# Maternal and Child Health Services Title V Block Grant

## New Mexico

## FY 2020 Application/ FY 2018 Annual Report

Created on 9/26/2019 at 3:39 PM

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## I. General Requirements

## I.A. Letter of Transmittal

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO DEPARTMENT OF HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

July 15, 2019

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

Dear Ms. Marquardt,

The New Mexico Department of Health is pleased to submit the Title V Maternal and Child Health Block Grant report for Federal Fiscal Year 2018 and application for Federal Fiscal Year 2020.

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

Sincerely,

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

PUBLIC HEALTH DIVISION
1190 St. Francis Dr., Suite 1000 • P.O. Box 26110 • Santa Fe, New Mexico • 87502
(505) 827-2009 • FAX: (505) 827-2329 • www.nmhealth.org

## I.B. Face Sheet

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

## I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

## I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

## II. Logic Model

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

## III. Components of the Application/Annual Report

## III.A. Executive Summary

### III.A.1. Program Overview

## Program Overview

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

## Maternal Health

The Maternal Health Program (MHP) is the regulating agency for licensing both certified nurse-midwives (CNMs) and licensed midwives (LMs), in New Mexico. Recently, the CNM Practice Rule was revised to help clarify processes in regulatory and disciplinary actions, and to include guidance on opioid and controlled substance prescriptions. The revision is due to publish in June 2019. In July 2019, an online application for midwifery licensing will be launched, finally removing a paper-based process.

In 2017, plans were made to re-launch the Maternal Mortality Review committee (MMRC) to examine maternal deaths occurring in the perinatal period up to a year following delivery and to make recommendations to improve systems of care for pregnant, delivering and postpartum women. The MMRC receives organizational support from the MHP staff and receives technical assistance from Centers for Disease Control and Prevention staff to standardize committee, data collection and analysis procedures. The MMRC has been active since 2018 and will meet quarterly in 2019-2020.

Maternal health is moving forward with the priorities of improving access and continuity of healthcare services for women in the perinatal period through direct programming and systems level changes. The project to improve follow up care for mothers diagnosed with gestational diabetes continues in 2019 with planned implementation in 2020. In the area of perinatal mental health and mood disorders, the MHP manager is involved with a state-based work group to strengthen the services for infants and their caregivers (mom, parents, families). We are utilizing Project ECHO at the University of New Mexico (UNM) to disseminate information to pediatric providers. Training on assessing the mother's mental health needs will be covered; and support will be available to providers for making referrals in their geographic areas.

Title V-Family Health Bureau staff participate in the statewide Birth Equity Collaborative (BEC) to improve the quality of care among women of color in New Mexico. Black/African-American women experience the highest burden of infant mortality and drivers including low birth-weight and preterm delivery. Preliminary analysis of severe maternal morbidity hospitalizations (2014-2016) also indicated that Black and Native American women have those experiences more often than Hispanic or non-Hispanic white women. We are taking a multi-disciplinary and community-based approach to addressing these disparities and applying equity principles to changing the course of unjust maternal and birth outcomes for women of color.

## Infant/Perinatal Health

The Office of Injury Prevention and Family Health Bureau Title V programs collaborate in safe sleep for infants through education, surveillance and messaging with community programs such as home visiting, perinatal case management and public media. Both program areas participate with the Office of the Medical Investigator (OMI) Child Fatality Review in the Sudden Unexpected Infant Death (SUID) Registry. These programs also drafted a statewide Safe Sleep Strategy, and staff work together to plan and evaluate trainings to case management, hospitals and home visiting programs on safe sleep, SUID prevention and Shaken Baby Syndrome prevention throughout the state.

NMDOH staff, led by the Maternal Health Program, completed an assessment and follow up consultations with birthing facilities on neonatal and maternal/obstetric levels of care in NM and in bordering states. The NM DOH Chief Medical Officer and MHP manager developed a plan to approach facilities whose self-assessment of levels of care varied greatly from the CDC tool assessment results. The results of these conversations will be used to update New Mexico levels of care with an official key to be used in birth certificate analysis.

Title V staff have collaborated with staff from the state's Children, Youth and Families Department (CYFD) to complete a state plan for care of infants born exposed to substances. Like many states, NM continues to see a surge in babies born with Neonatal Opioid Withdrawal Syndrome (NOWS). CYFD has a federal mandate to ensure safe plans of care are developed for all babies born exposed to substances. As we work together to achieve this mandate we are also going upstream to develop recommendations for prenatal screening and preventive protocols for hospitals and primary practice.

**Child Health**

The Child Health Program Manager partners with the Early Childhood Comprehensive Systems-Act Early (ECCS-AE) State Team and other stakeholders to work on issues such as increasing developmental and social/emotional screening in early childhood and increasing parent access to early childhood information and resources. The MCH health educator continues to conduct ASQ and ASQ-SE trainings to increase the capacity for developmental screening and continues to advocate for the use of standardized screening tools. Additionally, both the Program Manager and the Health Educator participate on the J Paul Taylor Early Childhood Task Force to develop recommendations and support legislation regarding plans of care for infants born exposed to opioids and other substances.

**Oral Health**

The NM State Office of Oral Health (OOH) provides preventive care to early head start, head start, preschool and school-aged children throughout New Mexico in urban/rural schools. OOH also provides funding to deliver dental treatments and prevention at no cost to low income and uninsured children and pregnant women. With combined funding from the CDC, the program is hoping to increase the number of middle and high schoolers having screening, dental sealant program, and referral to dental care through School-Based Health Centers. OOH is improving overall health and oral health literacy for New Mexicans through social media campaigns in TV, radio and internet. Additionally, the OOH is working to promote fluoridated water consumption among Albuquerque and Santa Fe residents. Title V provides funds used for the purchase of fluoride varnish (used at preschool clinics), educational materials (oral health curriculum), and staff attendance to the annual National Oral Health Conference. Educational materials are used to support the CHI Saint Joseph Foundation in improving oral health education, promotion and support to pregnant women and their babies, before and after birth.

**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), the newly formed Navajo Family Voices, and the strong family advocacy component of the Center for Development and Disabilities (CDD) at the University of New Mexico, among many others. Title V FHB staff meet regularly with our family support agencies and partner with them on several initiatives. Current collaborations include the CSHCN health finance ECHO project and a Mountain States Genetics initiative focused on improving access to genetic services for Native American families and other underserved areas of the State using telehealth. We continue to include family representatives and consumer stakeholders on all program advisory boards as well.

**Children and Youth with Special Health Care Needs (CSHCN)**

The Children and Youth with Special Health Care Needs (CYSHCN) program in NM, Children's Medical Services (CMS), has been specifically focused on increasing numbers of CYSHCN who receive care in a Medical Home and ensuring successful transitions to adult healthcare. CMS employs licensed medical social workers trained in the provision of care coordination for CYSHCN from birth to age 21 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.

CMS began a contract with the Center for Development and Disability (CDD) at the University of New Mexico to evaluate the effectiveness of the care coordination that is provided to CYSHCN in the state. The purpose of this project was to design and implement an evaluation that collects valid, reliable information on the impact that CMS social workers and other CMS staff have on clients and their families served by the program including health-related outcomes and quality of life measures. Results of this evaluation are being utilized to drive other quality initiatives.

The Newborn Genetic Screening program, a sub-program of CMS, is part of the Mountain States Regional Collaborative and is participating in the second year of Underserved Populations Project (UPP) which was undertaken to develop strategies to increase access to genetic services for individuals in rural, Hispanic, and American Indian communities in the Mountain States.

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

The contract with the New Mexico Quality Improvement Partnership (NMQIP) will assist the Title V program with the strategies identified to meet the objectives for improving transition process for youth. NMQIP will conduct a needs assessment with CMS staff and providers this year to identify barriers, successes and other areas were improvements could be made when transitioning YSHCN to adult medical care. Part of the goal with this new project will be to work on partnering more closely with the adult providers (either medical home or specialist) through a warm hand off or other strategies to be identified through a Plan, Do, Study, Act approach. This will be done to help bridge the gap between pediatric and adult providers and to improve the transition and transfer process.

**Adolescent Health**

The NM Family Planning Program (FPP), Family Health Bureau, PHD/DOH provides evidence-based prevention programs and clinical services to decrease the teen birth rate through increasing access to reproductive clinical services, increasing awareness of birth control options, and providing 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 bring about measurable reductions in unintended teen births. NM Title V continues to support the implementation of two evidence-based unintended teen pregnancy prevention programs and one parent workshop*: Teen Outreach Program* (TOP) and *Project AIM* (Adult Identifying Mentoring) for teens and *From Playground to Prom: Talking with Your Child about Sexuality*. TOP is implemented in nine counties at 13 sites statewide by seven different organizations. *Project AIM* is implemented in three counties at four sites statewide by two different organizations. The *From Playground to Prom* two-hour workshop is offered to each parent whose teen participates in one of the two evidence-based prevention programs.

NM Department of Health (NMDOH) Adolescent & Young Adult (AYAH) Collaborative Improvement & Innovation Network (CoIIN) continued to strive toward their project aim which to increase the percentage of adolescent and young adults that have preventative care such as annual well exams, also referred to as Early & Periodic Screening, Diagnostic & Treatment (EPSDT) services. The project goal is for all NM adolescents and young adults to be healthy and engaged in self-care and community care. Adolescents is defined as age 10-25, however we also refer to young adults for those age 18-25 as this is the title they prefer. The AYAH CoIIN, in partnership with local and national organizations, developed the "*Know Your Health Toolkit (KYHT)*" which is intended for healthcare providers who work in clinics that serve adolescents and young adults. The toolkit emphasizes increasing youth-friendly services, preventative services (such as the AWE/EPSDT) and youth health literacy. Currently, we are working on the KYHT evaluation tools. In January 2020 we plan to pilot the KYHT in 3-5 clinics and/or school-based health centers (SBHC). By January 2021, there will be enough data gathered from the pilot period of the KYHT so we can evaluate and understand the strengths and weaknesses of the toolkit. After adjustments have been made, the plan is to share the KYHT and results with the MCO's and other possible funders so we can continue to share the toolkit with clinics and SBHCs across New Mexico.

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

The Title V MCH Block Grant funding comes to the Family Health Bureau (FHB) in the NM Department of Health. These federal funds are spread across the several program areas, and help pay the salaries of the FHB Administrative staff who support all programs in the Bureau. Each FHB program has multiple funding streams, including state general funds, program revenues and other federal grants. The Federal Title V funds are a critical piece of supporting this work. As an example, the MCH Epidemiology section receives Title V funds and is also supplemented by the State Systems Development Initiative (SSDI) grant, Pregnancy Risk Assessment Monitoring System (PRAMS) Centers for Disease Control (CDC) funding, Medicaid revenue and Kellogg Foundation funding.

Because Title V funds are somewhat flexible, they can support statewide infrastructure and system-building. For example, Title V federal funds (and state match) support the Maternal Health program, which is responsible for coordinating the state Maternal Mortality Review Committee as well as licensing of all midwives in the state; and the CYSHCN program (Children's Medical Services), which works on the policy and system level as well as providing care coordination and direct service through outreach clinics. In addition, small amounts of funds are leveraged to support various projects in partnership, such as a contract with the NM Perinatal Collaborative, and a documentary project on youth mental health and suicide.

### III.A.3. MCH Success Story

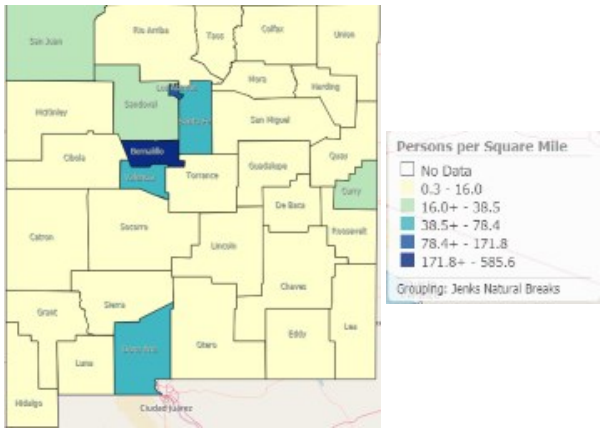
Children's Medical Service (CMS) has been providing care coordination to a child with cleft palate/bilateral cleft lip which was diagnosed at birth. He began attending the cleft palate clinics in 2001. Over several years, this client had eight surgeries, along with braces and other procedures. He had excellent family support and grew into a confident and self-assured young man despite his challenges who has decided to become a veterinarian. His CMS social worker assisted him and his family with coordination of medical care and help navigating the complex schedule of surgeries and procedures. At age 16 the client and his social worker began the transition process by developing a transition plan. The client is successfully taking care of his own health needs. He is still on Medicaid and understands the need to maintain health insurance. He still needs some support from his social worker to keep dental appointments but is independent in determining further surgeries and recently declined a graft on his lip and nose offered by the oral surgeon. He has been attending clinics by himself for the past few years, and at his last clinic he asked to become a youth mentor at the clinics in order to help others. He will receive mentoring from our family liaison and will attend the clinics in the upcoming year. He will receive a stipend for his services. If successful, this peer/youth mentoring will be a new model of support that other clinics can adopt in the future.

## III.B. Overview of the State

### Geography and Population

New Mexico (NM) is the fifth largest U.S. state in area, yet its population is only 2.09 million. These wide-open plains provide breathtaking scenery; however, this vastness makes it a challenge to provide access to services such as health care. Fifty percent of New Mexico's population live in three counties (Bernalillo, Doña Ana, and Santa Fe) which together comprise only 6% of the state's land area. In more sparsely-populated rural areas of the state, providing health care and public health services pose challenges, such as the ability to hire and maintain full-time clinicians and specialists, and the great distances that many people must travel to get care. (See Figure 1)

Figure 1: Estimated Population County by County- Population Density, 2017




While 62% of the population lives in the seven more urban counties -- including Bernalillo County, which is home to a third of the state's population-- over 7% of the population resides in frontier or sub-frontier areas. Most counties, 25 out of 33, have population densities of less than 15 persons per square mile (US Census).
From 2010 to 2018, nearly two-thirds of the state's counties experienced a decline in population. Population growth by age group was confined entirely to the population aged 65 and over. While retirees are moving into the state, young people are leaving rural communities in favor of metropolitan areas in New Mexico and elsewhere to take advantage of education, employment, and entertainment opportunities. And, the proportion of New Mexicans aged 65 and over is outpacing that of other states.

