest regions have the largest estimated opioid-dependent treatment gap in the nation. 70.3% of the population of New Mexico lives in rural or frontier counties, where treatment of opiate use disorder may be far less accessible and rural hospitals may have less experience managing neonatal abstinence syndrome.

A newly formed Perinatal Collaborative in NM (2013) chose NAS as one of four areas of focus (the others being early elective deliveries, maternal mortality/hemorrhage, and increasing the availability and use of LARCs). In 2015 NMDOH applied for a small AMCHP grant which we used to assess current hospital practices around NAS with regards to training of staff and protocols for treatment. In addition, the March of Dimes in NM has chosen NAS as its area of focus for 2015. The March of Dimes supports policy initiatives aimed at providing care for mother and baby which include the following elements:

- Access to comprehensive services: Pregnant women who abuse drugs, such as opioids, should have access to comprehensive services, including prenatal care, drug treatment, and social support services. These women often have other psychosocial risk factors that need to be addressed in order to ensure they successfully stop abusing drugs.

- Priority access and flexible treatment: Drug treatment programs should be tailored to pregnant or parenting women, taking into account the woman's family obligations, and should provide priority access to pregnant women.

- Immunity during prenatal visits: Research has shown that obtaining prenatal care, staying connected to the health care system, and being able to speak openly with health care providers about drug use creates a healthy environment for mothers at risk of drug abuse to seek treatment that can improve birth outcomes.

- Provider Education: Provider education and public awareness efforts can increase the patient-provider discussion on the risks and benefits of various medications, including opioids, and potential risks to the unborn child. Additionally, providers should be educated on the most updated substance abuse screening tools and the standard of care for all obstetrics patients.

We are also using some Title V funds to hire an NAS coordinator to help move the Perinatal Collaborative project along. This person is in the process of being identified/hired and will work on training hospital staff and other providers. NAS education and protocols are crucial to addressing this problem in our state, and addiction relates to several priority areas identified in the needs assessment: child maltreatment and neglect, access to behavioral and mental health, teen pregnancy and births, and bullying, depression and suicide. NAS is a cross-cutting, emergent issue which ties into our life-course strategies to address Title V priorities within a systems framework. It requires a long-term, multi-disciplinary approach to assuring access to healthcare and treatment for families in New Mexico.

II.F.6. Public Input

New Mexico has made many efforts to open dialogue and include community members in many aspects of the five-year needs assessment and Title V plans for 2016-2020. Domain groups and the Assessment leadership engaged with the Public Health Regions and Community Health Councils to solicit input on DOH health priorities for Maternal Child Health. Chris Whiteside, Title V Epidemiologist, worked consistently with the Regional and Community Epidemiologists to compile a County-level MCH health profile for input starting in November, 2014. We met with the NMDOH tribal epidemiologist, Samuel Swift, the NW Regional Epidemiologist, Kelly Gallagher, and SE Regional Epidemiologist Ervin Garcia, several times to consolidate data and agree on topics potentially valued by community and tribal health councils. The profiles were released and shared with communities in March, 2015. The MCH Epidemiology staff then followed up gathering input from the statewide alliance of community health councils and at the New Mexico Public Health Association. The profiles are a living document which can be tailored to each county or small area, depending on statistical stability, and can be updated each year. We felt this was an important part of obtaining input early on because the county health councils represent and feed from a wide variety of community stakeholders in each county. Participants range from medical professionals to parents to school staff and health-related organizations working on many different initiatives. In New Mexico we have a centralized Health Department but our Public Health Regions are rural, expansive and diverse, both geographically and demographically. It is important that we connect to communities as much as possible in our planning stages, action-strategic design, implementation, and evaluation over the next five years. It is also paramount that we interact with tribal leadership and regional leadership as much as possible to align our goals and objectives across jurisdictions. Therefore, public input includes the continuous engagement with Navajo Nation, Albuquerque Area Indian Health Board and family advocacy groups, including those not always in our usual stakeholder communications.

Family Organizations are invited to provide input into the CYSHCN Program activities and the Title V Block Grant during scheduled MCH Collaborative meetings. Input is also obtained when CMS makes direct referrals to family support organizations for family-to-family connections. This includes referrals to Parents Reaching Out (PRO), Education of Parents of Indian Children with Special Needs (EPICS), the family liaisons from the NM School for the Deaf (NMSD), and family guides through Hands & Voices for children deaf or hard of hearing. The Cleft Palate clinics employ a family support agent who is available to families during the clinic. An exit interview is conducted with each family after the clinic to provide input on effectiveness and processes. Family Health Bureau representatives participate in many councils that provide direct input into Title V Services, needs and gaps such as the Maternal and Child Health (MCH) Collaborative, NM Interagency Coordinating Council (ICC), Newborn Hearing Screening (NBHS) Advisory Council, Early Hearing Detection and Intervention (EHDI) advisory group. CMS recruited a parent representative to join the Newborn Genetic Screening Advisory Council, which includes participation in the Mountain States Regional Advisory Collaborative. CMS contracts with and provides funding to family organizations to ensure that families who have children with special needs have input into programming and serve in an advisory role regarding policy. The funding also supports family participation in local, State and National meetings/conferences and provide training for staff/families.

Each domain group will distribute the final block grant and/or Executive Summary to stakeholders and requested input, specifically on the state selected priorities, the state performance measures, evidence or informed-based strategy measures and action plan for the application year. All existing public input will be compiled and summarized prior to grant submission. We will post the block grant on a page of the NMDOH Health website and agency-sponsored Facebook for feedback from the public. Our population domain groups will also share the developed action plans directly with stakeholders to assure we were articulating plans which reflected their initial input and brainstorming. Because of these activities, most of the action plans were updated prior to the final updates to the block grant. We will continue to meet quarterly within the Family Health Bureau executive committee to assure we are continuously working with stakeholders and engaging with public input processes over the next five years. This will allow us to address emerging issues and to follow up on or modify our action plans throughout the year.

Specific plans for the coming year include working with the March of Dimes, Medicaid/Human Services Department and the Department of Health leadership to engage and interact with ongoing community health assessments conducted throughout the state. In particular, we are working with the University of New Mexico and the NM Alliance of Community Health Councils to assess community understanding of Title V priorities over the next several years. Quarterly meetings/webinars giving updates of Title V activities and plans will commence with the submission of the Title V report/application.

II.F.7. Technical Assistance

New Mexico would also like assistance with its CoIIN efforts, specifically enhancing its data linkages and geospatial analysis capabilities.

Behavioral health was identified as one of our MCH priority needs however strategies were difficult to implement and develop due to a broad definition and a lack of information and resources.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$3,812,187	$3,606,780	$4,006,215	$3,783,840
Unobligated Balance	$0	$0	$0	$0
State Funds	$3,087,900	$6,575,915	$7,264,811	$6,669,159
Local Funds	$0	$0	$0	$0
Other Funds	$0	$0	$0	$0
Program Funds	$0	$4,653,306	$0	$6,501,745
SubTotal	$6,900,087	$14,836,001	$11,271,026	$16,954,744
Other Federal Funds	$82,886,700		$68,379,602	$42,768,655
Total	$89,786,787	$14,836,001	$79,650,628	$59,723,399

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$4,048,292	$4,376,866	$4,075,191	
Unobligated Balance	$0	$0	$0	
State Funds	$6,675,779	$6,984,517	$6,963,800	
Local Funds	$0	$0	$0	
Other Funds	$0	$0	$0	
Program Funds	$7,314,571	$10,487,490	$6,501,745	
SubTotal	$18,038,642	$21,848,873	$17,540,736	
Other Federal Funds	$53,072,414	$42,501,710	$45,775,263	
Total	$71,111,056	$64,350,583	$63,315,999	

	2018	
	Budgeted	Expended
Federal Allocation	$4,063,782	
Unobligated Balance	$0	
State Funds	$6,019,300	
Local Funds	$0	
Other Funds	$0	
Program Funds	$9,377,300	
SubTotal	$19,460,382	
Other Federal Funds	$49,335,723	
Total	$68,796,105	

III.A. Expenditures

For FY16 New Mexico spent $4,376,866 of federal funds from the Title V Grant during this project period. The state spent 38% of the Title V funds on preventive and primary care for children, including adolescent health, family planning services for adolescents and young adults up to 21, injury prevention, MCH Epidemiology work and child health programs addressing safe sleep, child development and preventing child maltreatment. A little over 32% of the grant was spent on Children's Medical Services, the NM Title V program for Children and Youth with Special Healthcare Needs. This program provides unduplicated services to this unique population and is a flagship program for the Dept. of Health in NM, with CMS social workers throughout the state providing care coordination and specialty outreach clinics to improve access to care for children with chronic medical conditions. Only 3.6% of the grant expenditures went to Administrative costs, which included a portion of the salary of the Title V Director and Medical Director for the Family Health Bureau, an administrative position that oversees and assists all the MCH programs within the Bureau, and a portion of the Bus-Ops position. The remaining funds were spent by the maternal health program to provide high risk prenatal services for pregnant women with no other source of coverage.