Minority groups make up a majority of the population. According to the NM Indicator-Based Information System (NM-IBIS), in 2017, NM's total population consisted of 48.8% Hispanic, 38.2% non-Hispanic White, 9.08% American Indian, 2.2% African American, and 1.7% Asian and Pacific Islander. In 2018, 6.1% of persons were under the age of 5, 23.4% were under the age of 18 and 50.5% were female. (US Census, American Community Survey, 2018). The Hispanic population of NM is a mix of deeply rooted families that have been in NM for generations and more recent immigrants. Many families are of mixed status, documented and undocumented, and several NM cities have passed policies supportive of immigrants.

### Poverty

Poverty is a root cause of many other health issues and inequities, such as inability to access medical care, inadequate school readiness, food insecurity, and obesity. New Mexico continues to be one of the five poorest states in the nation, with a median household income of $46,718 compared to of US median of $57,652 for the time period of 2013-2017. According to the most current American Community Survey estimates, in 2018, 19.7% of New Mexicans are now living in poverty, compared to 12.3% nationwide. (https://www.census.gov/quickfacts/fact/table/nm,US/PST045218?).

Children perhaps suffer the most from the high poverty rate, with almost a third of NM children, aged 0-17, living in poverty (27.2% in 2017, according to the Annie E. Casey Foundation). The elevated percentage of those living in

poverty in New Mexico is especially true for those children living with grandparents (23%) as well as single-mother households (24%) for the year 2016. New Mexico has seen a slow decrease in the unemployment rate annually since the year 2013, and unemployment was at the lowest in a 5-year period in 2017 at 6.2% (Annie E. Casey Foundation). But the decrease in unemployment rates does not seem to have affected the poverty level, probably due to low wages.

**Education**

In recent years, early learning (including the first 3-5 years of brain development, early literacy, and school readiness) has received focused attention from legislators. United Way of Santa Fe County has made early learning their sole focus for the past several years and several other private foundations have also been funding efforts to improve the early learning and support system. In 2019, legislation passed to create a new Early Childhood Education and Care Department in state government.

In New Mexico, we have seen that at least since 2007, more than 50% of 3 and 4-year-olds have not been enrolled in prekindergarten programs. Increased access to Pre-K programs may be most beneficial to the highest-risk children, as the greatest gains have been seen in this demographic (Annie E. Casey Foundation). Between 2015-2017, this equates to an estimated 29,000 children that are missed.

New Mexico's 2016-2017 high school completion rate (71.1%) remains fairly consistent since 2010 (KidsCount data center). NM needs an educated workforce to meet the needs of businesses and attract technology and other new companies to the state. In the same year, 7% of teens ages 16-19 were not in school and not high school graduates (national average is 4%), ranking NM as one of the worst in the nation in this indicator (2017, Annie E. Casey Foundation, Kids Count).

**Access to Healthcare**

There are many barriers to accessing health care in NM, including provider shortages, lack of affordable insurance, and having to travel long distances for specialty care. Travel is even more of an issue for pediatric subspecialty care, since most of the subspecialists, and the state's only Children's Hospital, are in Albuquerque. Due to a shortage of medical providers, many families are referred out of state to receive specialty care. Thirty-two of NM's thirty-three counties are "health professional shortage areas".

Cultural barriers to care include language barriers and lack of trust in health providers and systems, which can affect healthcare utilization, most notably among women and children residing on tribal reservations. New Mexico was one of the states that expanded Medicaid to include low-income adults under the Affordable Care Act (ACA). This has helped improve access to some extent, although having insurance does not guarantee access to a healthcare provider. Immediately after ACA implementation, the state's uninsured rate was down to 12.8% in 2015, compared to 20.2% in 2013, and current estimates are approximately 10%.

At the end of 2018, 840,486 New Mexico children and adults were enrolled in Medicaid. Over 40% of Medicaid enrollees were children under age 21 years. (NM IBIS May 2019). The majority of new enrollees were in the Adult Expansion category. For children in NM, Medicaid, Children's Health Insurance Program (CHIP), and the managed care organizations that contract with the Human Services Department are vital to healthcare access. Medicaid covers over 70% of births in NM (NM PRAMS data 2018).

To help support retention and recruitment of primary care and behavioral health providers, the Human Services Division (HSD), in collaboration with the Governor's office, has proposed nearly $60 million in payment rate increases. The impact to the state general fund for these proposed changes is $13.1 million. HSD proposes to increase payment for Evaluation and Management (E&M) office visits from 70% to 90% of the 2019 Medicare fee schedule, effective July 1, 2019. E&M patient visits represent the core of most family practice, primary care, and specialty provider practices, and close to half of all Medicaid patient encounters. By raising these payment rates, HSD hopes to bolster its network of primary care and family practice providers, many of whom also provide behavioral health services through regular office visits in rural NM.

**NMDOH Priorities**

The 2017 – 2019 DOH Strategic Plan outlines the vision, mission, values, and priorities for the Department. It is part of the NMDOH Strategic Planning Roadmap, which also includes the State Health Assessment (SHA), a systematic

review of New Mexico's health status, and the State Health Improvement Plan (SHIP), a collaborative effort to identify, analyze, and address health issues in the state.

In the FY19 Strategic Plan, NMDOH identified a set of guiding principles to inform program strategies and actions and the development of cross-agency partnerships. These guiding principles establish a framework for the Department and its partners to act collectively to implement comprehensive programs that are efficient, effective, and sustainable. NMDOH has been using these guiding principles to inform programmatic activities. Below are some examples of how Title V staff are contributing to this work.

*Create accountable programs and engage communities in aligned, collective impact partnerships to achieve optimal population health status.*

The Family Health Bureau (FHB) is working with the Children, Youth and Families Department (CYFD) to develop a multi-disciplined, multi-sectorial program to provide a safe plan of care for all infants exposed to harmful substances. FHB/PHD collaborates with multiple partners as members of the statewide Long Acting Reversible Contraception (LARC) working group to align activities and leverage different funding streams to achieve the goals of reducing unintended pregnancies and increasing knowledge of and access to LARC.

*Achieve health equity by addressing the social determinants of health; partnering with communities and American Indian tribes, pueblos, and nations to reduce health disparities; and applying a health in all policies philosophy.*

NMDOH, and FHB in particular, has identified health equity as a guiding principle. We strive to establish partnerships with communities, other agencies, and organizations to reduce health disparities and we implement evidenced-based models and best practices that consider the roots of inequity and the diversity of the populations we serve. FHB is working with the Office of African American Affairs and multiple other stakeholders to reduce disparities in birth outcomes through data analysis, provider education, and increasing public awareness. We have also committed to making health equity the overarching framework for our 2020 Title V Needs Assessment.

*Promote access to person- and community-centered health and wellness by aligning and integrating public health, behavioral health, oral health, and primary care.*

FHB is working to transition more patients into a medical home that provides comprehensive primary care services. One example is to co-locate Women, Infants and Children (WIC) and public health clinics with rural and primary health care centers. This co-location facilitates warm handoffs to a medical home for more comprehensive care. PHD's social workers actively work to connect children with special health care needs to a medical home and to facilitate the communication between the pediatric subspecialists and the medical home for patients seen in the Children's Medical Services specialty outreach clinics.

*Gather and analyze data for meaningful use.*

FHB gathers data from every birthing hospital in NM to ensure that every baby receives the mandatory newborn screenings, including screening for metabolic and hematologic conditions, screening for congenital heart disease, and screening for hearing loss. Feedback is provided to hospitals and audiologists for quality assurance purposes such as improving blood spot collection and transit times and improving appointment times for infants needing audiologic diagnoses.

*Empower and educate individuals in self-responsibility for their health.*

The Family Planning Program's comprehensive sex education programs promote self-responsibility by helping youth to make responsible choices and to develop effective life skills and healthy relationships. Service learning programs provide positive alternatives and leadership opportunities and engage youth to build on their strengths and interests in constructive ways. Adult-teen communication programs give adults information and skills to communicate effectively with young people about reducing risky sexual behavior.

In addition, the DOH retained the four priority areas from the prior strategic plan: *obesity, substance misuse, diabetes and teen pregnancy*. FHB/Title V staff work on these priority areas in the following ways:

*Obesity*: Obese children are more likely to become obese adults and to suffer from chronic diseases such as heart disease, cancer, and diabetes. WIC staff continue to educate families who receive WIC services about the importance of healthy diet and healthy weight in childhood. The Title V Director and the WIC Director, along with staff from the Chronic Disease Bureau, have been working on a collaboration with NM State University (NMSU) to teach healthy eating and cooking habits to WIC and other PHO clients in public health offices. NMSU staff provide cooking classes for clients who can get their WIC benefits at the same time.

*Drug and Alcohol Misuse*: The Family Health Bureau works on substance misuse and its effects in many ways. The PRAMS survey added supplemental questions in 2014 that have helped inform programs on drug use in pregnancy. FHB leadership has been on the Board of the NM Perinatal Collaborative (NMPC) for several years and FHB has helped provide funding for one of the NMPC projects to improve diagnosis and treatment of babies born with NAS/NOWS (Neonatal Abstinence Syndrome/Neonatal Opioid Withdrawal Syndrome). The NMPC is also working with hospitals to implement the Maternal Opioid AIM bundle.

The Children, Youth and Family Department engaged with us to help them respond to federal requirements to report all babies born exposed to substances and develop safe care plans for each of these infants. This has been a wonderful opportunity for interagency collaboration. Together, we were able to pass legislation in 2019 that will promote a less punitive approach to mothers whose babies are born exposed to substances, which we hope will encourage more pregnant women to self-report and enter treatment earlier in pregnancy.

New Mexico, like many parts of the country experienced a sky-rocketing (about 9 times) increase in neonatal abstinence syndrome (NAS) diagnosis in infants born between 2000 and 2015. Just between 2011 and 2017, the statewide rate increased more than two-fold from 6.1 to 14 per 1,000 live births. It is important to note that it is hard to discern the exact cause of the rising NAS rates. Several contributing factors include: more women being surveyed for NAS and overall more attention being paid to the current opioid crisis in the US. (See Figure 2)

Figure 2:

| NAS Diagnosis in Infants per 1000 live Births | | | | | | | |
|---|---|---|---|---|---|---|---|
| Year | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
| Rate | 6.1 | 7.6 | 8.8 | 9.4 | 10.3 | 12.3 | 14.0 |

*Data Source: NMDOH - Hospital Inpatient Discharge Database (HIDD), 2008-2017. Catron, De Baca, Harding, and Union counties have been removed due to lack of cases throughout the period here reported.*

*NAS cases were identified by presence of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code 779.5 (through 2015 third quarter) and the ICD-10-CM code P96.1 (starting in 2015 fourth quarter) on any of the diagnosis fields on the infant's record. Cases have been deduplicated and are presented by birth-year.*

In 2017, NM had the 17th highest drug overdose death rate in the nation. Drug overdose death rankings have seemingly been improving for NM since 2014 when NM was the second highest in the nation. However, these changes are not due to an improvement in the death rate, but rather the worsening of the rates in other states. Between 1999 and 2015, the overdose death rated in NM increased by 62.0% and since 2014, rates have remained fairly stable. Between 2013-2017, the average rate of drug overdose death was 24.6 per 100,000 in the population (NM DOH BVRHS, 2018). Among women, drug overdose death from prescription drugs was more common than from illicit drugs, across all age ranges (NM Substance Use Epi Profile, 2018).

Legalization of marijuana was again considered in the 2019 legislative session, and the bill received more support than in previous sessions but still did not pass. The Medical Marijuana program continues to expand in the number of eligible conditions and in the number of certified growers and users. Opioid misuse in 2019 became the newest condition to be added to the list of qualifying conditions for a medical marijuana card. One of our upcoming challenges will be to make sure any changes in marijuana laws consider the safety of children; we have already started to see incidents of children finding or accidentally ingesting marijuana and other substances.

Along with smoking, alcohol abuse also has its place in the top preventable causes of death in the United States. Since 1997, NM has had the nation's highest alcohol-related death rate and is nearly twice as high as the US average rate. The negative health consequences of excessive alcohol use include domestic violence, crime, poverty,

unemployment, injury, mental illness among other problems (NM Substance Use Epidemiology Profile, 2018).

Youth in New Mexico are slightly above the average rate in the US for binge drinking. Alcohol is the most commonly used drug among youth in New Mexico, though most high school students do not drink with 26.2% of students saying that they were current drinkers in 2017. Students who identify as Hispanic are more likely to currently drink while American Indians are the least likely to drink. Since 2003, self-reporting data shows that the rate of youth who are current drinkers has been declining (NM Substance Use Epi Profile, 2018).

*Diabetes*: Generally, both New Mexico and the U.S. prevalence of diabetes have remained similar since the mid-1990s. However, rates among different populations vary drastically. Diabetes rates are highest in the American Indian/Alaska Native population, whose rate is three times that of white adults. For women, the Hispanic rate was twice the rate of that for Whites. Both of these disparities are important in the context of NM where the respective populations are higher in percentage than other states. (https://ibis.health.state.nm.us/indicator/complete_profile/DiabPrevl.html).

A partnership between the University of New Mexico and the Maternal Health program at DOH is currently working to address the issues faced by mothers diagnosed with gestational diabetes to help ensure follow-up care to prevent the development of Type II diabetes later in life. An important part of this project is that the clinics that we are working in serve a majority of low-income and Hispanic ethnicity women. More about this project is in the Maternal Health Domain Annual Report section of this submission.

*Teen Births:* The Title V Director and the Family Planning Program staff have been working diligently on the issue of reducing unintended births in NM and increasing access to long-acting reversible contraception (LARC). They work with UNM, Young Women United, Planned Parenthood, the ACLU and others as part of the LARC Statewide Working Group to train providers and promote access to LARC. In 2017, there were 23,708 births to NM resident mothers. According to data from NM IBIS, NM's birth rate for teens has declined 57.9% between 2000-2017 but remains higher than the national rate. The 2017 NM rate for 15-19-year-old females was 27.6 per 1,000 live births down even from last year (29.4) (2018, NM-IBIS).

Disparities persist for Hispanic and American Indian teens. While most rates decreased since 2016, the 2017 data shows that American Indian teens had the highest birth rates in NM (34/1000) followed by Hispanic teens (31.7/1000). Hispanics constitute more than half of NM's 15-19-year-old female population, and their share of teen births is higher, representing about 60% of the births in this age group. African-American females ages 15 to 19 gave birth at a rate of 25.1 per 1,000; White females ages 15 to 19 gave birth at 16.4 per 1,000. Using the majority population (White) as the reference group, both Hispanic and American Indian teens have about two more births to every White birth. Births to Black teen mothers did increase in NM in 2017 from the previous year (NM-Indicator Based Information System [IBIS], 2017 births).

In 2017, teen mothers were the most likely to report an unintended pregnancy (54.7% of 15-17 year olds and 39.4% of 18-19 year olds). Broken down by race/ethnicity, unintended pregnancy rates do not vary so vastly. Between 2015-2017, Hispanics had the highest unintended pregnancy rate at 26%, followed by Native Americans, 24% and Whites, 21% (NM Pregnancy Risk Assessment Monitoring System [PRAMS], 2017 births).

The Family Planning Program (FPP) applied for and were given a two-year grant from the Brindle Foundation to fund a social media campaign; this campaign, which wrapped up in spring, 2019, aims to educate NM teens about contraceptive options and how to access these options. Response rates were excellent and FPP is considering how to replicate and expand on this effort. In addition, FHB received $250,000 from the Legislature in 2018 and $1.1 million in 2019 for LARC training and stocking. Through an RFP process, Envision NM was awarded the contract for training. FHB is requiring comprehensive training for the whole office, including clerical staff, that includes life planning and a reproductive justice framework.

The NMPC has also worked for three years on a project to increase Immediate Post-Partum LARC insertion in hospitals. This project, originally started by ASTHO, has moved slowly due to several roadblocks having to do with data collection and billing problems, as well as resistance from hospital administrators. However, the work continues. NMPC was awarded $100,000 for general administration by the 2019 NM Legislature and will receive another $100,000 from the LARC legislative funding to continue the IPP work with hospitals and birth centers.

**Current and Emerging Issues**

*Oral Health:* Access to oral health care in NM continues to be largely inaccessible to individuals who are uninsured and are low-income. In 2016, 37.7% of New Mexican residents reported not having a dental visit in the past year and 85.1% of residents over age 65 have had all of their natural teeth extracted (2018, NM-IBIS). Tooth decay and other oral diseases are attributable to lack of understanding of the importance of oral health, poor oral hygiene, poor nutritional habits, and lack of access to care. 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. 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. Additionally, 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 for this population.

*Climate Change*: Climate change is an ongoing threat with potential to impact human health in numerous ways: by making existing diseases and conditions worse, by helping to introduce new pests and pathogens, through extreme weather events (e.g., floods, droughts, heat waves, storms, hurricanes, wildfires), by influencing illnesses transmitted by food and water, by decreasing air quality, and by affecting the transmission of numerous infectious diseases whose agents are sensitive to weather conditions. The new Governor and the legislator are taking steps to address our dependence on oil and gas production and increase alternative energy sources such as wind and solar.

*Leadership Changes:* The Public Health Division will have a new Director starting in July of 2019. The previous Director retired in December and the two Deputy Directors have been filling in since then. In addition, three of the four PHD Regional Director Positions have turned over in the past year and two of the three are still in the process of being hired, with interim directors filling in. We also have a new Governor, Secretary and Deputy Secretary for DOH, all of whom started their positions in January 2019. DOH staff are hopeful about the new leadership and the opportunity for improvement in some of the inefficient processes that have plagued the Department in recent years.

*Public Health Transformation:* The Public Health Division (PHD) continues its discussions around the "transformation of public health". The PHD Leadership team has struggled somewhat with regard to maintaining or decreasing clinical services in the health offices. There has been a slight trend towards decreasing clinical services, and there is interest in making the public health offices hubs of community activities, but more discussion is needed to reach agreement and alignment in all regions. Family Planning services, in particular, have continued to decrease every year, possibly due to the Medicaid expansion giving low-income residents more options for medical care or possibly due to staffing issues.

*Legislative Updates:* The establishment of a new Early Childhood Education and Care Department will bring an even higher profile to the early childhood programs. The Governor's Children's Cabinet has been reconvened and had its first meeting in May 2019. This will be an opportunity for collaboration at the highest agency level and will hopefully result in better use of resources and alignment of the different Departments' work. Title V leadership is meeting with the Director of the Children's Cabinet (and will meet with the head of the new Early Learning and Care Department once a Secretary and Deputy Secretary are named) to discuss our programs and how our work in Title V supports the early learning system. Two programs from DOH, including Families FIRST from FHB, will be moved into the new Department, which will also house federally funded home visiting, Pre-K, childcare, and the Part C Early Intervention Program.

*Data Improvements*: Over the last four years, several programs in the FHB have been undergoing major changes in their IT and client data collection systems. Children's Medical Services (CMS) and Families FIRST share a new case management system named CACTUS, which was originally scheduled to be fully rolled out in 2015-2016 but had several delays. It has been implemented statewide and program staff are using it for their work, but the system is still not fully developed. Both programs continue to work with DOH IT and with the IT vendor (ACRO) to improve these systems. NM WIC partnered with Texas and Louisiana in a three-state IT solution called MOSAIC; this system was rolled out statewide in September 2018 and is almost complete, although reports are still in the validation phase.

The Human Services Department (Medicaid agency) is developing a new Management Information System that they anticipate rolling out in the next 2-3 years. The plan is for this system to serve as a "hub" for data from all state agencies, both receiving this data and acting as a source for data review and analysis. CMS and Families FIRST received some state funding to ensure the connection of CACTUS with the new MMIS system. WIC is also working with the Human Services Department (HSD, the NM Medicaid agency) to develop a shared application portal so that clients can apply simultaneously to both Medicaid and WIC.

## Challenges

Many of the same challenges continue as in previous years, including the constant challenges of high poverty rates, health care provider shortages, inadequate funding, and the challenges of addressing health inequities in a multi-cultural state. The state budget has improved due to oil and gas revenues increasing; however, hiring in state government remains a challenge due to changes in the hiring process and loss of staff. The challenges inherent in a multi-layered bureaucracy include lengthy and complicated contracting and hiring processes that can make the programmatic work more difficult.

Insurance coverage for all New Mexicans remains a significant challenge. NM has a large population of immigrants, many of whom are undocumented or reside in mixed-status families. Insurance coverage for the undocumented is a major challenge, as the undocumented are not eligible for subsidies to buy insurance on the Health Insurance Exchange, and anecdotal reports seem to show that the undocumented have trouble purchasing private insurance on the open market. Currently the only affordable insurance coverage for the undocumented is through the Low Income Premium Plan, which is part of the NM Medical Insurance Pool (High Risk Pool). Title V, Children's Medical Services' funds are used to procure insurance for children with chronic or high cost conditions who are not eligible for any other coverage.

NM is bordered by Arizona, Utah, Colorado, Oklahoma, Texas, and Mexico, which presents unique challenges as there has been a recent increase in migrant families coming to the border seeking asylum. Our status as a border state with Mexico influences many aspects of life in New Mexico, and national and local debate over immigration issues are more than just theoretical for those residing here. The recent increase in migrants coming into the US through the Southern border has impacted life in many NM communities including Las Cruces, Deming, Albuquerque and more as volunteers try to meet the needs of the continued influx of migrant families, including children, who are passing through, many of whom have been affected by trauma, violence, and mental and physical exhaustion. NM DOH is trying to assure that all migrants receive medical screening and that those who seem ill receive treatment, either on site or by referring them to a local hospital or urgent care. NM DOH was able to obtain a mobile van from Santa Fe County and it is being used in Las Cruces as a place where migrants can receive private medical exams from volunteer medical providers.

**III.C. Needs Assessment**

## FY 2020 Application/FY 2018 Annual Report Update

Every five years, the Maternal Child Health Epidemiology (MCH Epi) Program leads the statewide five-year needs assessment. The Title V Epidemiologist/Grant Coordinator is responsible for leading and coordinating needs assessment activities, which includes identifying ongoing opportunities to seek input on needs and priorities throughout the state. MCH Epi staff support all programs receiving Title V funding, and they support many unfunded partnerships with planning, goal development and implementation of Title V-related activities. This year, in 2019, we added an additional staff person (an evaluator) to the MCH Epi program who has already made significant contributions to the evaluation of current Title V objectives, strategies and evidence-based measurements.

The MCH Epi program collaborates on many different projects and analyses related to the MCH population in NM. Program staff interface with community-based health promotion teams located in each of New Mexico's Public Health Regions, regional epidemiologists, community health councils, and representatives from tribes, primary care and hospital systems. To assure ongoing communication and opportunities for input among stakeholders, the Title V Epidemiologist leads quarterly meetings of Title V internal and external participants, and the MCH Epi PRAMS team holds quarterly Steering Committee meetings for the Pregnancy Risk Assessment Monitoring System (PRAMS) and Toddler Survey surveillance activities, with Steering Committee members drawn from clinical and program partners and those who work with MCH data around the state.

### MCH Data Collection

Data collection is monitored through several main sources, including the National Survey of Children's Health, the NM Behavioral Risk Factor Surveillance Survey (BRFSS), NM Vital Statistics birth and death data, and PRAMS, which are accessible within the NM Indicator-Based Information System (NM-IBIS) data query system. NM-IBIS draws from other databases such as Census/American Community Survey, NM YRRS (state equivalent to YRBS) and hospital discharge data. Since PRAMS is housed in the MCH Epidemiology program, we utilize this database conveniently and quickly. Staff publish indicator reports throughout the year and routinely prepare datasets for sharing through the NM-IBIS and data dashboards. MCH Epi also administers the NM Toddler Study, a follow-up study to PRAMS. This study has produced early childhood data that can be used to monitor longitudinal MCH indicators in New Mexico.

Other databases used in continuous needs assessment include:
**The Guttmacher Institute-** The Guttmacher Institute (AGI) is a leading research and policy organization committed to advancing sexual and reproductive health and rights in the US and globally. Data from AGI is used by NM FPP and MCH Epidemiology to track changes in the teen birth rate by state and to provide comparisons with other states and national trends.
**Kids Count Data Center-** The Kids Count Data Center is a project of the Annie E Casey Foundation, which annually compiles a robust list of indicators on economic, health, education and community well-being at the state level.
**National Survey of Children's Health-** This survey provides a comprehensive data query system for national and state-level indicators on child well-being at the state level.
**RWJF County Health Rankings**- RWJF provides a source of county and sub-county wellness data and provides rankings of health outcomes for each jurisdiction.
**Environmental Tracking System-** This is a CDC-sponsored birth defects tracking tool which also measures environmental exposures for the birth through early childhood population.

At the community level, we work with the state's health promotion teams in each of the four health regions including the metropolitan area. These teams are made up of an epidemiologist and health promotion/education staff who work closely with regional health councils and are well connected to resources and stakeholders in the community. Annual data reports from home visiting and other early childhood programs are also a useful way to monitor indicators in the MCH population. Additionally, many of the activities written about in the Family Engagement and Public Input narratives of this grant are used as mechanisms for continuous feedback for the needs assessment.

### Program Evaluation

There are many efforts in each program which serve to inform the effectiveness of strategy areas and to measure

client satisfaction. These are described in detail in the Family Engagement narrative. Starting in 2019, the new Epi/Evaluator in the MCH Epi program began evaluating parts of the Title V program. Starting with our safe sleep initiatives, he has worked with the Title V Director and other partners on a statewide safe sleep plan, which includes objectives and strategies to align and evaluate the disparate safe sleep efforts going on in the state. This is an important first step to be able to evaluate safe sleep-related indicators in the future. This position will also work with the Title V Epidemiologist and domain leaders to evaluate the alignment and measurability of each domain's objectives, strategies and ESM's in place and going forward to the 2020 needs assessment.

This year the Adolescent Health Coordinator and the Title V Epidemiologist worked with a contracted evaluation company, APEX Evaluation, to create a thorough evaluation of the Peer Youth Development program. This evaluation not only meets program objectives, but it facilitates feedback from adolescents on health topics they deemed most important.

The Children's Medical Services (CMS) program has been historically difficult to evaluate due, in part, to problems with the program's data systems and difficulty measuring the ROI of care coordination provided by the medical social workers. CMS has contracted with the Center for Development and Disability (CDD) evaluation team headed by Dr. Anthony Cahill to provide an evaluation of the work of the program. The evaluation will include both qualitative and quantitative data. This is described further in the report narrative. The work will also include assistance with the CYSHCN portion of the 2020 Needs Assessment.

**Noted Changes to the MCH needs from 2015 Needs Assessment**

One change in the needs for the MCH population in New Mexico is in the infant and maternal health domains. While New Mexico does not have an elevated overall infant mortality, rate compared to the national rate, African Americans do have an alarmingly high rate compared to the state. For the time period of 2015-2017, the rates of infant mortality in New Mexico were as follows:

| Race/Ethnicity | Deaths per 1,000 live births |
|---|---|
| American Indian or Alaska Native | 6.3 |
| Asian or Pacific Islander | 3.2 (unstable) |
| Black or African American | 10.5 |
| Hispanic | 6.1 |
| White | 4.7 |

The New Mexico Birth Equity Collaborative was officially founded in 2018 to focus on, or center, black women and their babies. There has been significant collaboration between this group including the Title V Director/Bureau Chief, MCH Epidemiology, the Maternal Health Program and the Child Health Program. For New Mexico, this not an emerging public health issue, but rather one that the state now has more capacity and commitment to address. We have incorporated the work of the Birth Equity Collaborative into our social determinants of health CoIIN through provider bias and paid family leave policy work.

Health equity is the lens that the Title V team has chosen to use for the upcoming needs assessment. This guides the work we are doing now and plans going forward. The Title V Epidemiologist has been working with the DOH Office of Health Equity to actively integrate equity into needs assessment practices. This includes, but is not limited to: health literacy, asset-based data presentation, equitable practices in research, cultural competency, and incorporating social justice. This is an area that our Title V Director/Bureau Chief is committed to, not just for Title V but for the entire Bureau. The plan over the next year is to provide staff trainings on health equity and ensure that the principles are incorporated into all FHB programming. The DOH Office of Health Equity has also been reinvigorated now with a new administration, and the Title V Director is working with them to completely revamp the DOH Health Equity Report.

**Emerging MCH Issues**

Two areas of concern have emerged over the past two years demanding response from public health practitioners in NM and across the United States. Migration and immigration pose growing challenges for our state on the southern border with Texas and with Mexico. A re-emerging issue, the separation of children from their families is gravely concerning to us as health professionals. Governor Lujan Grisham has made a priority for NM DOH staff to help assess the health and needs of unaccompanied and separated minors at the border, and we as Title V staff are part of the responding personnel.

Another area of concern is for missing and murdered indigenous women in New Mexico. Albuquerque, NM has the highest number of missing or murdered Native American women in the United States. Deb Haaland, U.S. Representative from Laguna Pueblo, is bringing national legislative policy and awareness to this problem. Along with tribes and UNM colleagues, we will support efforts to prevent violence against these women and to strengthen data systems for analysis of missing or murdered women.