The FHB spent $451,745 of Title V funds on direct services; of that amount, $126,162 was spent on the previously mentioned high risk prenatal services for pregnant women. The vast majority of the Title V funding for CSHCN provides enabling services rather than direct service, paying salaries for CMS social workers to provide care coordination to families and children with special healthcare needs and chronic medical conditions. The majority of Title V funds were spent on enabling services (mostly social workers providing care coordination for CYSHCN). Of the Federal funds to CMS, only $238,759 was spent on direct services, which included payments for medical care provided to CMS clients who had no other insurance/payment source. The remaining $1,203,684 was used to support public health services and systems by paying partial salaries for staff who support this work in a variety of ways. Examples include data surveillance and analysis, assisting with the neonatal abstinence project of the Perinatal Collaborative, midwife licensure, work on youth transition and teen pregnancy issues, and coalition building to address developmental screening, safe sleep, and child maltreatment.

State general fund support to the DOH and the Public Health Division/Family Health Bureau has been cut over the past several years and continues to be cut annually. The FHB programs continue to struggle to meet the needs of our MCH population with the funding limitations we have. Children's Medical Services staff are overloaded in several areas carrying high caseloads and stretching to cover areas where positions have been lost or are currently vacant. Safety net services including the High Risk Prenatal Care Fund, Maternal Health, and Children with Special Healthcare Needs clinics continue to be funded; however, it is always a stretch to try to meet all the needs in such a large and rural state.

Many of the FHB programs have worked diligently to increase their program revenues in order to supplement the federal and state funds to better meet the needs of the populations they serve. The Bureau continues to try to proactively address factors impacting birth outcomes and infant mortality, including prenatal care utilization, substance abuse, tobacco use, mental health, unintended pregnancy, and disparities among populations such as the undocumented and the Native American population. The Family Planning Program continues to receive funding via Title X, Teen Outreach program (TOP), and Personal Responsibility Education Program (PREP). A separate Title V Abstinence grant is administered out of the PHD Director's office and focuses on counties in the southwest with some of the highest teen birth rates.

The expenditures show that the amount spent on direct services has been decreasing over the years and the amounts spent on enabling services and public health services and systems have increased. This reflects a general nationwide trend of funding for direct services being increasingly available through Medicaid or private insurance, due in part to effects of the ACA and Medicaid expansion. At the same time, costs of medical services are escalating, requiring more funding to maintain previous levels of safety net services, especially with regards to children with special health care needs. There is an ever-increasing demand for more specialty clinics, especially in the areas of asthma and cardiology. Increased revenues allowed the CMS program to increase payment for

clinics going into FY17, adding more cardiology and neurology clinics and increasing the UNM asthma clinics to make up for losing the Presbyterian clinic provider. For FY17 we also added a few Cystic Fibrosis clinics, the first time this has been offered.

Salaries for critical positions such as nurses and social workers remain well below market value, although the CMS social workers did get reclassified to begin to address this issue. Low salaries directly impact the ability of the programs to recruit and retain staff resulting in a large number of vacancies throughout the state. This results in the variance between budgeted funds and expended as funds allocated to salaries cannot easily be used for other purposes.

III.B. Budget

The budgeted amounts for FY18 reflect a continued commitment on the part of the state to meet the matching requirements of the Title V grant, and to comply with the 30/30/10 target percentages for Preventive and Primary Care for Children, Children with Special Healthcare Needs, and Administration. The proposed budget for FY18 also reflects the department's commitment to CSHCN, with CMS receiving over 32% of the Title V block grant funds rather than the minimum requirement of 30%. The state general fund is predicted to be somewhat lower in the coming budget cycles. Declining oil and gas revenues led to a much smaller state budget than had been predicted and DOH was again cut for FY18, although the cut to PHD was less than in FY17. The Title V funding budgeted for 2018 reflects uncertainty about the budget on the federal level. A Federal budget has not yet been approved and it is not clear if MCH funds will be maintained at current levels. Direct health services are targeted to those with low incomes or with limited access to services who are uninsured or underinsured. The administrative component is comprised of the Family Health Medical Director/Bureau Chief's budget and includes fiscal, program, and personnel management, systems maintenance, strategic planning, and advocacy.

Budgeted amounts for other federal funds including the PREP grant, the EHDI grant, the Universal Newborn Hearing Grant, Title X, SSDI, PRAMS, ECCS and WIC are an estimate of the projected funding that will be available in 2018 from these sources, which is of course subject to change on the federal level. The majority of the Title V funding continues to be budgeted for enabling services; this reflects the work of the CMS program staff in the field providing care coordination to children and youth with special healthcare needs. Approximately $700,000 continues to be budgeted for direct services to address the gaps in services (mostly prenatal and high risk) where other funding sources are not available. This is a decrease of approximately 12% from last year’s expended amount in direct services, reflecting the federal goal of spending lesson direct services.

The Department of Health's accounting system, SHARE, contains defined accounting codes for revenues and expenditures in each specific component of the maternal and child health program. Budgets are detailed by these accounting codes and expenditures charged to each specific component. The Department maintains financial accounting records and has a fiscal management system, both of which ensure a clear audit trail. Programs are allocated shares of the Title V block grant along with the required state match. Budgeted Title V amounts for FY18 are expected to be similar to FY16 since Title V and match supports mainly salaries and these are not expected to change dramatically. The summary budgets for FHB programs are an aggregation of all of the Project Identification Codes (programmatic financial accounts) that relate to Maternal and Child Health. These Project Identification Codes are program specific: e.g., Maternal Health, Title V, Adolescent Pregnancy Prevention/Family Planning, Child Health, Adolescent Health/Youth Development, Children's Medical Services, etc. Each Project I.D. is allocated funding showing the federal/state distribution. The state match amount is the required three state dollars to four federal dollars and is also greater than the 1989 Maintenance of Effort amount of $3,087,900.

The Department of Health, including the CMS and Families FIRST case management programs, has contracted with the four managed care organizations under the Human Services State Medicaid program (MCO's). This has brought sorely needed revenues to FHB, especially within the CMS program. However, there is no guarantee that the contracts will continue, which is disconcerting as general fund decreases and we are relying increasingly on the revenues from these contracts to maintain services and salaries. These services cover Medicaid eligible clients and the billing is kept separate from that of the Title V funded clients. However, the more clients that can be determined Medicaid eligible the more it benefits the Title V population. CMS and Families FIRST, the two programs generating the most revenue, are moving into a new case management/billing system which is projected to be fully functional by September 2017. This system has the potential to increase revenues somewhat if tracking of billing and payments can be improved and submission errors reduced.

IV. Title V-Medicaid IAA/MOU

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

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Appendix A. Public input agencies.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: New Mexico

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,063,782	
A. Preventive and Primary Care for Children	$ 1,662,889	(40.9%)
B. Children with Special Health Care Needs	$ 1,652,042	(40.6%)
C. Title V Administrative Costs	$ 251,522	(6.2%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,019,300	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 9,377,300	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 15,396,600	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,087,900		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 19,460,382	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 49,335,723	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 68,796,105	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 129,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 114,623
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 90,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 232,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,112,400
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 45,657,700

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 4,048,292		$ 4,376,866	
A. Preventive and Primary Care for Children	$ 1,280,909	(31.6%)	$ 2,307,283	(52.7%)
B. Children with Special Health Care Needs	$ 2,188,017	(54%)	$ 1,430,195	(32.6%)
C. Title V Administrative Costs	$ 181,363	(4.5%)	$ 156,671	(3.6%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,675,779		$ 6,984,517	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 7,314,571		$ 10,487,490	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 13,990,350		$ 17,472,007	
A. Your State's FY 1989 Maintenance of Effort Amount $ 3,087,900				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 18,038,642		$ 21,848,873	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 53,072,414		$ 42,501,710	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 71,111,056		$ 64,350,583	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 336,080	$ 276,337
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 117,154	$ 42,437
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 140,123	$ 134,143
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 128,582	$ 141,400
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 91,290
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 227,280	$ 218,687
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 2,806,704	$ 2,616,987
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 47,992,248	$ 37,961,602
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 1,224,243	$ 1,018,827

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: FY18 budgeted Infants plus Children 1-22 from Form 3a	
2.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Programs are still spending the FY16 grant and plan to spend down by 9/30/17. Total from 3a program expenditures	
3.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Infant plus Children 1-22 from form 3a	
4.	**Field Name:**	**Federal Allocation, B. Children with Special Health Care Needs:**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Federal allocation was lower this year because the Program had more revenue to spend and federal could be spent in the following year	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Revenue less than expected - working on new billing system.	