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

The partnerships that the Title V program have cultivated over the years reach across the entire state and exist in every domain. The Title V Director, the MCH Epi staff, the Maternal and Child Health Programs and the Children's Medical Program make up the leadership team of Title V in New Mexico, and we have representation from this team in all our collaborations that work to serve the MCH populations in New Mexico.

NM Title V staff have led the state's CoIIN efforts to improve infant mortality since 2012. Currently staff are participating in two CoIIN projects, one on social determinants of health and the other focused on prenatal care in the border region. The CoIIN projects involve multi-sector participation and have been a springboard for many partnerships, including working with the NM Hospital Association. This partnership initially started with a focus on reducing non-medically indicated deliveries, but now has branched out into support for other Title V efforts around perinatal regionalization and the maternal mortality review.

The MCH Epidemiology program works closely with both area and Navajo Tribal Epidemiology Centers (AASTEC and NEC). We participate in NM Tribal PRAMS, the Navajo area MCH workgroup, and cross-jurisdictional needs assessments and data sharing. We initiated the NM Tribal PRAMS census surveillance starting in 2018. Tribal PRAMS data collection began in May 2018, and AASTEC is completing its first year of data collection. MCH Epidemiology (PRAMS) staff also worked with both TECs to plan a two-day MCH Tribal Maternal Child Health Symposium in the fall of 2018.

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

The Maternal Health Program (MHP) has experienced changes that have created some difficulty in reporting on the NPM that was selected during the 2015 needs assessment process. The MHP is staffed by the program manager and an administrative assistant. Much of the program work is concentrated on licensing the midwife workforce for the state as well as with the High-Risk Fund program.

The High-Risk Prenatal Fund is a program that provides Title V funding to clinics that serve high-risk (socioeconomic and health outcomes) pregnant women. These funds are an important safety net for those who need prenatal, delivery and post-partum care and do not qualify for any other form of healthcare assistance. While these numbers are reported in the Title V yearly application, the programming is spread over numerous organizations so that is difficult to create unified objectives and measurements for this program. The gestational diabetes project (referenced in the 2018 Annual Report for Maternal Health Domain) is the closest that we are able to get to preventative clinical visits for women served by Title V dollars.

Since 2016, capacity to address maternal mortality has increased substantially, as has its focus as an emerging issue in New Mexico. While it did not emerge as a focus during the last 5-year needs assessment, it has steadily risen in importance as a public health problem, both in NM and across the United States. In response, the Maternal Health Program (MHP) worked for three years to institutionalize a Maternal Mortality Review (MMR) board. While the rates of well-women visits could always be improved, New Mexico does not currently have a specific program to directly fit this measure. However, we have tracked postpartum (inter-conception) visits and leveraged opportunities

to connect women to services along the life course.

Programmatic and leadership changes and vacancies in the Adolescent Health Program also created some changes in activities with the adolescent domain NPM. The NPM around adolescent well-visits was addressed with a project between the Title V Office of School and Adolescent Health and Envision NM, a partner at the University of New Mexico. While the need to increase well visit rates has not changed, the Title V program capacity changed due to vacancies. Envision NM also experienced a leadership change, which slowed the work. These changes did lead to expansion and deeper development by Title V staff in the Peer Youth Development program in 2019.

**Changes in organizational structure and leadership**

The entire leadership of the Department changed in January 2019, with the election of a new Governor Michelle Lujan Grisham. The new DOH Secretary is Kathyleen Kunkel, and the Deputy Secretary is Dr. Abinash Achrekar, a cardiologist who previously worked at UNM. At the time of this writing we do not yet have a new Public Health Division Director; however, Dr. Karin Rhodes is planning to start in this position July 8, 2019. Three of the four PHD Regional Directors also changed in 2019, so we will have a new and revitalized PHD Leadership team moving forward.

The structure of the Family Health Bureau has stayed mostly the same, although we will be losing one of our programs in 2020 with the creation of a new Department of Early Childhood Education and Care. From DOH this will take the Families FIRST perinatal case management program from FHB, the FIT Early Intervention (Part C) program from the Developmental Disabilities and Supports Division, and home visiting and childcare programs moving from CYFD.

## FY 2019 Application/FY 2017 Annual Report Update

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

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

**Data Sources and Tools Used in Assessment**

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

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

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

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

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

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

**Child Health**

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

**Adolescent Health**

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

Representation to local/county Health Councils at state-wide meetings;

Information on NM Title X goals and work plan shared with NM FPP Information & Education Committee Members;

Information for non-profits or government agencies interested in decreasing unintended teen pregnancy and increasing access to family planning services;

Participation with community members at community and/or school health fairs;
Sharing an overview of NM Title X goals and clinical services to participants in NM FPP Education Programs;
Input on community engagement from Title X clinical providers;
Administration of client surveys, to inform local PHO and State Office staff of the availability, access, and appropriateness of family planning clinical services through client self-report.

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

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

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

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

**Maternal Health**

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

**CYSHCN**

Children's Medical Service (CMS) continues its established partnership with the MCH Collaborative, which meets quarterly and provides input to CMS on the unmet needs of the CYSHCN population. The MCH Collaborative is comprised of CMS, Family Voices, Parents Reaching Out (PRO), the Pediatric Pulmonary program at UNM, the UNM Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Program, the Developmental Disability Planning Council (DDPC), and the organization Education of Parents of Indian Children with Special Needs (EPICS). The collaborative is a good mechanism for CMS to receive feedback from other MCH funded programs and parent organizations representing diverse backgrounds.

CMS also receives feedback from various sources including the Newborn Hearing Screening Advisory Council, the Newborn Genetic Screening Advisory Council, the Pediatric Council, CMS social workers, and the CMS Advisory Board, which is part of the New Mexico Medical Society. Family satisfaction surveys are completed at the cleft palate clinics and an exit interview is done with each family to clarify their unique needs. CMS staff attend health fairs, outreach events and have staffed a table at both family leadership conferences held by PRO and EPICS. The NM team for the Mountain States Regional Genetics Collaborative is in the process of conducting a needs assessment of families who have a child with a genetic condition, focusing primarily on feedback from Native American families in rural areas.

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

With all the information gathered from these various sources noted above, and considering the FHB and DOH capacity to

address the needs, the Title V FHB team made the decision to narrow down our priorities this year so that we could focus our work and energy on the high priority areas where we feel we can have the biggest impact.

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

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

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

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

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

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

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

**Changes in organizational structure and leadership**

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

regarding proposals that might be suggested to a new administration.

**Zika Virus Update in New Mexico**

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

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

## 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 ($8^{th}$ 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.

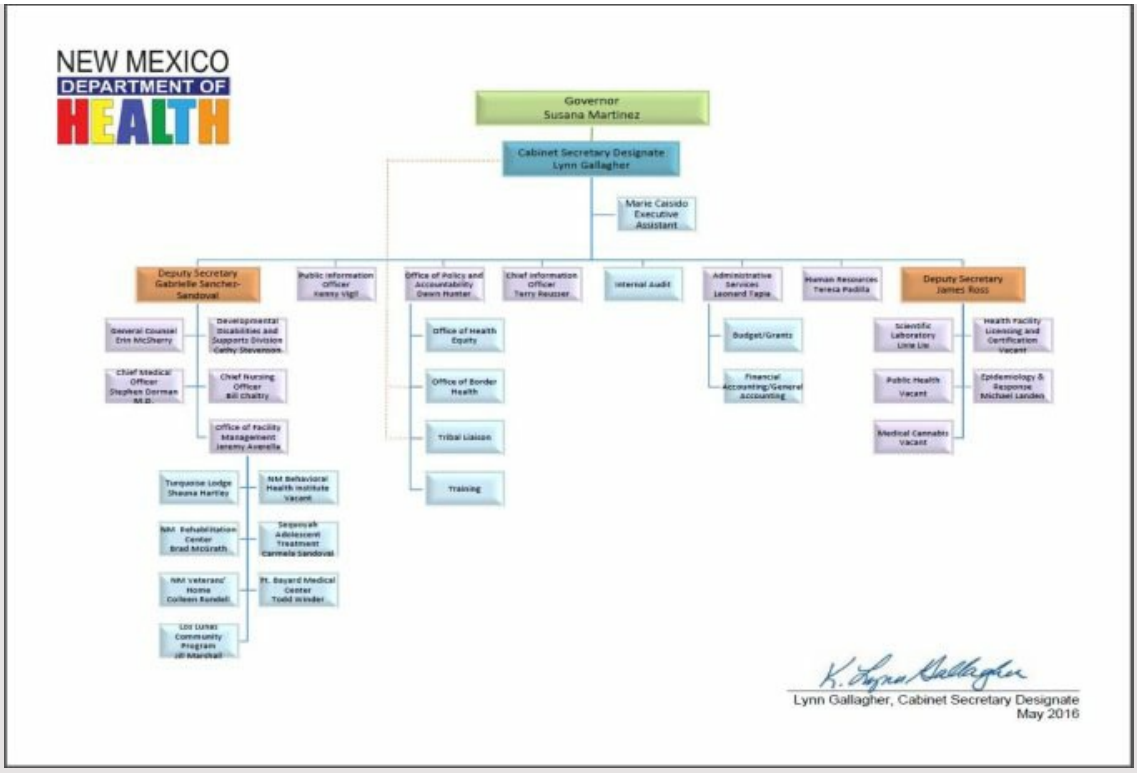
**Adolescent Health**

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 Arenella
Turquoise Lodge
Sheana Hartley
NM Behavioral
Health Institute
Vacant
NM Rehabilitation
Center
Brad McGrath
Sequoyah
Adolescent
Treatment
Carmela Sandoval
NM Veterans'
Home
Colleen Randall
Ft. Bayard Medical
Center
Todd Wieder
Las Lunas
Community
Program
Jill Marshall
Office of Health
Equity
Office of Border
Health
Tribal Liaison
Training
Budget/Grants
Financial
Accounting/General
Accounting
Scientific
Laboratory
Lina Liu
Public Health
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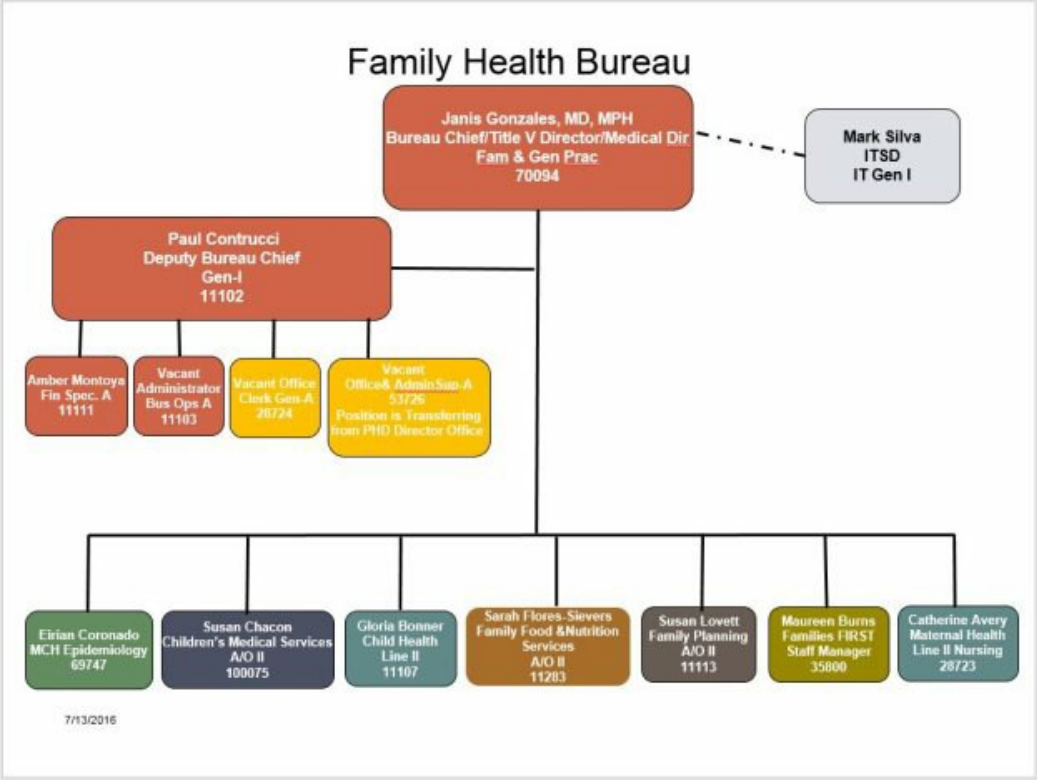
Licensing and
Certification
Vacant
Epidemiology &
Response
Michael Landen
Lynn Gallagher, Cabinet Secretary Designate
May 2016


Family Health Bureau
Janis Gonzales, MD, MPH
Bureau Chief/Title V Director/Medical Dir
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

## FY 2017 Application/FY 2015 Annual Report Update

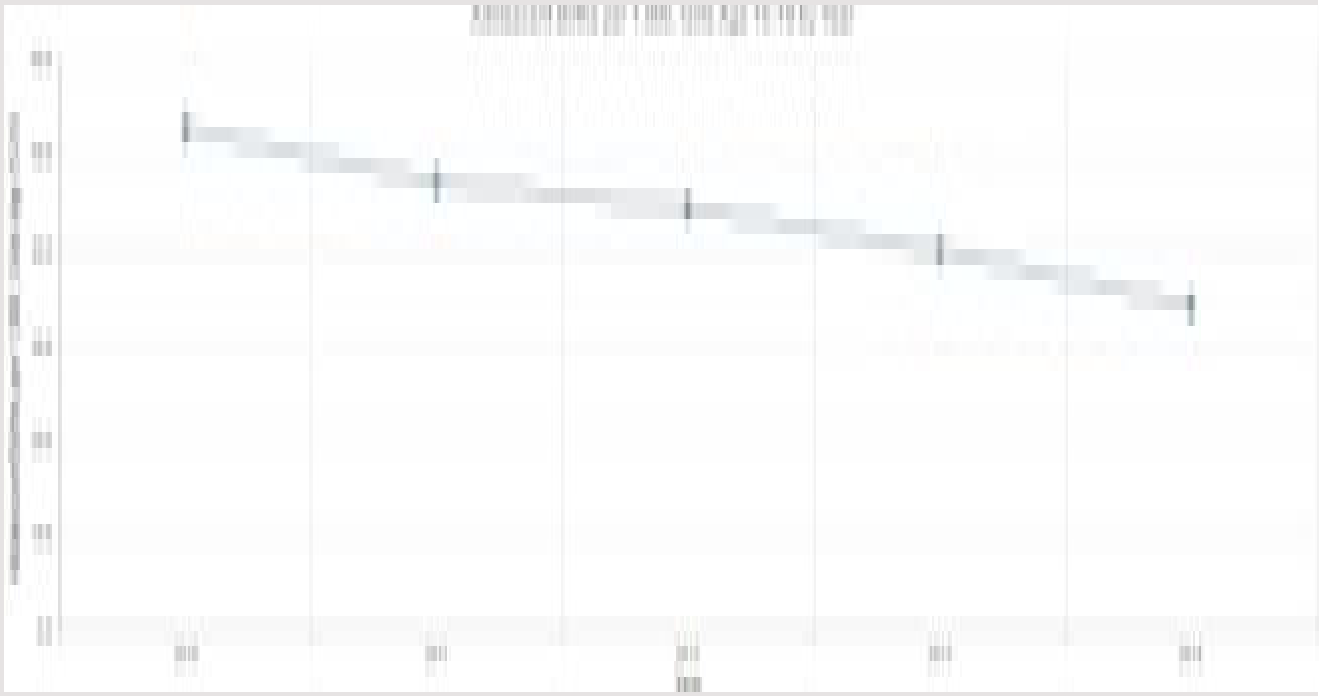
**Needs Assessment Annual Update**

**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 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 1$^{st}$ 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.