Data Alerts:

1.	The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

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

State: New Mexico

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 497,329	$ 482,717
2. Infants < 1 year	$ 782,852	$ 971,962
3. Children 1-22 years	$ 880,037	$ 1,335,321
4. CSHCN	$ 1,652,042	$ 1,430,195
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 3,812,260	$ 4,220,195

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	$ 815,787	$ 704,878
2. Infants < 1 year	$ 1,370,333	$ 1,442,019
3. Children 1-22 years	$ 559,548	$ 691,695
4. CSHCN	$ 1,782,375	$ 2,858,539
5. All Others	$ 0	$ 0
Non Federal Total of Individuals Served	$ 4,528,043	$ 5,697,131
Federal State MCH Block Grant Partnership Total	$ 8,340,303	$ 9,917,326

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	**Field Name:**	**IA. Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: 100% maternal health from FY16IBA	
2.	**Field Name:**	**IA. Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: 50% Injury, 25% CMS, 100% MCHEpi, 10% child health From FY16IBA	
3.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: This does not equal form 2 preventive and primary care for children because some of the children we serve are under one so we included infants AND children 1-22 on form 2. There was no other place to put the infants. Injury 50%, FPP 100%, Adolescent health 100%, child health 90%, Adolescent Preg. Prevention 100% From FY16 IBA	
4.	**Field Name:**	**IA. Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: 75% CMS From FY16 IBA	
5.	**Field Name:**	**IA. Federal MCH Block Grant, 5. All Others**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**

	Field Note: Zero because of note stating "do not include administrative costs reported on form 2 line 1C"	
6.	**Field Name:**	**IB. Non Federal MCH Block Grant, 1. Pregnant Women**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: General Fund only Non federal includes 50% of Families FIRST	
7.	**Field Name:**	**IB. Non Federal MCH Block Grant, 2. Infant < 1 Year**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Injury 50%, CMS 25%, Epi 100%, Child Health 10%, FF 50% From FY16 IBA	
8.	**Field Name:**	**IB. Non Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Injury 50%, FPP 100%, Adolescent Health 100%, child health 90%, adolescent pregnancy prevention 100% From FY16 IBA	
9.	**Field Name:**	**IB. Non Federal MCH Block Grant, 4. CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: 75% CMS FY16 IBA	
10.	**Field Name:**	**IA. Federal MCH Block Grant, 3. Children 1-22 years**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Does not equal preventive and primary care because that also included infants	

Form 3b
Budget and Expenditure Details by Types of Services

State: New Mexico

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 701,278	$ 808,300
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 382,943	$ 482,717
B. Preventive and Primary Care Services for Children	$ 142,117	$ 86,824
C. Services for CSHCN	$ 176,218	$ 238,759
2. Enabling Services	$ 2,384,314	$ 2,721,437
3. Public Health Services and Systems	$ 978,190	$ 847,129
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 45,305
Physician/Office Services		$ 539,405
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 204,000
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 19,590
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 808,300
Federal Total	$ 4,063,782	$ 4,376,866

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	$ 631,931	$ 609,267
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 371,692	$ 180,436
B. Preventive and Primary Care Services for Children	$ 70,119	$ 123,920
C. Services for CSHCN	$ 190,120	$ 304,911
2. Enabling Services	$ 3,165,503	$ 4,505,374
3. Public Health Services and Systems	$ 730,608	$ 582,488
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 48,700
Physician/Office Services		$ 302,890
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 146,195
Dental Care (Does Not Include Orthodontic Services)		$ 58,140
Durable Medical Equipment and Supplies		$ 12,159
Laboratory Services		$ 41,183
Direct Services Line 4 Expended Total		$ 609,267
Non-Federal Total	$ 4,528,042	$ 5,697,129

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. - 1. Direct Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Numbers came from FY16 IBAs	
2.	**Field Name:**	**IIA. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Maternal Health 100%	
3.	**Field Name:**	**IIA. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: FPP 30%	
4.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: CMS 8%	
5.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: CMS 92%, Adolescent Pregnancy 100%, Injury 100%, Child Health 100%, Med Director 75%	
6.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2018**

	Column Name:	**Application Budgeted**
	Field Note: Med Director, Epi 100%, FPP 70%, Adolescent Health 100%,	
7.	**Field Name:**	**IIB. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: Maternal Health 100%	
8.	**Field Name:**	**IIB. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: 30% FPP	
9.	**Field Name:**	**IIB. - 1. C. Services for CSHCN**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: 8% CMS	
10.	**Field Name:**	**IIB. - 2. Enabling Services**
	Fiscal Year:	**2018**
	Column Name:	**Application Budgeted**
	Field Note: CMS 92%, 100% FF, adolescent preg, injury, child health, and 75% med director	
11.	**Field Name:**	**IIA. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 100% Maternal From pivot tables run from SHARE	
12.	**Field Name:**	**IIA. - 1. B. Preventive and Primary Services for Children**

	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: FPP30%,	
13.	**Field Name:**	**IIA. - 1. C. Services for CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 8% CMS	
14.	**Field Name:**	**IIA. - 2. Enabling Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 92% CMS, 100% Adolescent pregnancy, injury, child health, FF, and 75% med dir	
15.	**Field Name:**	**IIA. - 3. Public Health Services and Systems**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 25% med dir, 70% FPP, 100% Epi and Adolescent health	
16.	**Field Name:**	**IIA. - 4. Pharmacy**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 100% FPP Pharmacy from last year included CMS special foods and this year it does not	
17.	**Field Name:**	**IIA. - 4. Physician/Office Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: Maternal Health UNM acct code 5351, 5352 and 5353	
18.	**Field Name:**	**IIA. - 4. Hospital Charges (Includes Impatient and Outpatient Services)**

	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: maternal health code 5473	
19.	**Field Name:**	**IIA. - 4. Durable Medical Equipment and Supplies.**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: FPP account code 5442	
20.	**Field Name:**	**IIA. - 4. Laboratory Services**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: act code 5352 and 5351 maternal health FPP and CMS	
21.	**Field Name:**	**IIB. - 1. A. Preventive and Primary Care Services for all Pregnant Women,Mothers, and Infants up to Age One**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 100% maternal health	
22.	**Field Name:**	**IIB. - 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 30% FPP	
23.	**Field Name:**	**IIB. - 1. C. Services for CSHCN**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 8% CMS	
24.	**Field Name:**	**IIB. - 2. Enabling Services**

	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 92% CMS, 75% med dir, 100% adolescent preg, injury, child health and FF	
25.	**Field Name:**	**IIB. - 3. Public Health Services and Systems**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: 100% Epi and adolescent health, 70% FPP, 25% med dir	
26.	**Field Name:**	**IIB. - 4. Dental Care (does not include Orthodontic Services)**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: CMS from HSD report	
27.	**Field Name:**	**IIB. - 4. Durable Medical Equipment and Supplies**
	Fiscal Year:	**2016**
	Column Name:	**Annual Report Expended**
	Field Note: FPP acct code 5442	

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

State: New Mexico

Total Births by Occurrence: 23,322

1. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	22,720 (97.4%)	1,648	87	79 (90.8%)