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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.

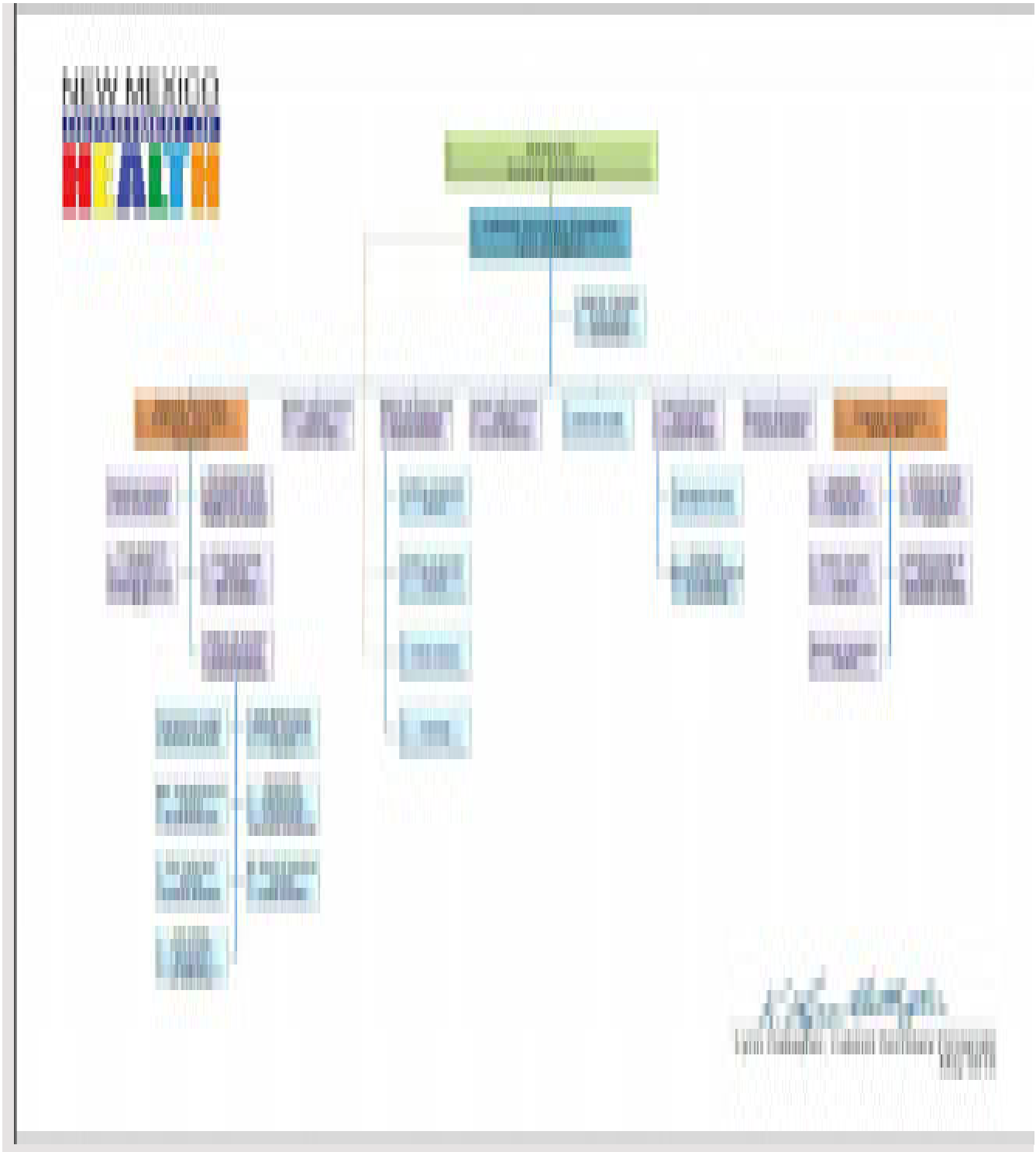
**Adolescent Health**

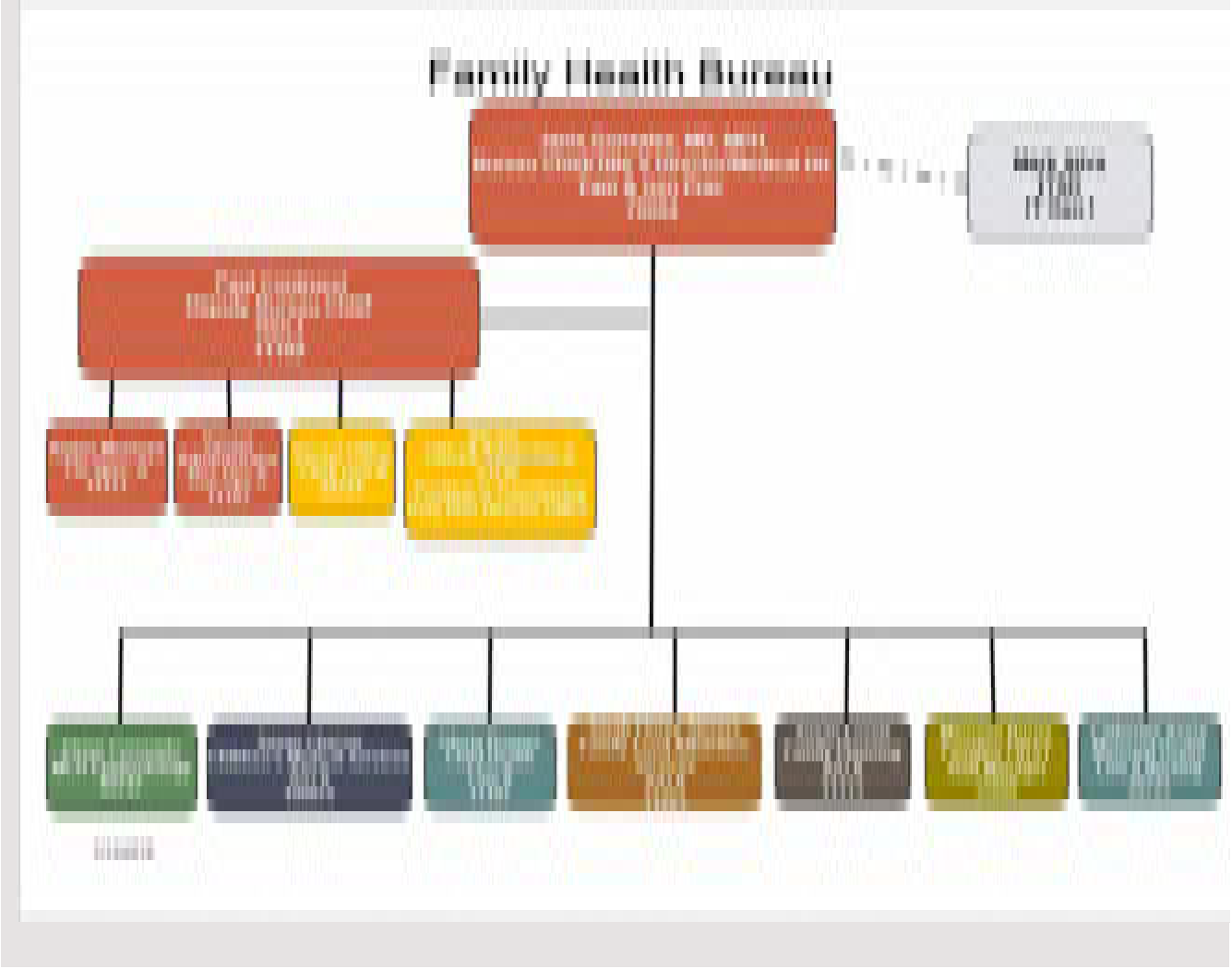
Bullying remains a priority in adolescent health and in the Office of School and Adolescent Health; therefore, there will still be some effort to reduce impact of bullying on adolescents because the programs will continue the efforts that have already been put in place.

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.




Family Health Bureau

# 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.

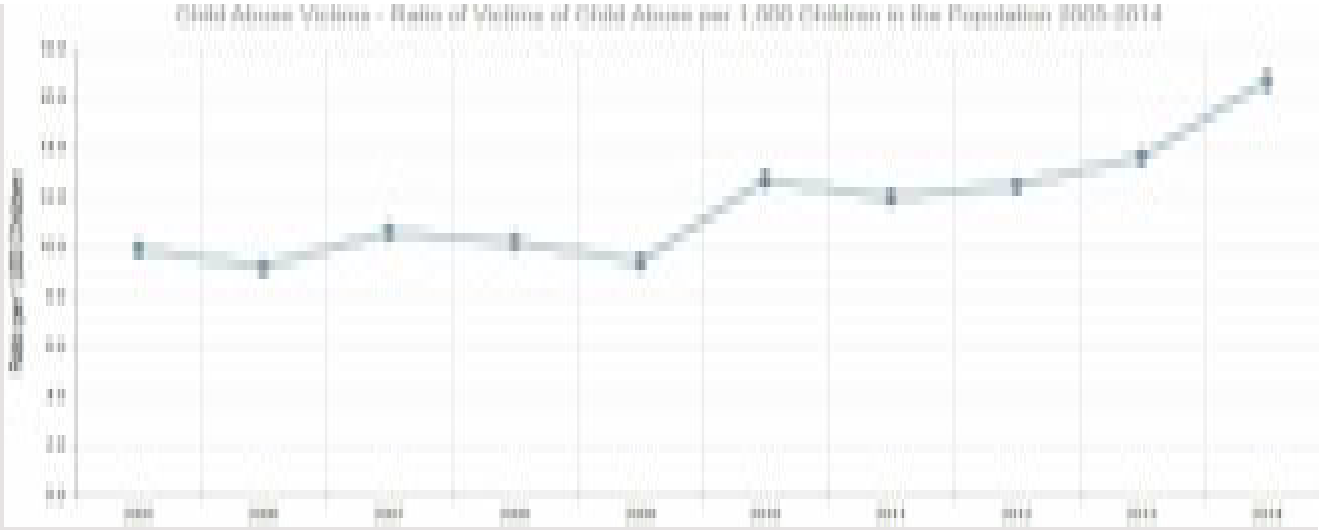
Relating to maternal and women’s health, participants surveyed were asked to rate relative importance of several health needs; the highest need is prenatal care (63%); the lowest, elective C-section (25%). Relating to infant health, the highest need was treatment referrals for infant drug exposure (56%);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

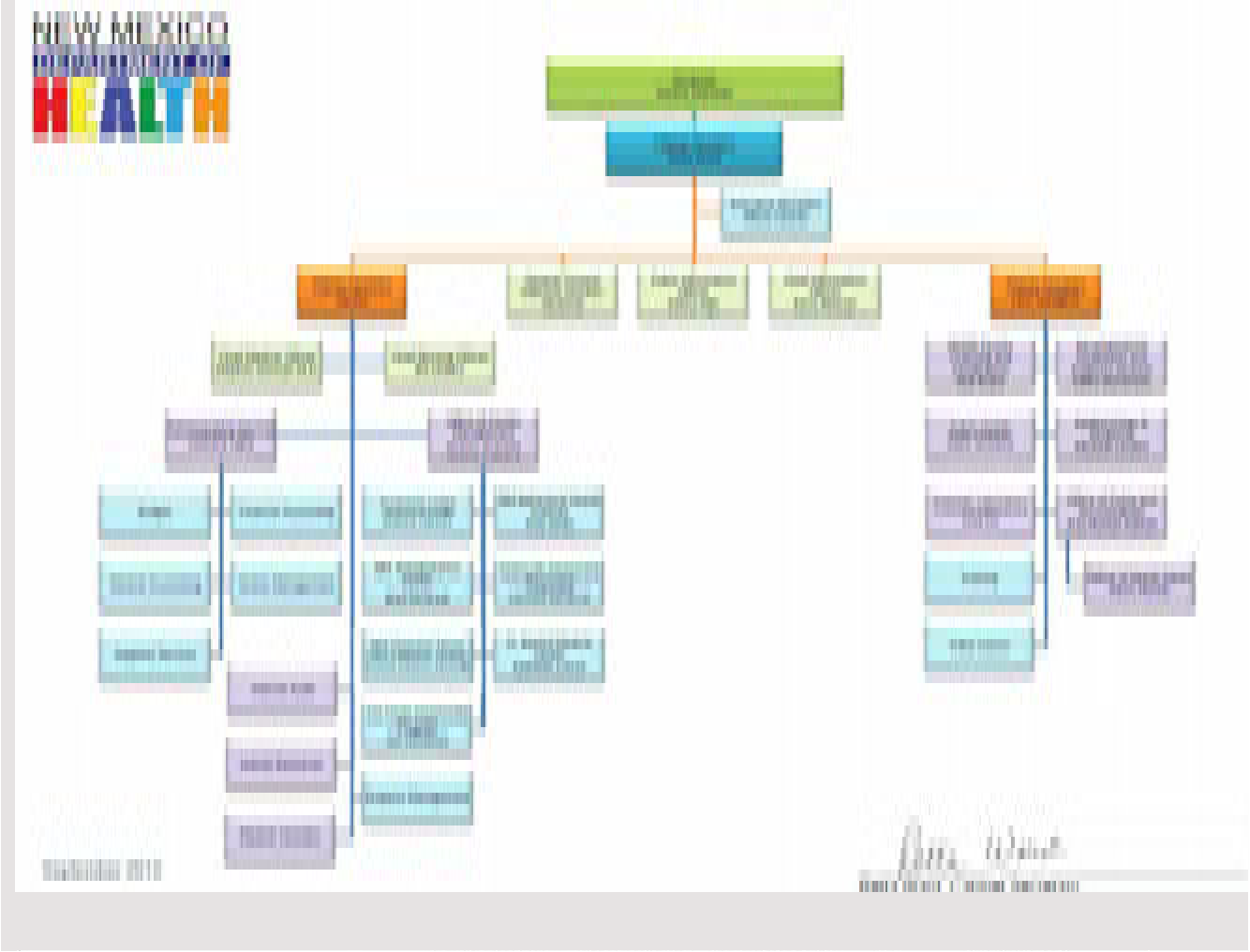
The Public Health Division (PHD) consists of 5 Region Offices, an Office of Border Health, a Pharmacy Office, and 5 Bureaus: Program Support, Health Systems, Chronic Disease, Infectious Disease, and Family Health. The Family Health Bureau is the largest bureau in the Public Health Division. The Family 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.