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

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

New Mexico (NM) long term follow up starts at the time of diagnosis up to age 21. Any client diagnosed with a condition identified by Newborn Screen is offered long term follow up. NM long term follow up is a case management system set up to support parents/client after diagnosis. We have social workers though out the state located at every public health office. Once referred the social worker will make contact with the parent quarterly for the first five years then every 6 months up until the age of 21, after age 21, follow up is as needed. The Newborn Screening Program wants to ensure that there are no barriers to health care. A follow up form is completed by the social worker at the time of visit and it consists of questions involving how often they see their Primary Care Physician, Specialist, do they have insurance, are developmental milestones achieved, any barriers/challenges in Housing, financial, transportation, obtaining medication etc.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Receiving At Lease One Screen**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: Northern Navajo medical center is excluded. They do their own screening and do not send us their data	
2.	**Field Name:**	**Core RUSP Conditions - Confirmed Cases**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: CCHD cases are not included because limited resources has created a backlog into entering CCHD screening information. CY2016 will be available in Nov of 2017.	
3.	**Field Name:**	**Core RUSP Conditions - Referred For Treatment**
	Fiscal Year:	**2016**
	Column Name:	**Core RUSP Conditions**
	Field Note: Genetic screening had 8 of 36 cases that did not require treatment. of the 28 cases that required treatment in genetic screening, all cases received treatment. Need to add Hearing Tx	

Data Alerts: None

Form 5a
Unduplicated Count of Individuals Served under Title V

State: New Mexico

Reporting Year 2016

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,229	59.0	0.0	34.1	6.9	0.0
2. Infants < 1 Year of Age	2,756	59.0	0.0	34.1	6.9	0.0
3. Children 1 to 22 Years of Age	13,475	52.8	0.0	42.0	5.2	0.0
4. Children with Special Health Care Needs	3,876	66.2	0.0	5.8	28.0	0.0
5. Others	0					
Total	23,336					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2016**
	Field Note: This number includes counts from the High Risk Pregnancy Fund, CYFD Home Visiting and Prenatal related medications (including multivitamins) program. Primary source of coverage from Birth Certificate, 2015	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2016**
	Field Note: These are infants that the NBHS and NBGS program follow up for an abnormal screening and CYFD home visiting. Primary source of coverage from birth certificate, 2015	
3.	**Field Name:**	**Children 1 to 22 Years of Age**
	Fiscal Year:	**2016**
	Field Note: This includes counts from Family Planning, Adolescent Health, Injury Prevention, and CYFD Home Visiting. Primary Source of coverage ACS, 2015	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2016**
	Field Note: This count includes CYSHCN that receive care coordination from CMS Social Workers and/ or payment of insurance premiums (source of coverage from CMS client data). Note Medicaid and SCHIP numbers are combined because New Mexico houses and manages both programs under Medicaid. For CSHCN, those who were only insured by Children's Medical Services were categorized as having no insurance because the program acts as safety net for individuals who cannot be insured through Medicaid.	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: New Mexico

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	24,503
2. Infants < 1 Year of Age	25,907
3. Children 1 to 22 Years of Age	156,377
4. Children with Special Health Care Needs	80,500
5. Others	0
Total	287,287

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2016**
	Field Note: This count includes the entire birth population (implementation of risk-appropriate perinatal care). Population estimate source NM-IBIS	
2.	**Field Name:**	**Infants Less Than One Year**
	Fiscal Year:	**2016**
	Field Note: Includes the entire birth population (implementation of risk-appropriate perinatal care). Population estimate source NM-IBIS, 2016.	
3.	**Field Name:**	**Children 1 to 22 Year of Age**
	Fiscal Year:	**2016**
	Field Note: Includes counts from programs administered by MCH Title V including: WIC,Families First, Title X, Home visiting (CYFD), and injury prevention (safe-sleep education). Also includes Adolescent Health reach within the public education system (AYAH CoIIN).	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2016**
	Field Note: The estimate is from the population definition of Children with Special Health Care Needs and accounted for the fact that this is 13 percent of the Child population. Population estimates NM-IBIS, 2016	

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

State: New Mexico

Reporting Year 2016

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	23,321	19,152	326	2,950	417	0	0	476
Title V Served	13,942	11,449	195	1,764	249	0	0	285
Eligible for Title XIX	16,618	11,527	302	2,991	0	0	0	1,798
2. Total Infants in State	25,907	20,656	1,132	3,545	574	0	0	0
Title V Served	22,720	18,113	998	3,106	503	0	0	0
Eligible for Title XIX	6,921	4,754	427	1,555	185	0	0	0

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	10,419	12,426	476	23,321
Title V Served	6,229	7,429	284	13,942
Eligible for Title XIX	6,675	9,749	194	16,618
2. Total Infants in State	10,528	15,379	0	25,907
Title V Served	9,294	13,426	0	22,720
Eligible for Title XIX	1,900	5,021	0	6,921

Form Notes for Form 6:

This data is populated with 2015 data until the 2016 population estimates become available.

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Provisional data, finalized data available by Aug. 2017	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: This number corresponds to the number of pregnant women served by Title V on form 5B. The racial breakdown is proportionate to the percentage of births from each racial category.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Title XIX eligibility is estimated from PRAMS 2014 birth data. The eligible population in PRAMS is slightly smaller than the total resident birth population.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2016**
	Column Name:	**Total All Races**
	Field Note: Native Hawaiian or other Pacific Islander is included with Asian	

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

State: New Mexico

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting Year
1. State MCH Toll-Free "Hotline" Telephone Number	(877) 725-2552	(877) 725-2552
2. State MCH Toll-Free "Hotline" Name	Nurse Advice NM	Nurse Advice NM
3. Name of Contact Person for State MCH "Hotline"	Connie B. Fiorenzio	Connie B. Fiorenzio
4. Contact Person's Telephone Number	(505) 855-7744	(505) 855-7744
5. Number of Calls Received on the State MCH "Hotline"		28,931

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names		
2. Number of Calls on Other Toll-Free "Hotlines"		
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

This form is populated with 2015 data until 2016 data available

Form 8
State MCH and CSHCN Directors Contact Information

State: New Mexico

1. Title V Maternal and Child Health (MCH) Director	
Name	Janis Gonzales, MD, MPH, FAAP
Title	Family Health Bureau Chief, Title V Director
Address 1	2040 S. Pacheco st. NW
Address 2	
City/State/Zip	Santa Fe / NM / 87144
Telephone	(505) 476-8854
Extension	
Email	janis.gonzales@state.nm.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Susan Chacon, MSM, LCSW
Title	CMS Director Title V CSHCN
Address 1	2040 S. Pacheco st. NW
Address 2	
City/State/Zip	Santa Fe / NM / 87144
Telephone	(505) 476-8860
Extension	
Email	susan.chacon@state.nm.us

3. State Family or Youth Leader (Optional)	
Name	Trish Thomas
Title	Family Voices National Director of Diversity and Outreach
Address 1	3701 San Mateo Blvd, NE
Address 2	
City/State/Zip	Albuquerque / NM / 87144
Telephone	(505) 872-4774
Extension	
Email	tthomas@familyvoices.org

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: New Mexico

Application Year 2018

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

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	To maintain and increase breastfeeding initiation and duration	New	
2.	To increase the percentage of children receiving a developmental screen	New	
3.	Increase access to care to a family-centered comprehensive medical home for children and adolescents	New	
4.	To increase the amount of services available to assist adolescents to make successful transitions to adult health care services	New	
5.	To reduce birth rates among teens 15-19	New	A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application
6.	To improve access and quality of comprehensive well exams for adolescents	New	
7.	Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.	New	
8.	To increase access to resources and increase awareness on bullying prevention	New	
9.	To improve safe sleep practices among home visiting participants and birthing facility medical staff	New	A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application
10.	To decrease abuse and maltreatment on children	New	A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 10

Field Note:
This is a new priority identified in FFY 2016 as an emerging priority need.