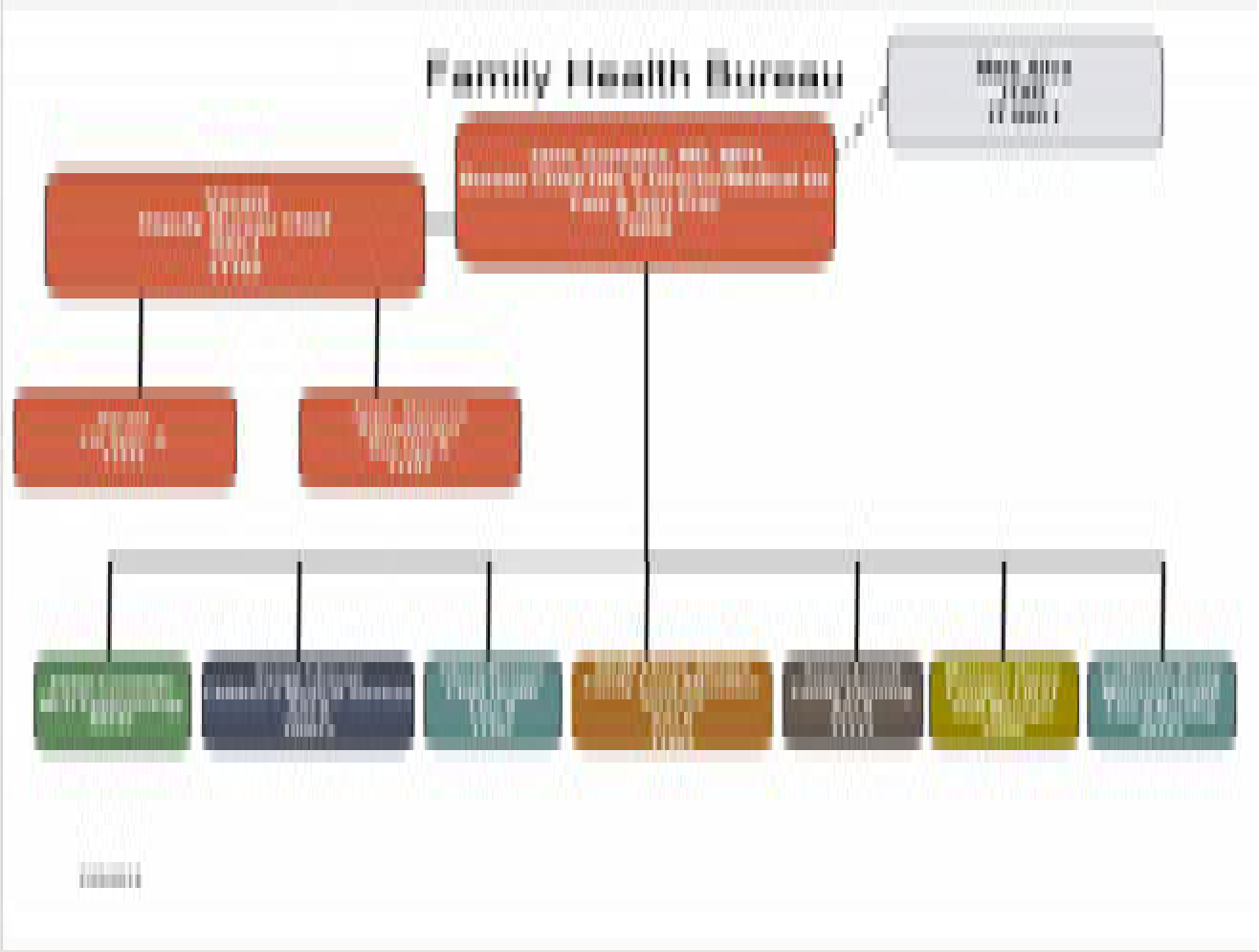
The MCH Epidemiology Program serves the data and information needs of the FHB and its many partners. It has incorporated tl genetic
sreening, newborn hearing screening. Analysis of the CYSHCN survey and NSCH is also performed within this group. The MCH staff, including a position funded by SSDI, aid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






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

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

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

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

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

**CYSHCN**

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

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

**State Program Support for Communities**:

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

**Coordination with Health Components of Community Based Systems:**

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

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

**Coordination of Health Services with Other Services at Community Level:**

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

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

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

**Title V Director's Office**

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

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

**Maternal & Child Health, Title V Funded Staff**

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

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

**CYSHCN Children's Medical Services**

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

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

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

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

**Maternal & Child Health Epidemiology**

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

**The Family Planning Program (FPP):**

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

**Other Workforce capacity:**

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

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

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

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

### III.D. Financial Narrative

| | 2016 | | 2017 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $4,048,292 | $4,376,866 | $4,075,191 | $3,505,374 |
| State Funds | $6,675,779 | $6,984,517 | $6,963,800 | $9,686,381 |
| Local Funds | $0 | $0 | $0 | $0 |
| Other Funds | $0 | $0 | $0 | $0 |
| Program Funds | $7,314,571 | $10,487,490 | $6,501,745 | $13,650,046 |
| SubTotal | $18,038,642 | $21,848,873 | $17,540,736 | $26,841,801 |
| Other Federal Funds | $53,072,414 | $42,501,710 | $45,775,263 | $39,695,243 |
| Total | $71,111,056 | $64,350,583 | $63,315,999 | $66,537,044 |

| | 2018 | | 2019 | |
|---|---|---|---|---|
| | Budgeted | Expended | Budgeted | Expended |
| Federal Allocation | $4,063,782 | $3,849,336 | $4,067,381 | |
| State Funds | $6,019,300 | $5,883,664 | $8,430,253 | |
| Local Funds | $0 | $0 | $0 | |
| Other Funds | $0 | $0 | $0 | |
| Program Funds | $9,377,300 | $12,906,507 | $8,818,600 | |
| SubTotal | $19,460,382 | $22,639,507 | $21,316,234 | |
| Other Federal Funds | $49,335,723 | $41,641,331 | $52,117,307 | |
| Total | $68,796,105 | $64,280,838 | $73,433,541 | |

| | 2020 | |
|---|---|---|
| | Budgeted | Expended |
| **Federal Allocation** | $4,130,727 | |
| **State Funds** | $5,883,664 | |
| **Local Funds** | $0 | |
| **Other Funds** | $0 | |
| **Program Funds** | $8,513,300 | |
| **SubTotal** | $18,527,691 | |
| **Other Federal Funds** | $46,475,877 | |
| **Total** | $65,003,568 | |

**III.D.1. Expenditures**

## Budget Narrative – Expenditures FY18

The set of Budget Forms (2, 3a and 3b) were prepared with assistance from the FHB Admin staff and the Title V Financial Manager, who is also the Financial Manager for CMS. Expenditures are monitored to ensure programmatic spending is occurring according to plan and discussions occur periodically with program personnel with adjustments as needed. The distribution of grant funds reflects the wide variety of programs needed to support our performance measures across all the MCH domains, including maternal/prenatal, infant, child, adolescent and young adulthood.

Title V is the payer of last resort, so the direct services we cover reflect unmet needs and gap-filling for the uninsured population that is low income and not eligible for Medicaid. Funding is leveraged by blending Title V federal funds with state general funds and programmatic revenues. For example, in FY18 this included blending funding from a CDC grant around Zika, which was through the Birth Defects program in the Epidemiology and Response Division, to support a CMS social worker who connects the birth defects data with the CMS staff who follow-up and provide resources to families.

Population-based and public health system work continues to be an increasing focus as direct service expenditures have decreased in recent years. This is consistent with the overall mission of DOH and public health in general, as we always seek to serve the entire population to the extent possible. For FY18, because we have until Sept. 30th of 2019 to spend the federal funds, at the time of this writing $3.85 million out of approximately $4.1 million has been expended; however, the program will spend the grant in full before the end of the project period. We are also moving to a new spending cycle so that in the future grant funds will be spent down earlier.

As reflected on Form 2, 44% of the grant was spent on the CMS program serving the children with special healthcare needs population. Administrative expenses, including indirect and administrative staff support, totaled 6.2%. Total State funds expended, which includes the Title V Match as required as well as program revenues, totaled $17 million. Non-federal expenditures were slightly higher than budgeted because anticipated cuts to state funds did not occur as the state received an increase in oil and gas revenue in the past year.

Form 3b shows that in addition to funding mostly population-based efforts at $1.16 million, $2.1 million of the federal grant was spent on enabling services; this is due to the care coordination provided by licensed social workers in the CMS program, all of whom are partially paid out of the Title V grant. Only a little over $500,000 of federal funds were spent on direct services. Population-based efforts include support to the maternal child health epidemiology program, injury prevention, child and adolescent health system-building efforts, working on coalitions and support for the NM Perinatal Collaborative, among other things.

**III.D.2. Budget**

## Budget Narrative – Budgeted FY20

The budgeted federal amount of $4,130,727 on Form 2 is level with the FY19 budgeted amount for long-term program planning purposes. State general funds (including Title V match) and program revenues are budgeted based on budget allocations from the Division and revenue estimates from the programs. Revenues are closely monitored and tracked to ensure billing is meeting projected needs. Administrative expenses are budgeted to remain between 6 and 7 percent, to comply with the required 10% cap, and budgets for preventive and primary care for children and children with special healthcare needs are also budgeted to make a good faith effort to comply with the 30% - 30% requirement.

Form 3a shows that the budgeted amount for Pregnant Women in FY20 is $595,491, an increase of just over $100,000 from FY18. The maternal health program administers the high risk prenatal fund, which provides funding for care of uninsured, high risk prenatal clients in NM, and the program manager identified an increased need for prenatal care services. This change also reflects the Title V commitment to the Maternal Mortality Review Committee, newly reinstituted and coordinated by the Maternal Health Program Manager. While the MMRC is not directly funded by DOH, the Title V staff in the maternal health program spend a large percentage of their time on this work.

The total MCH Partnership funds as reflected on Form 3a are budgeted at $21,121,665 for FY20, a slight increase from FY18 expenditures due to increased revenue expected from increasing care coordination rates with the MCOs. In FY21 the Families FIRST perinatal case management program will likely be moving to a new Early Childhood Department. The program has experienced a decrease in revenues in due to staffing vacancies and the change in managed care organizations that occurred in January 2019. Molina, which was the largest utilizer of the Families FIRST program, lost the contract to provide Medicaid managed care.

Because of the increased funding for prenatal care services, direct services are budgeted slightly higher in FY20, as shown on Form 3b. Enabling services will continue to be budgeted at just over $2 million to reflect the work done by CMS social workers, and public health services and systems will be budgeted at an increased amount, which reflects the increased commitment to population-based efforts. Direct Services paid out of non-federal funds continue to be high mostly due to the Laboratory Services required to be paid out of the Newborn Genetic Screening Program (under the CMS program umbrella); this program contracts with Oregon Public Health Laboratory for screening of all newborns in NM.

## III.E. Five-Year State Action Plan

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

**State: New Mexico**

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

**III.E.2. State Action Plan Narrative Overview**

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

Purpose and Design

The Title V block grant in NM supports a network of professionals and organizations across the state that focus on Maternal and Child Health. Collaboration is built into the way the grant is allocated. Partnerships both within the Department of Health and outside of it are essential to be able to extend the reach of Title V to the largest percentage of the populations that we serve. The Family Health Bureau (FHB), Maternal Child Health Division of the NM Department of Health (DOH) is the home base for the Title V block grant, where the staff take the lead on the overall design of how Title V funds are used in NM. The Title V leadership works with partners to develop the goals and strategies for the application. Title V leadership includes individuals and organizations within the DOH as well as in the community and strives to create accountable programs that achieve optimal health status for the MCH population.

The Family Health Bureau takes the lead in preparing and submitting the Title V Block Grant yearly application/report as well as the Five-Year Needs Assessment. The MCH Title V Epidemiologist and FHB leadership within the DOH are responsible for the coordination of the grant submission, but they rely heavily on the numerous programs around the state that contribute to Title V strategies. Title V also has to fit into the overall DOH framework as we are part of the Department of Health, Public Health Division. The mission of Title V is well-aligned with the NM state DOH mission to promote health and wellness, improve health outcomes, and assure safety net services for all people in New Mexico. We are committed to improving the health of the MCH population in NM and to assuring access to the delivery of quality, family-centered health care services for mothers, infants and children, including CSHCN.

The Title V block grant is an important part of the base funding of the FHB. The Bureau's purpose is to assess and respond to identified priority needs in the maternal and child health population of the state in order to improve health outcomes for those populations, which includes access to care. To do this, the FHB staff realize the need to connect and collaborate with many other individuals, groups and agencies all around the state whose work and interests overlap with our goals. Being part of this broad network of stakeholders not only enables us to leverage resources but provides a foundation and a focus for the maternal child health work. The matrix attached (see Supporting Documents) shows the variety of partnerships we participate in and how they contribute to the Title V work.

The Title V CSHCN program, Children's Medical Services, works with medical providers, disability advocates, Medicaid and Managed Care Organizations, family organizations and many others to ensure that the special needs of children are addressed on various levels. This program has staff in all the public health offices across NM, so the program has a broad overview of what is currently happening in the state with regard to children with special needs and access to care. CMS social workers live and work in the communities across the state and connect intimately with the families they serve, giving them a solid understanding of what families are going through. Other FHB/Title V funded programs such as WIC, Families FIRST, and Family Planning have similar reach, which is important when working in a large rural and multi-cultural state.

The Title V MCH Director and Family Health Bureau Chief is constantly looking for connections between our MCH work and the work being done by others. FHB staff are dedicated to the importance of this work and committed to moving it forward in a patient/family-centered way with a focus on health equity and underserved populations. Health equity is especially important as a framework in NM because greater than 50% of the population identifies as an ethnic minority. FHB is working to infused health equity into everything we do on every level of programming. We are working with the Office of Health Equity in DOH to enhance our health equity framework moving forward as well as helping to revise the DOH Health Equity Report.

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

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

## Title V Funded Staff

### Title V Director's Office

The Family Health Bureau (FHB) houses seven separate programs. The Bureau Chief/Medical Director/Title V MCH Director, Dr. Janis Gonzales, oversees all programs and works with each of the program managers who have direct oversight of each program. Dr. Gonzales is Board Certified in Pediatrics and has a master's degree in Public Health. She previously spent nine years in private practice followed by work in hospice and in Early Childhood Developmental Screening before joining Children's Medical Services (CMS)/FHB. She also had a daughter with special needs. For the past ten years, she has served as Medical Director for the Title V CYSHCN program (CMS) in New Mexico. In addition, she has served as the Family Health Bureau Medical Director for the past four years. She was promoted to Bureau Chief and Title V Director in Feb. 2015. She is also the Vice-President of the NM Perinatal Collaborative and the President of the NM Pediatric Society (the NM Chapter of the AAP). She has a Deputy Bureau Chief, a Business-Operations specialist, and a Financial Specialist on her Administrative Team.

### Maternal & Child Health

Katie Avery, MS, CNFP is the Maternal Health Program Manager, responsible for the High-Risk Prenatal Care Fund program, Midwifery Licensure & Regulation and the Maternal Health program. This Program is also the NMDOH coordinating lead for the NM Maternal Mortality Review Committee proceedings. The Child Health Manager, Gloria Bonner, is responsible for child health program activities with a focus on improving screening and referrals and parent education, as well as building partnerships throughout the early childhood system in NM. The program has a strong collaboration with other agencies and community programs around the state. Gloria was the lead on the Early Childhood Systems Grant for many years and has recently been appointed as the CDC's Act Early Ambassador to New Mexico for 2019-2021. The MCH Section is also strongly supported by Health Educator, Sabrina Curry and Administrative Assistant Jessi Sanchez.

### CYSHCN: Children's Medical Services

Susan Chacon, LCSW is the Title V CYSHCN Director. Ms. Chacon has 12 years of program management within the Children's Medical Services Program. The Title V CYSHCN Director position is the Statewide Program Manager for Children's Medical Services (CMS), under which fall the CYSHCN Program, the Multidisciplinary Specialty Outreach Clinics, the Newborn Genetic Screening program and the Newborn Hearing Screening program.

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

Brenda Romero, RN, is the State Genetics Coordinator and Carla Ortiz, RN, is the nurse consultant for screening; both have been with the program for over 12 years. Robert Morrison was hired as the Newborn Hearing Screening Coordinator in February 2017. He has a Master's in Public Administration and many years of experience coordinating Public Health programs. Lydia Sanchez is the advanced clerk and has been with the program for over 15 years. She bills the managed care organizations for case management and the outreach clinics, which brings in revenues to the program. These revenues support staff salaries and have helped the program expand staff positions in underserved areas. The clerk specialist position that provides administrative support to the Newborn Screening Programs is currently vacant, and applicants are being recruited.

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 who oversees financial transactions. The Finance Manager position, which oversees the budget including the Title V grant, is currently vacant. Adrienne Miera-Branch is the Clinic Coordinator and oversees all clinic operations. Susan Merrill, LCSW, is the birth defects coordinator and is heavily involved in the CARA (Comprehensive Addiction & Recovery Act) work with CYFD. Reanna Garcia is the data manager who oversees the data bases for the newborn screening programs. The CMS staff in the Public Health

offices are licensed professionals and consist of regional program managers, social work supervisors, social workers, clerks and nutritionists who specialize in children with special needs. Fully staffed, CMS has about 90 personnel statewide. The program has had success recently in filling vacant positions and even creating new social work positions in high need areas, which has boosted morale and productivity. There are also several contractors in place that help to support the program, including an additional nurse who assists with follow-up on unsatisfactory bloodspots and several contractors who assist with follow-up on newborn hearing screens and evaluation of the newborn screening data base.

The regional staff meet monthly to keep up to date on program initiative and procedures. Trainings relevant to cultural competency and social work practice and interwoven into the monthly meetings. The social work staff must maintain Certificates of Education (CEUs) including six hours of cultural competency training every two years as part of professional licensure. This year CMS held a statewide training which gave staff time to interact as a program and receive training to improve skills and sensitivity to working with families with CYSHCN.

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

**Maternal & Child Health Epidemiology**

Currently, there are four epidemiologists in addition to the Section Manager (also an epidemiologist), a data manager, and two FTE data collection staff. Eirian Coronado, MA, is the Section Manager with over 16 years working in public health. She fills the role of Principal Investigator for the Pregnancy Risk Assessment Monitoring System (PRAMS), the NM Toddler Survey and the State Systems Development Initiative (SSDI). Christina Brigance, MPH, coordinates the Title V Block Grant & Needs Assessment and was hired in January 2018. This is her second grant cycle for Title V. Glenda Hubbard, MPH, RN, is the PRAMS analyst and newborn hearing screening analyst and has been with the group for four years. Sarah Schrock, MPH, coordinates the PRAMS and NM Toddler Study and was hired in March 2018. Nicholas Sharp, MPH, is a program evaluator and was hired in January 2019. Dorin Sisneros is a Management Analyst-Supervisor and provides fiscal oversight to the program. Carol Hust, Data Collections Clerk joined the team in June 2019. The MCH Epidemiology program supports data collection, data management & analysis for Children's Medical Services (CMS) in newborn hearing and newborn genetic screening programs. They provide data from PRAMS to support WIC nutrition program evaluation, and they analyze client data for WIC and the Family Planning Title X Program.

**Office of School and Adolescent Health**

There is one staff member in the Office of School and Adolescent Health (OSAH) that is supported by Title V funds. Tessa Medina-Lucero, MPH, is the Adolescent Health coordinator which belongs to the Population and Community Health Bureau within the NM DOH. She works in the Peer-to-Peer Youth Empowerment Program, coordinating all aspects. She also supports work in the NM Adolescent and Young Adult CoIIN. Christina Brigance, MPH, from the MCH Epi Program out of the Family Health Bureau, also works with OSAH to aid in evaluation and epidemiological needs for Title V- related projects.

**Office of Injury Prevention**

John McPhee is the Childhood Injury Prevention Coordinator for NM DOH. He works to implement and coordinate prevention programs and education for both unintentional and intentional childhood injury. His work includes providing a range of safety trainings to service providers and parents, assembling and distributing safety information statewide, as well as providing media interviews, press releases and articles specific to child safety. His training topics include safe sleep, helmet safety, and car seat safety. His position also entails maintaining membership and actively supporting the state Safe Kids Coalition. John is required to have continuing affiliation with Consumer Product Safety Commission as he is the NM State Designee. He contributes to two state Child Fatality Review Panels, as well as membership on advisory committees for EMS For Children, the Child Ready Program, the NM Poison and Drug Information Center and the NM Injury Prevention Coalition.

**The Family Planning Program (FPP)**

Susan Lovett, the Title X Director in the State Office, manages the statewide Family Planning Program including oversight of budget, personnel, and federal grant requirements. The Clinical Team consists of the Medical Director Christopher Novak, MD, MPH; Georgina Gomez-Lieberman, Nurse Practitioner Consultant; Veronica Trujillo, Nurse Consultant; and, Tina Sanchez, Nurse Consultant. The Education Team consists of Kate Daniel, an Epidemiologist, and Julie Maes and Mercedes Gonzales-Clay, who are both Educational Project Officers. The Administrative Team includes Genevieve Lujan, the Fiscal Manager, who supervises two Contract Specialists, Cindy Martinez and Joseph Arguello, and Margie Vigil, the Purchasing Agent. There are also two consultants to the clinical team: Rameet Singh, MD, MPH and Terry Waters, CNP.

**III.E.2.b.ii. Family Partnership**

New Mexico will continue to foster established family and consumer partnerships and seek out new partnerships for the application year. Our partner agencies and advocacy groups represent families and family-consumer partnerships formed before and during the ongoing Needs Assessment process. These partnerships, some of which go back many years, help our programs understand if our efforts are resonating with the people that we serve. These relationships also cross over with our efforts to obtain public input on Title V. For both efforts, we are working to make sure that our resources are used to make changes that are right for our communities in New Mexico.

**Maternal Health**

*Maternal Mortality Review Committee (MMRC)*: Currently the Committee's Core Planning Group is actively seeking committee membership that will reflect community-based organizations (e.g., home visiting, parent support), as well as health equity/birth advocacy persons and/or persons with "lived experience" in maternal mortality or morbidity events. An invitation letter will go out to proposed candidates, and three committee members will be selected to fill the three newly-created seats representing community groups, therapeutic communities and health and birth equity voices.

*Gestational Diabetes (GDM) project:* The plan for this project is to utilize staff of the University of New Mexico's *Consumer Research* Program and/or the School of Population Health to assist with garnering persons or consumer groups to gain feedback on the materials that would be introduced to clients awaiting GDM lab testing. The work group desires to introduce this information in a culturally sensitive and self-empowering manner.

*Zero to Three*: This work, prompted by a national effort and led by the Human Services Department (HSD), focuses on provision of adequate services to address the maternal and infant mental health needs (dyadic approaches) in primary and behavioral health settings. The core membership in this group includes staff from HSD, DOH and the state Children, Youth and Families Department (CYFD). Periodically, this committee holds focus groups with clients/families to gauge the acceptance and effectiveness of services.

*Midwifery Licensing*: The state Maternal Health Program manages the licensing of two midwife groups in the state, the certified nurse-midwives (CNMs) and the licensed midwives (LMs). Both groups have Advisory Boards that meet quarterly. In both boards there are two or three members from the consumer sector (individuals who have used a midwife in their birthing care.) The input from these members is useful to inform midwifery practice policy and initiatives in the state.

**Child Health**

The Child Health Program's MCH Health Educator provides training to many partners throughout the state, including community-based programs, childcare centers, home visitors, and other early childhood providers. Trainings cover multiple topics, but primarily focus on the administration and scoring of the Ages & Stages Questionnaire (ASQ) and ASQ: Social Emotional (ASQ:SE) screening tools and safe sleep/shaken baby prevention. We know this is what the direct-service providers want/need because they continue to ask for these trainings, and several have requested that the MCH Health Educator create topic-specific trainings for them -- for example, how home visitors can address opioid use with the moms they visit and more information about adverse childhood experiences. Recently, a professor from the nursing program at Carrington College called to request developmental screening training for her nursing students.

The MCH Health Educator attends health fairs, conferences, symposiums, and community family events that allow her to promote and raise awareness of the programs and activities of the Family Health Bureau. These events serve as outreach, promotion, and networking opportunities. Through them, new community partners are reached, trainings are advertised and scheduled, and educational materials are provided. The anecdotal feedback around the materials provided is always positive, so we know this is serving the population of families with young children well. Many times, families will come back to get more resources for their friends and relatives who also have young children.

Another activity the Child Health program leads is the ECCS-AE State Team (Early Childhood Comprehensive Systems-Act Early). This team is an open-membership group of direct-service providers, representatives of advocacy groups, parents, grandparents, and state agency employees who are interested in improving developmental monitoring, screening, and referral of children ages birth-8, for both physical and social-emotional delays. These stakeholders represent the diverse interests of the early childhood community and help drive the State Team priorities and project goals.

**Adolescent Health**

The Office of Adolescent Health (OSAH) believes that youth and partner voices are vital for program quality improvement. OSAH is working with the Adolescent & Young Adult (AYAH) Collaborative Improvement & Innovation Network (CoIIN), which consists of member from Title V Maternal & Child Health, Apex Evaluation, Western Sky Community, Programs for Adolescents and other partners, to ensure youth and partner voice for the NM Know Your Health Toolkit (KYHT) pilot project. Evaluation tools are being created to get input from the healthcare providers perspective of implementing the toolkit.

The team is also developing a youth satisfaction survey so young people can provide feedback right after their health visit at the clinic. The youth satisfaction survey results will be shared with the pilot health clinic sites as a way to increase youth-friendly and high quality healthcare to adolescents and young adults. OSAH also funds 32 Youth Peer-to-Peer Helper Programs and networks with various partners across New Mexico who can help ensure youth and partner voice for our Title V efforts. OSAH has contracted with APEX Evaluation in order to design evaluations and youth-friendly input sessions for this program.

**Children and Youth with Special Health Care Needs**

Children's Medical Services receives input from both clients and families themselves and from family organizations. The program has a family-centered and patient-centered approach to care coordination, including involving youth in transition planning for the state Children and Youth with Special Health Care Needs (CYSHCN) Program. CMS makes direct referrals to family support organizations for family-to-family connections. This includes referrals to Parents Reaching Out (PRO), Education of Parents of Indian Children with Special Needs (EPICS), the family liaisons from the NM School for the Deaf (NMSD), and family guides through Hands & Voices for children that are deaf or hard of hearing. The Cleft Palate clinics employ a family support agent who is available to families during the clinic. CMS sustains family participation in the Maternal and Child Health (MCH) Collaborative, NM Interagency Coordinating Council (ICC), and the Early Hearing Detection and Intervention (EHDI) stakeholder committee.

CMS staff participate in the Mountain States Regional Genetics Advisory Committee, which includes the CMS NBG program, CMS Statewide Manager, Parents Reaching Out, Family Voices, the Navajo Nation Family Voices, the UNMH Genetics program, the UNMH Office of telehealth and several other parents who have children with genetic conditions with a mutual goal to improve genetic services to families in rural and underserved areas. The New Mexico team developed a needs assessment of parents on the Navajo Nation and other Native communities to better understand the needs and gaps in services.

Family Organizations are invited to provide input into the CYSHCN Program activities and the Title V Block Grant during scheduled MCH Collaborative meetings and the other named stakeholder meetings. CMS contracts with and provides funding to family organizations to ensure that families who have children with special needs have input into programming and serve in an advisory role regarding policy. The funding also supports family participation in local, state and national conferences and provides training for staff/families.

Funds from the CMS program support an annual family leadership conference sponsored by EPICS and PRO where over 400 families who have children with special needs gain new skills, support and resources. Each agency holds their own family leadership conference and a diverse contingency of parents attend. 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 to provide input into program goals and objectives.