Form 10a
National Outcome Measures (NOMs)

State: New Mexico

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

This is ESM is identical to ESM11.2 because it will impact both priority needs and State Performance Measures

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	72.4 %	0.3 %	17,960	24,802
2014	71.5 %	0.3 %	17,633	24,674
2013	67.1 %	0.3 %	16,677	24,862
2012	68.8 %	0.3 %	17,154	24,946
2011	67.7 %	0.3 %	17,401	25,694
2010	68.9 %	0.3 %	17,935	26,046
2009	66.4 %	0.3 %	16,863	25,394

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	181.9	9.1 %	410	22,544
2013	200.8	9.4 %	465	23,158
2012	221.2	9.8 %	523	23,641
2011	185.4	9.0 %	436	23,517
2010	166.0	8.4 %	399	24,031
2009	153.2	7.8 %	388	25,319

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2015	25.7	4.4 %	34	132,579
2010_2014	23.0	4.1 %	31	134,613
2009_2013	21.1	3.9 %	29	137,561
2008_2012	23.3	4.1 %	33	141,380
2007_2011	26.9	4.3 %	39	144,928
2006_2010	24.4	4.1 %	36	147,575

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	8.7 %	0.2 %	2,244	25,767
2014	8.8 %	0.2 %	2,282	25,950
2013	8.9 %	0.2 %	2,333	26,283
2012	8.8 %	0.2 %	2,381	26,948
2011	8.8 %	0.2 %	2,385	27,227
2010	8.7 %	0.2 %	2,427	27,828
2009	8.3 %	0.2 %	2,416	28,969

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.2 %	0.1 %	302	25,767
2014	1.3 %	0.1 %	349	25,950
2013	1.3 %	0.1 %	346	26,283
2012	1.2 %	0.1 %	330	26,948
2011	1.3 %	0.1 %	359	27,227
2010	1.3 %	0.1 %	371	27,828
2009	1.2 %	0.1 %	355	28,969

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.5 %	0.2 %	1,942	25,767
2014	7.5 %	0.2 %	1,933	25,950
2013	7.6 %	0.2 %	1,987	26,283
2012	7.6 %	0.2 %	2,051	26,948
2011	7.4 %	0.2 %	2,026	27,227
2010	7.4 %	0.2 %	2,056	27,828
2009	7.1 %	0.2 %	2,061	28,969

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	9.5 %	0.2 %	2,462	25,803
2014	9.2 %	0.2 %	2,387	26,017
2013	9.3 %	0.2 %	2,439	26,255
2012	9.6 %	0.2 %	2,576	26,983
2011	9.7 %	0.2 %	2,648	27,229
2010	9.1 %	0.2 %	2,534	27,747
2009	9.3 %	0.2 %	2,682	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.5 %	0.1 %	643	25,803
2014	2.5 %	0.1 %	657	26,017
2013	2.7 %	0.1 %	707	26,255
2012	2.5 %	0.1 %	682	26,983
2011	2.6 %	0.1 %	707	27,229
2010	2.6 %	0.1 %	710	27,747
2009	2.6 %	0.1 %	762	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.1 %	0.2 %	1,819	25,803
2014	6.7 %	0.2 %	1,730	26,017
2013	6.6 %	0.2 %	1,732	26,255
2012	7.0 %	0.2 %	1,894	26,983
2011	7.1 %	0.2 %	1,941	27,229
2010	6.6 %	0.2 %	1,824	27,747
2009	6.6 %	0.2 %	1,920	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	27.3 %	0.3 %	7,040	25,803
2014	26.9 %	0.3 %	6,986	26,017
2013	27.3 %	0.3 %	7,162	26,255
2012	26.9 %	0.3 %	7,254	26,983
2011	26.8 %	0.3 %	7,309	27,229
2010	27.0 %	0.3 %	7,492	27,747
2009	28.1 %	0.3 %	8,140	28,953

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	4.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	3.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.1	0.4 %	134	26,117
2013	5.0	0.4 %	133	26,404
2012	5.8	0.5 %	157	27,130
2011	4.8	0.4 %	131	27,348
2010	4.8	0.4 %	133	27,908
2009	5.1	0.4 %	148	29,081

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.2	0.5 %	136	26,052
2013	5.3	0.5 %	139	26,354
2012	6.8	0.5 %	184	27,068
2011	5.6	0.5 %	152	27,289
2010	5.6	0.5 %	156	27,850
2009	5.3	0.4 %	154	29,000

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	3.5	0.4 %	92	26,052
2013	3.9	0.4 %	103	26,354
2012	4.7	0.4 %	126	27,068
2011	3.4	0.4 %	92	27,289
2010	3.4	0.4 %	95	27,850
2009	3.2	0.3 %	92	29,000

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	1.7	0.3 %	44	26,052
2013	1.4	0.2 %	36	26,354
2012	2.1	0.3 %	58	27,068
2011	2.2	0.3 %	60	27,289
2010	2.2	0.3 %	61	27,850
2009	2.1	0.3 %	62	29,000

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	180.4	26.3 %	47	26,052
2013	223.9	29.2 %	59	26,354
2012	247.5	30.3 %	67	27,068
2011	216.2	28.2 %	59	27,289
2010	161.6	24.1 %	45	27,850
2009	151.7	22.9 %	44	29,000

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	46.1	13.3 %	12	26,052
2013	60.7	15.2 %	16	26,354
2012	92.4	18.5 %	25	27,068
2011	77.0	16.8 %	21	27,289
2010	43.1	12.4 %	12	27,850
2009	86.2	17.3 %	25	29,000

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	6.4 %	0.7 %	1,507	23,569
2013	5.5 %	0.6 %	1,310	24,003
2012	4.5 %	0.8 %	1,111	24,695
2011	6.6 %	0.6 %	1,668	25,192

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	18.3	0.9 %	419	22,847
2013	16.2	0.8 %	379	23,408
2012	12.7	0.7 %	299	23,642
2011	10.8	0.7 %	253	23,517
2010	7.8	0.6 %	187	24,033
2009	6.2	0.5 %	156	25,319

Legends:

Indicator has a numerator ≤10 and is not reportable

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

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

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

FAD Not Available for this measure.

NOM 13 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	23.9 %	1.7 %	115,158	482,872

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	23.7	3.1 %	59	248,557
2014	17.0	2.6 %	43	252,620
2013	19.9	2.8 %	51	256,147
2012	22.0	2.9 %	57	259,441
2011	27.8	3.3 %	73	262,232
2010	21.1	2.9 %	55	260,110
2009	22.2	2.9 %	57	256,535

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	43.0	3.9 %	119	276,621
2014	43.9	4.0 %	122	278,105
2013	35.5	3.6 %	100	281,413
2012	43.3	3.9 %	123	284,233
2011	39.3	3.7 %	113	287,793
2010	49.7	4.1 %	145	291,552
2009	53.6	4.3 %	156	291,043

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	13.7	1.8 %	57	416,705
2012_2014	17.1	2.0 %	72	420,608
2011_2013	14.5	1.8 %	62	427,695
2010_2012	17.8	2.0 %	78	437,214
2009_2011	19.1	2.1 %	85	446,029
2008_2010	22.8	2.3 %	103	451,937
2007_2009	24.9	2.4 %	113	453,253

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	14.9	1.9 %	62	416,705
2012_2014	16.2	2.0 %	68	420,608
2011_2013	17.5	2.0 %	75	427,695
2010_2012	19.2	2.1 %	84	437,214
2009_2011	17.5	2.0 %	78	446,029
2008_2010	19.7	2.1 %	89	451,937
2007_2009	20.5	2.1 %	93	453,253

Legends:

Indicator has a numerator <10 and is not reportable

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

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.0 %	1.4 %	92,930	517,036
2007	16.2 %	1.2 %	79,908	493,495
2003	17.7 %	1.1 %	88,375	499,905

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	12.3 %	1.3 %	7,735	63,029

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	0.8 %	0.4 %	3,587	430,746
2007	1.0 %	0.4 %	3,871	405,714

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	5.8 %	0.9 %	24,769	429,287
2007	4.1 %	0.6 %	16,430	405,155

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	58.0 %	6.7 %	20,730	35,727
2007	53.1 %	6.6 %	16,425	30,924
2003	58.2 %	5.9 %	18,741	32,179

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

NOM 18 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	81.4 %	1.5 %	421,029	517,036
2007	85.1 %	1.2 %	420,042	493,495
2003	81.9 %	1.1 %	409,326	499,905

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	32.9 %	2.6 %	72,205	219,833
2007	32.7 %	2.6 %	69,914	214,080
2003	28.9 %	2.0 %	62,347	215,788

Legends:

Indicator has an unweighted denominator <30 and is not reportable

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	26.6 %	0.3 %	5,447	20,515
2012	28.4 %	0.3 %	6,037	21,220
2010	32.1 %	0.3 %	7,061	21,968
2008	27.4 %	0.3 %	6,172	22,514

Legends:

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

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

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	31.8 %	0.7 %	29,981	94,186
2013	27.6 %	1.9 %	25,408	91,951
2011	27.3 %	1.4 %	25,094	92,021
2009	28.0 %	1.5 %	25,677	91,635
2007	24.3 %	1.6 %	22,038	90,582
2005	26.6 %	1.9 %	24,749	92,966

Legends:

Indicator has an unweighted denominator <100 and is not reportable

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

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.4 %	0.5 %	22,133	498,999
2014	7.6 %	0.6 %	37,982	497,539
2013	9.0 %	0.8 %	45,457	506,345
2012	8.0 %	0.8 %	41,412	514,814
2011	9.1 %	0.7 %	47,170	518,003
2010	10.0 %	0.7 %	51,481	517,558
2009	12.0 %	0.8 %	61,415	513,468

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	70.1 %	4.0 %	27,390	39,050
2014	75.9 %	3.5 %	29,643	39,058
2013	65.7 %	3.7 %	25,879	39,405
2012	71.6 %	3.4 %	28,790	40,234
2011	69.8 %	3.4 %	29,615	42,427
2010	53.1 %	3.4 %	23,204	43,706
2009	45.8 %	3.4 %	19,433	42,442

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	68.9 %	2.2 %	329,679	478,767
2014_2015	65.4 %	2.0 %	318,477	486,893
2013_2014	66.6 %	2.0 %	325,864	489,437
2012_2013	66.9 %	2.3 %	326,700	488,661
2011_2012	60.8 %	2.4 %	291,085	478,706
2010_2011	57.2 %	3.9 %	271,893	475,337
2009_2010	51.8 %	3.0 %	254,462	491,239

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	66.7 %	3.9 %	45,476	68,188
2014	59.0 %	4.5 %	40,822	69,208
2013	67.1 %	4.4 %	47,255	70,410
2012	51.1 %	5.1 %	35,880	70,235
2011	58.1 %	4.4 %	40,768	70,188
2010	48.4 %	4.3 %	32,952	68,025
2009	53.1 %	4.1 %	36,140	68,124

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	54.3 %	4.3 %	38,476	70,913
2014	42.8 %	4.7 %	30,712	71,752
2013	31.4 %	3.9 %	22,858	72,775
2012	20.2 %	4.1 %	14,752	72,871
2011	11.3 %	2.5 %	8,224	73,055

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	85.9 %	2.2 %	119,455	139,101
2014	83.3 %	2.7 %	117,458	140,960
2013	85.6 %	2.3 %	122,630	143,185
2012	82.6 %	2.9 %	118,201	143,106
2011	81.3 %	2.6 %	116,512	143,243
2010	71.8 %	2.9 %	99,579	138,689
2009	63.5 %	2.8 %	88,052	138,699

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	72.5 %	2.7 %	100,907	139,101
2014	75.1 %	2.8 %	105,921	140,960
2013	70.9 %	2.9 %	101,451	143,185
2012	54.2 %	3.6 %	77,578	143,106
2011	64.8 %	3.1 %	92,755	143,243
2010	52.9 %	3.2 %	73,319	138,689
2009	51.2 %	2.9 %	71,032	138,699

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)

State: New Mexico

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

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

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	62.0	62.3	63.5	64.8	66.1	67.3

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	78.5
Annual Indicator	85.5
Numerator	21,270
Denominator	24,890
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	87.0	88.4	89.8	91.2	92.6	94.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	25.6
Annual Indicator	26.6
Numerator	6,319
Denominator	23,784
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	27.2	28.0	28.8	30.4	32.0	33.8

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	39.3
Annual Indicator	38.3
Numerator	54,323
Denominator	141,890
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	40.0	41.0	42.0	43.0	45.0	46.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	78.2
Annual Indicator	77.7
Numerator	130,533
Denominator	168,106
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	79.4	80.8	82.2	83.5	84.7	85.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2016
Annual Objective	38.9
Annual Indicator	38.6
Numerator	34,748
Denominator	90,144
Data Source	NSCH-CSHCN
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	40.0	41.1	43.1	45.0	47.0	49.5

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	36.8
Annual Indicator	35.7
Numerator	9,776
Denominator	27,412
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	38.6	40.0	41.4	42.8	44.2	45.6

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	46.9
Annual Indicator	48.1
Numerator	11,379
Denominator	23,671
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	48.3	49.6	51.0	52.0	52.0	53.5

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	82.7
Annual Indicator	81.1
Numerator	389,669
Denominator	480,550
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.3	85.9	87.5	89.2	90.0	90.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	82
Annual Indicator	80.4
Numerator	386,077
Denominator	480,422
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	**2018**	**2019**	**2020**	**2021**	**2022**
Annual Objective	84.0	85.7	87.3	89.0	90.0	90.0

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: New Mexico

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	83.0	84.7	86.5	88.2	90.0	90.0

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	79.5
Numerator	19,194
Denominator	24,144
Data Source	NM PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.3	81.9	83.5	84.1	85.7	86.5

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.9	15.1	14.3	13.5	12.7	11.9

Field Level Notes for Form 10a SPMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	31.6	28.8	26.1	23.4	20.7	18.2

Field Level Notes for Form 10a SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Provisional Data from 2015 until Final Data from 2016 is available.

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

State: New Mexico

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Quarterly Midwife Licensure Survey
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	150.0	167.0	167.0	167.0	170.0	170.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
No data available, at the time reporting the survey data had not been collected. Will be available January 2018. There are 300 LM attended births, and the data to measure are not available at baseline. The initial target in 50%, aiming to 89% in subsequent years.

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	20
Numerator	
Denominator	
Data Source	2015
Data Source Year	NM HSD
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	35.0	40.0	40.0	40.0	40.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
Baseline data are not yet available. Estimate is based on number of licensed midwives who accept Medicaid as of 2015. That denominator is currently estimated at 40 individuals.

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	26.4
Numerator	318
Denominator	1,205
Data Source	NM PRAMS
Data Source Year	2014
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.0	31.7	34.3	37.0	39.6	42.2

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Child Health Program
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	300.0	325.0	350.0	375.0	400.0	425.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Inactive - Replaced

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	128
Data Source	AYAH CoIIN site clinic visit clinic data.
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	0.0	0.0	0.0	0.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	25.0	25.0	25.0	25.0	25.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	10.0	10.0	10.0	10.0	10.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	CMS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	50.0	50.0	50.0	50.0	50.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.

Measure Status:	Active

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	2.0	2.0	2.0	2.0	2.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Office or Oral Health
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	3.0	3.0	3.0	3.0	3.0	3.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	MCH Epidemiology
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	Yes	Yes	Yes	Yes	Yes	Yes

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active

State Provided Data	
	2016
Annual Objective	
Annual Indicator	38.9
Numerator	14
Denominator	36
Data Source	ACS
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	55.0	60.0	65.0	70.0	70.0

Field Level Notes for Form 10a ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**

Field Note:
This is the percent of previously uninsured in 2014 to insured in 2015 from the ACS

Form 10b
State Performance Measure (SPM) Detail Sheets

State: New Mexico

SPM 1 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
Population Domain(s) – Perinatal/Infant Health, Women/Maternal Health

Measure Status:	Active
Goal:	To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.
Definition:	**Numerator:** Number of VLBW infants born in a hospital with a level III or higher NICU **Denominator:** Number of VLBW infants (< 1500 grams) **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 33: Increase the proportion of VLBW infants born at level III hospitals or sub-specialty perinatal centers (Baseline: 75%, Target: 83.7%)
Data Sources and Data Issues:	NM Bureau of Vital Records and Health Statistics. NM is involved in implementing the CDC LoCATe tool, an assessment tool that CDC is developing to build state capacity for understanding neonatal and maternal risk appropriate care capacity (based on AAP and ACOG criteria).
Significance:	Low birthweight increases the risk for infant mortality and morbidity. As birthweight decreases, the risk for death increases. Low birthweight infants who survive often require intensive care at birth, may develop chronic illnesses, and later may require special education services. Health care costs and length of hospital stay are higher for low birthweight infants. VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a sub-specialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (sub-specialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).

SPM 2 - Percent of infants placed to sleep on their backs
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active
Goal:	To improve safe sleep practices among home visiting participants and birthing facility medical staff.
Definition:	**Numerator:** Number of mothers reporting that they most often place their baby to sleep on their back only **Denominator:** Number of live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Identical to Maternal, Infant, and Child Health (MICH) Objective 20: Increase the proportion of infants placed to sleep on their backs (Baseline: 69.0%, Target: 75.9%)
Data Sources and Data Issues:	New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the AAP has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

SPM 3 - Rate of Victims of Child Abuse per 1,000 Children in the Population
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To reduce the physical, psychological, and behavioral impact of child maltreatment on not just the child and family, but society as a whole.
Definition:	**Numerator:** Number of substantiated victims or allegations of child abuse and/or neglect. **Denominator:** Number of children under age 18 **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 3.2: Reduce the rate of deaths among children aged 5 to 9 years (Baseline: 29.4 deaths per 100,000 in 2007, Target: 26.5 deaths per 100,000) Related to Maternal, Infant, and Child Health (MICH) Objective 3.2: Reduce the rate of deaths among children aged 1 to 4 years (Baseline: 13.8 deaths per 100,000 in 2007, Target: 12.4 deaths per 100,000)
Data Sources and Data Issues:	NM CYFD, Population Estimates: University of New Mexico, Geospatial and Population Studies (GPS) Program
Significance:	In New Mexico, child maltreatment includes physical neglect, sexual abuse and physical abuse. Child maltreatment can range from relatively minor (bruises or cuts) to severe (broken bones, acute subdural hematoma, or even death). In addition to these physical effects, additional outcomes of abuse or neglect may include behavioral changes, developmental delays or life-long disabilities. Regardless of the physical effects, the emotional pain and suffering they cause a child should not be minimized. Additionally, adults who experienced abuse or neglect during childhood are more likely to suffer from physical ailments such as allergies, arthritis, asthma, bronchitis, high blood pressure, and ulcers. The effects vary depending on the circumstances of the abuse or neglect and personal characteristics of the child. Also impactful is the child's environment, including the array of services available to the child and family to address the underlying issues which lead to child maltreatment. Consequences of abuse might be mild or severe, may disappear after a short period or last a lifetime. Child maltreatment can impact the child physically, psychologically, behaviorally, or in some combination of all three ways. Ultimately, due to related costs to public entities such as the health care, human services, and educational systems, abuse and neglect impact not just the child and family, but society as a whole.

SPM 4 - Teen Birth Rate, Girls ages 15 to 19 years
Population Domain(s) – Adolescent Health, Women/Maternal Health

Measure Status:	Active
Goal:	To reduce birth rates among adolescent females 15 to 19 years
Definition:	**Numerator:** Births to adolescent females aged 15 to 19 years **Denominator:** Number of adolescent females aged 15 to 19 years **Unit Type:** Rate **Unit Number:** 1,000
Healthy People 2020 Objective:	Related to Family Planning (FP) Objective 9.1: Reduce pregnancies among adolescent females aged 15- to 17 years Related to Family Planning (FP) Objective 9.2: Reduce pregnancies among adolescent females aged 17- to 19 years
Data Sources and Data Issues:	NM birth certificate database, Bureau of Vital Records and Health Statistics, NM Department of Health; Population Estimates: University of New Mexico, Geospatial and Population Studies (GPS) Program. This rate includes New Mexico RESIDENT births only. Birth records are filed electronically by hospitals. Medical records staff use standard mother and facility worksheets and medical charts to complete the birth registration. Population estimates use decimal fractions. This may cause totals to vary slightly due to rounding. These estimates are considered the most accurate estimates for the state of New Mexico.
Significance:	Teen birth rate is a significant indicator for population health. It is one of the three goals for NM's Title X program and it is a super-priority for the NM Department of Health. Factors in New Mexico's high teen birth rates are poverty, education, rural vs. urban population and access to services. There is a lack of access to family planning services with all but one of NM counties classified as a health professional shortage area. Poverty is one of the most important contributing factors to teenage pregnancy. In 2014, New Mexico ranked 1st among all states and the District of Columbia in percentage of children living in poverty (30% of children age 0-17 in poverty). Teens who have dropped out of school are more likely to become pregnant and have a child than their peers who stay in school. The NM high school dropout rate in 2012 was 29.6%, compared to 24.5% nationally. Teen parenthood is most common in rural areas. In the 26 rural counties in NM, the teen birth rate was 51.1/1,000, whereas the teen birth rate in the seven urban counties, the teen birth rate was 33.8/1,000

Form 10b
State Outcome Measure (SOM) Detail Sheets

State: New Mexico

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: New Mexico

ESM 1.1 - Number of completed postpartum visits by maternal clients followed by Licensed Midwife providers
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To increase the completion postpartum visit under the care of midwives to increasing the likelihood of comprehensive well exam in the maternal population.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	Maternal Health Program quarterly survey of midwives.
Significance:	The postpartum visit is an opportunity for review of medical and behavioral issues that may have been present in the pregnancy, with a referral for appropriate ongoing follow-up care. It is also an opportunity for contraceptive planning, birth-spacing discussion and for general women's health care assessment. These areas are covered by direct entry midwife providers in accordance with their practice guidelines, and are reimbursable under Medicaid. In a 2016 publication by the Centers for Medicare and Medicaid Services, titled Perinatal Care in Medicaid and CHIP, NM had a 29.5 % rate of postpartum visit completion in the Medicaid and CHIP population (data from CY2013). The target goal for this ESM would be to reach 50% of the Medicaid population served by licensed midwife (LM) providers. This has not been measured in our state up to this point, so first year (CY17) data collection will establish baseline. If baseline meets the 50% target goal, then we will reassess whether a new target goal should be established for CY18.

ESM 1.2 - Number of licensed midwives trained in appropriate medical billing/coding
NPM 1 – Percent of women with a past year preventive medical visit

Measure Status:	Active
Goal:	To increase access to home birthing options in New Mexico, especially among Medicaid-insured women
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	Medicaid
Significance:	The Medicaid-carrying clients seen by direct entry midwives are often clients who do not easily access the health care system, or they may desire and utilize the NM Birthing Options Program which allows for a home-birth attended by a direct entry midwife. Direct entry midwives in NM can accept and be reimbursed for Medicaid clients however issues in billing, coding and seamless reimbursement have been identified over the past year in a project between the Maternal Health Program, Medicaid and the direct-entry midwives. A training will provide an opportunity to present the Birthing Options Program to the entities that need the information as well as educate the direct entry midwives on appropriate and accurate coding/billing to facilitate seamless reimbursement. This will promote greater cooperation between all the entities as well as maintain accessibility to the home-birth option for Medicaid clients.

ESM 4.1 - Percentage of mothers who report a baby-friendly experience at a New Mexico birthing facility
NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	To increase the number of birth facilities that have achieved baby-friendly status
Definition:	**Numerator:** Number of PRAMS respondent mothers who report experiencing 8 baby friendly steps at the hospital where they gave birth **Denominator:** Number of PRAMS respondent mothers who gave birth at a birthing facility **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	The New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS)
Significance:	Advantages of breastfeeding are indisputable and baby friendly hospitals provide an opportunity and for mothers to initiate breastfeeding by encouraging and recognizing hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. It recognizes and awards birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes. The New Mexico PRAMS survey includes 8 questions that correspond to baby friendly experience, this ESM will allow New Mexico to assess the mother's self-reported experience with the percentage of births at baby friendly facilities thereby utilizing PRAMS to measure the correspondence between self-reported baby-friendly experience and the number of births in New Mexico.

ESM 6.1 - Number of early childhood professionals and medical providers trained to administer and score developmental screening instruments
NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Measure Status:	Active
Goal:	To increase the number of early childhood professionals and medical providers trained to administer and score developmental screening instruments
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 9,999
Data Sources and Data Issues:	These numbers come from the attendance/sign-in sheets from the training sessions presented by the Child Health Program (funding from Project LAUNCH and Early Childhood Comprehensive Systems grants).
Significance:	Early childhood professionals which include educators, social workers, and medical providers are individuals who have early and frequent contact with children. Early childhood professionals should have access to developmental tools and resources and New Mexico seeks to increase this access through training and promoting the appropriate administration and scoring of developmental screening tools. These tools will contribute to improved health outcomes for young children by identifying developmental and social-emotional delays early. In the US, 17% of children have a developmental or behavioral disability. Less than half of children with developmental delays are identified before starting school. Research shows that when delays are identified and children and families are referred for appropriate early intervention treatment services, the child's development can be greatly improved and the child is better prepared to enter school ready to learn.

ESM 10.1 - The number of policies/or practices implemented at a clinical system, that helps improve access to or quality of the adolescent well visit.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To Improve State- and Systems-Level Policies and Practices
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 99,999
Data Sources and Data Issues:	Details of the policy/practice implemented provided by Office of School and Adolescent Health will be documented and the number of partnerships will counted.
Significance:	The quality of the adolescent well visit is of great importance and can impact the likelihood of an adolescents returning to an annual well visit. Each year New Mexico will develop or adopt at least one youth-centered policy and/or practice at the state, clinical system, or HMO level that helps improve access to or quality of the adolescent well visit.

ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Inactive - Replaced
Goal:	To improve the quality of preventive services among adolescents
Definition:	<table><tr><td>**Numerator:**</td><td>Total number of well-visit patients 10-17 that report they are satisfied or very-satisfied with their well visit/clinic encounter at a CoIIN site clinic.</td></tr><tr><td>**Denominator:**</td><td>Total number of surveys administered to patients 10-17 visiting for a well visit at a CoIIN site clinic.</td></tr><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr></table>
Data Sources and Data Issues:	AYAH CoIIN site clinic visit clinic encounter data.
Significance:	The quality of the adolescent well-visit/encounter is of great importance to the improving the uptake and access to preventive services. Adolescents are more likely to return to high quality visit. Improving education and marketing about the value of the preventive visit to adolescents will increase the value adolescents place on well-visits.

ESM 10.3 - Percentage of Well visits ages 10-25 for Medicaid patients
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	To improve the percentage of preventive services among adolescents in CoIIN site clinics
Definition:	**Numerator:** The number of Medicaid recipients ages 10-25 who received an adolescent well visit at each site. **Denominator:** The number of Medicaid recipients ages 10 - 25 who are patients in each site. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	AYAH CoIIN site clinic visit clinic encounter data.
Significance:	Improving Access and Utilization of Preventive Services will increase the number of Well visits ages 10-25 for Medicaid patients. Annual well-visits for adolescent is crucial to improving adolescent health outcomes.

ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care and family engagement
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	Increase the percentage of families who have access to patient and family centered care coordination that respects the culture and primary language of the family to assist in integrating physical, oral and behavioral health issues into the care plan.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100,000
Data Sources and Data Issues:	The CMS QI initiative roll.
Significance:	Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Pediatric clinicians in New Mexico who have effective policies and procedures in place to provide effective integration of physical health, oral and behavioral health care and have an effective method for cross-provider communication are needed to increase the percentage of children with a medical home. The QI initiative will increase the likelihood that pediatric providers utilize the appropriate policies and procedures.

ESM 11.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.
NPM 11 – Percent of children with and without special health care needs having a medical home

Measure Status:	Active
Goal:	To implement recommendations that result in policy changes in Medicaid and for the Managed Care organization that strengthen the system of care for CYSHCN.
Definition:	**Numerator:** NA **Denominator:** NA **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	The number of recommendations submitted to Medicaid will counted.
Significance:	Care coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and long-term care services and support and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes. Improvements to care coordination will Increase collaboration between the Title V CYSHCN program care coordinators, the Managed Care organizations who also provide care coordination and Family leaders representative of the diverse cultures in the State to strengthen the best practice model for children with special needs and their families across the state.

ESM 12.1 - The number of Health Care providers participating in health care transition education and training on the 6 core elements of transition
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	Increase the number of adult primary and specialty care practices that report they have a written health care policy or approach to support youth with special health care needs to integrate into the adult health care practice.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	CMS Training roll.
Significance:	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families.Collaboration with the NM Family to Family Health Information Center and the Center for Development and Disability to provider resources, supports training to adult health care providers, and to families and youth on physical and behavioral health care transition will invariably increase the number of Health Care providers participating in health care transition education and training on the 6 core elements of transition.

ESM 12.2 - The number of recommendations the Title V program makes to Medicaid on the redesign of the Medicaid 1115 waiver.
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	To implement recommendations that result in policy changes in Medicaid and for the Managed Care organization that strengthen the system of care for CYSHCN.
Definition:	**Numerator:** NA **Denominator:** NA **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	The number of recommendations submitted to Medicaid will counted.
Significance:	Care coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and long-term care services and support and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes. Improvements to care coordination will Increase collaboration between the Title V CYSHCN program care coordinators, the Managed Care organizations who also provide care coordination and Family leaders representative of the diverse cultures in the State to strengthen the best practice model for children with special needs and their families across the state.

ESM 13.1 - Number of interagency partnerships implemented to coordinate dental and other services
NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Form inter-agency partnerships to improve coordination between services
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Count **Unit Number:** 100
Data Sources and Data Issues:	Title V community-based services list
Significance:	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential components of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases. In New Mexico, inter-agency partnerships are essential to improving coordination of services and establishing programs and policies to increase access to oral health care. Promoting the importance of oral health via a statewide health education campaign will increase New Mexico's inter-agency partnerships.

ESM 15.1 - Develop at least one cross-agency agreement or policy developed to address insurance gaps for prenatal and child coverage.
NPM 15 – Percent of children ages 0 through 17 who are adequately insured

Measure Status:	Active
Goal:	Improve access to and navigation of health insurance coverage and resulting services.
Definition:	**Numerator:** N/A **Denominator:** N/A **Unit Type:** Text **Unit Number:** Yes/No
Data Sources and Data Issues:	Cross-agency agreements or policies developed will be in writing. The number of agreements and policies will be counted.
Significance:	Inter-agency agreements extend the reach of Title V and are of the utmost importance in improving access to care and ensuring that children are adequately insured. In New Mexico approximately 10% of children are uninsured. The American Academy of Pediatrics (AAP) highlighted the importance of this issue with a policy statement. The major problems cited by the AAP were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services.

ESM 15.2 - Percent of children 0-17 previously uninsured at baseline who are insured at period end, among Medicaid-eligible, insurance pool/high risk and private insurance populations.
NPM 15 – Percent of children ages 0 through 17 who are adequately insured

Measure Status:	Active
Goal:	To measure the proportion of women and children experiencing insurance gaps before and after targeted coordination of navigation
Definition:	**Numerator:** Number of children (0-17) previously uninsured at baseline who are insured at period end among medicaid eligible, insurance pool/high risk, and private insurance populations **Denominator:** Number of children (0-17) who are uninsured at baseline in the medicaid eligible, insurance pool/high risk and private insurance populations. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Baseline is 2014 Medicaid Medicaid-eligible, insurance pool/high risk and private insurance populations. Period end is 2016.
Significance:	New Mexico's five-year Needs Assessment found that people were confused about new or developing healthcare coverage options through Medicaid (Centennial Care). The strategies to increase insurance coverage tie to specific improvements in coordinated efforts to help people with insurance navigation during different stages of the life course. Of particular concern is access and healthcare utilization among women and children who do not qualify for Medicaid (by income or residence status) and cannot afford to purchase insurance outright. There are periods of time when families are particularly susceptible to these gaps. For example, women who are eligible for Medicaid during pregnancy and then fall out of insured population when that category of coverage ends, 6-8 weeks postpartum, may not have any form of healthcare coverage until their next pregnancy. Another example is for children whose family (parents or guardians) may be undocumented or who may not recognize what they can and cannot access based on that barrier. In addition, families whose income prohibits qualifying for Medicaid or SCHIP but may not work for an employer with affordable insurance. We do not yet know what portion of those families actually obtain health exchange plans and if they are able to maintain that coverage for over one year.

Form 11
Other State Data

State: New Mexico

The Form 11 data are available for review via the link below.

Form 11 Data

State Action Plan Table

State: New Mexico

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

Abbreviated State Action Plan Table

State: New Mexico

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.	NPM 1 - Well-Woman Visit	ESM 1.1 ESM 1.2	
			SPM 1

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
To maintain and increase breastfeeding initiation and duration	NPM 4 - Breastfeeding	ESM 4.1	
To improve safe sleep practices among home visiting participants and birthing facility medical staff			SPM 2

Child Health

State Priority Needs	NPMs	ESMs	SPMs
To increase the percentage of children receiving a developmental screen	NPM 6 - Developmental Screening	ESM 6.1	
To decrease abuse and maltreatment of children			SPM 3

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
To improve access and quality of comprehensive well exams for adolescents	NPM 10 - Adolescent Well-Visit	ESM 10.1 ESM 10.2 *Inactive* ESM 10.3	
To reduce birth rates among teens 15-19			SPM 4

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Increase access to care to a family-centered comprehensive medical home for children and adolescents	NPM 11 - Medical Home	ESM 11.1 ESM 11.2	
To increase the amount of services available to assist adolescents to make successful transitions to adult health care services	NPM 12 - Transition	ESM 12.1 ESM 12.2	

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization.	NPM 15 - Adequate Insurance	ESM 15.1 ESM 15.2	
To increase and improve access to preventive dental care in pregnant women and children	NPM 13 - Preventive Dental Visit	ESM 13.1	