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

New Mexico Title V has a Maternal Child Health Epidemiology Program with five full-time epidemiologists. The PRAMS surveillance team has over 30 years combined staff experience and is recognized as a premiere example among the states. The surveillance team developed a follow-up component to PRAMS in 2016 and now surveys mothers of two-year-old children in the PRAMS-2 NM Toddler Survey. The team made continuous improvements in the survey methodology to improve response rates, and they have a clean dataset now prepared for statistical weighting. State Systems Development Initiative (SSDI) grant objectives and activities support the ongoing longitudinal surveillance development and linkage to the PRAMS birth cohort.

Descriptive data in PRAMS-2 are provisional and fill important information gaps, including measures of Adverse Child Experiences (for mother and child), developmental screening, healthcare, social services and behavioral health experiences of mother and child. In addition, the PRAMS-2 provides the state's first population-level estimates on breastfeeding beyond the immediate postpartum period. For developmental screening we initially bolstered the PRAMS-2 survey tool with the complete Survey of Wellbeing of young Children (SWYC) to better support our early childhood wellness and developmental screening partners and constituents. The findings of that module will be shared with early childhood stakeholders during the process of Title V and complementary (pre-K and MIECHV) needs assessments in New Mexico.

Breastfeeding duration and exclusive breastfeeding estimates beyond 10 weeks are available in the unweighted dataset, but they will not be published until survey data are statistically weighted to the original birth cohorts, starting with 2016. In the meantime, they are used internally for evaluation and planning in Title V through the Envision NM Community Advisory Board and with NM WIC. For breastfeeding outcome monitoring, the MCH Epidemiology Program and UNM evaluators work together to link hospital-specific data to population surveillance data, but due to restrictions in NM Vital Records identification of facility-level data, those linkages cannot be publicized and even direct sharing with hospitals has been cautious. To address this barrier, NM PRAMS added state-specific questions for women to voluntarily report their delivery hospital in the 2017 birth data collection. Initial estimates for delivery hospital do not look reliable compared to known delivery volumes, and the CDC data collection system was significantly erroneous around these fields. Although NM program staff made various requests for the errors to be corrected, the CDC would not prioritize state-specific data supplements and did not rectify the problems until the end of the data collection year. Therefore, 2018 will be the first complete dataset we receive and assess the delivery hospital indicators in FY20. At that point, delivery volumes can be validated with other data sources.

FY18 objectives in the State Systems Development Initiative (SSDI) included a linkage between birth certificate records and New Mexico's hospitalization and Inpatient Dataset (HIDD) to measure the statewide prevalence of severe maternal morbidity (SMM) and learn more about predictors or underlying conditions reported on the birth certificate. The linkage was completed in October 2019 and preliminary analysis shared with perinatal collaborative and public health practitioners in November 2019. In NM only non-federal facilities are required to report quarterly into the NMDOH hospitalization database (HIDD), but most IHS facilities are voluntarily reporting on an annual basis. And because most severe morbidity incidents occur at non-federal hospitals with sufficient maternal levels of care, the expectation is we will find few additional cases in the IHS files. Analysis of 2017 SMM corroborate this expectation, except in one case. On the other hand, among the 437 2017 deliveries in NM IHS facilities, postpartum hemorrhage (n=48) (without transfusion) was captured in the IHS annual file, indicating a need for IHS inclusion in quality improvement efforts including the Alliance of Innovation in Maternal Health (AIM). We will consult with Navajo IHS to obtain a comparison of procedure and CPT codes available in their IHS 'DataMart' and determine next steps.

From 2016-2018, MCH Epidemiology analysts utilized syndromic surveillance from NM (non-federal) hospitals to conduct a pediatric asthma referral protocol and evaluation. We analyzed a cross-section of hospitalizations and referrals to Children's Medical Services serving infants and children with special healthcare needs. However, we were not able to pull CMS client records with required identifiers for linkage, and we utilized an intern to manually pull each record to update child DOB, residential address fields and date of admission to CMS case coordination (FY18). The linkage is planned for FY20 upon hiring of a data linkage epidemiologist or pending job duty reorganization for existing staff.

SSDI and Title V staff support an ongoing evaluation of provider training to educate primary health providers practicing in Federally Qualified Health Centers (FQHC) located in select rural areas of the state. The trainings build capacity for providers to counsel patients on contraceptive options, including the most reliable long-acting reversible contraceptives (LARC). Since LARCs require insertion of IUDs or contraceptive implants (and removals), primary care and family care providers require specialized training which is normally only offered to OB-GYBN or specialty providers.

The LARC evaluation team has worked across state agencies and with UNM pediatric staff to plan linkages between Medicaid claims and birth certificate denominator data. The first part of the evaluation is to obtain Medicaid claims for pre and post training for the FQHC sites already trained in LARC use with a comparison to other contraception methods (via procedure and remittance) and to the remaining rural providers in NM. We anticipate receipt of the claims by September 2019. To project the unmet need and costs for long-acting reversible contraceptives in NM, this team is pulling data from a variety of local and national datasets including PRAMS, Medicaid, Title X and birth certificate files. We hope to have our full evaluation available to the legislature in October 2019.

A 2017 data linkage between WIC nutrition client files (2014-2016) Medicaid client records was completed to conduct a brief follow-back survey with Medicaid-eligible families not accessing WIC. WIC obtained funding for the survey in May 2019, and they are pursuing the Medicaid client survey. These results will be used to design a post-partum support program called 'Welcome Home Baby' with cross-referral between that program, WIC and other early postpartum support services in the South Valley of Albuquerque. This program will utilize public health nursing staff to provide universal post-delivery visits with NM women and provide referral options to more intensive home visiting and case management options when needed. The community assessment and program readiness phase with Durham Connects (the administrator of the evidence-based postpartum home visiting model) started in March 2018 and culminates August 2019.

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

Title V staff monitor the insurance landscape in the state and work to ensure that women and children are insured. While we know insurance coverage does not completely ensure access to care, it is an important piece of assuring access. The uninsured population in NM continues to fall, to a current low of approximately 10%, and Medicaid rolls continue to increase. All told, the uninsured population in NM has dropped by 50% since inception of the Affordable Care Act (ACA), largely due to the Medicaid Expansion. It is unclear if the number of uninsured New Mexicans can be reduced much further as there will always be those who do not qualify for assistance, the undocumented, and those who choose not to purchase insurance.

If Medicaid buy-in becomes a reality in NM that may also help increase insurance coverage, although it may also just create a shift from private to public insurance. The NM Legislature did not pass the bill proposing a Medicaid buy-in program in New Mexico but they have said that they will convene a task force to continue studying the issue. The Legislature did pass some bills that were an attempt to enshrine ACA protections into state law, including one that requires insurance companies to cover all contraceptive options in parallel with the ACA requirements.

Title V works hard to maintain relationships with Medicaid staff and the managed care organizations. Medicaid now covers slightly more than 50% of all New Mexicans and over 70% of births. NM Medicaid re-issued its RFP for managed care in 2017. New contracts began January 1, 2019 with two of the insurers being the same as previous (Blue Cross Blue Shield and Presbyterian) and one new insurer (Western Sky Community Care/Centene). The loss of United and, in particular, Molina Health Plan was a blow to our Families FIRST perinatal case management program as Molina was by far the biggest utilizer of the program. Medicaid rates have been low for many years but the new Administration that came in January of 2019 has committed to increasing rates to 90% of Medicare for codes affecting primary care, behavioral health, and dental providers, among others.

NM has a Health Insurance Exchange (HIX) that was developed as a state-federal partnership, utilizing the federal portal (HealthCare.gov) for individual enrollment and the NM portal (BEWELLNM.com) for the state-run Small Business Health Options Program (SHOP) exchange. The Exchange provides subsidies for eligible individuals to increase affordability of health insurance; however, anecdotal reports from families show that even with the subsidies the cost of insurance is often seen as unaffordable, especially for families who are just over the Medicaid income level.

The NM Medical Insurance Pool (NMMIP), also known as the High-Risk Pool, continues to operate as a safety net for those with high cost medical conditions who are not eligible for other insurance or who choose not to buy insurance on the Exchange during open enrollment. Because the state provides the carriers with tax credits to offset their losses from the Pool, the NMMIP has at times been targeted for possible closure; however, it remains one of the strongest of the remaining state high risk pools. Membership has decreased from a high of over 8,000 to approximately 2,500 now. The DOH continues to rely on the Pool to insure Children and Youth with Special Health Care Needs (CYSHCN) and those living with HIV who are not eligible for Medicaid or any other insurance programs. The NM Title V Director attends the NMMIP Board meetings and serves as a liaison between the Pool and the DOH.

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

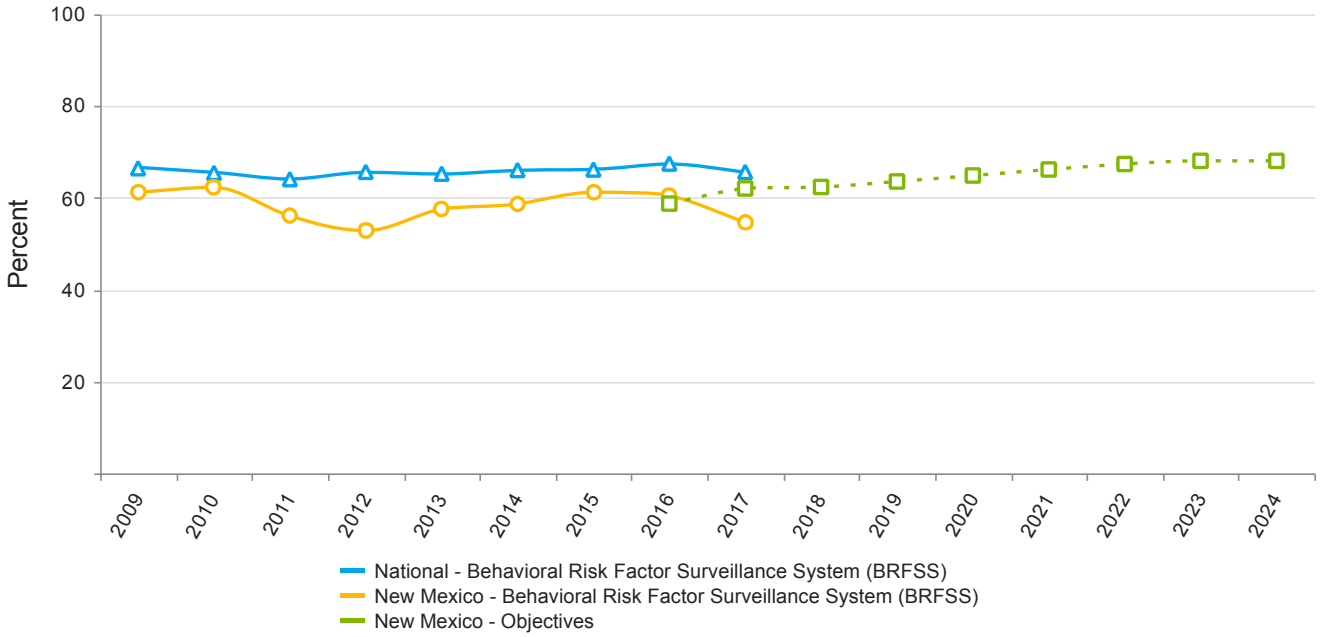
#### Women/Maternal Health

#### Linked National Outcome Measures

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations | SID-2015 | 163.5 | NPM 1 |
| NOM 3 - Maternal mortality rate per 100,000 live births | NVSS | Data Not Available or Not Reportable | NPM 1 |
| NOM 4 - Percent of low birth weight deliveries (<2,500 grams) | NVSS-2017 | 9.5 % | NPM 1 |
| NOM 5 - Percent of preterm births (<37 weeks) | NVSS-2017 | 10.3 % | NPM 1 |
| NOM 6 - Percent of early term births (37, 38 weeks) | NVSS-2017 | 28.0 % | NPM 1 |
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths | NVSS-2016 | 5.5 | NPM 1 |
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2016 | 6.2 | NPM 1 |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births | NVSS-2016 | 4.3 | NPM 1 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2016 | 1.8 | NPM 1 |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births | NVSS-2016 | 186.3 | NPM 1 |
| NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy | PRAMS-2015 | 4.5 % | NPM 1 |
| NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births | SID-2016 | 12.3 | NPM 1 |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females | NVSS-2017 | 27.9 | NPM 1 |
| NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth | PRAMS-2017 | 12.9 % | NPM 1 |

## National Performance Measures

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




| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | 58.7 | 62 | 62.3 |
| Annual Indicator | 61.1 | 60.6 | 54.5 |
| Numerator | 213,517 | 212,186 | 190,568 |
| Denominator | 349,603 | 349,927 | 349,904 |
| Data Source | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2015 | 2016 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 63.5 | 64.8 | 66.1 | 67.3 | 68.0 | 68.0 |

**Evidence-Based or –Informed Strategy Measures**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | | 75 |
| Annual Indicator | 0 | 0 | 47.7 |
| Numerator | 0 | 0 | 239 |
| Denominator | 100 | 100 | 501 |
| Data Source | UNM Cerner Hosptial Medical Records | UNM Cerner Hosptial Medical Records | UNM Cerner Hosptial Medical Records |
| Data Source Year | 2016 | 2017 | 2018 |
| Provisional or Final ? | Provisional | Provisional | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 60.0 | 65.0 | 70.0 | 75.0 | 80.0 | 80.0 |

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

| Measure Status: | Active |
|---|---|

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 70.0 | 80.0 | 90.0 | 93.0 | 95.0 | 95.0 |

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

| Measure Status: | Active | | | | | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 10.0 | 25.0 | 30.0 | 35.0 | 40.0 | 45.0 |

**State Performance Measures**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | 31.6 | 28.8 |
| Annual Indicator | 34.2 | 29.4 | 27.6 |
| Numerator | 2,307 | 2,000 | 1,889 |
| Denominator | 67,519 | 68,117 | 68,324 |
| Data Source | NM Vital Records | NM Vital Records | NM Vital Records |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 26.1 | 23.4 | 20.7 | 18.2 | 17.6 | 17.6 |

**SPM 5 - Adequate Insurance Across the Lifespan**

| Measure Status: | Active |
|---|---|

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 90.0 | 92.0 | 94.0 | 96.0 | 98.0 | 98.0 |

**State Action Plan Table**

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

### Priority Need

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

### NPM

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

### Objectives

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

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

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

### Strategies

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

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

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

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

| NOMs |
|---|
| NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations |
| NOM 3 - Maternal mortality rate per 100,000 live births |
| NOM 4 - Percent of low birth weight deliveries (<2,500 grams) |
| NOM 5 - Percent of preterm births (<37 weeks) |
| NOM 6 - Percent of early term births (37, 38 weeks) |
| NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths |
| NOM 9.1 - Infant mortality rate per 1,000 live births |
| NOM 9.2 - Neonatal mortality rate per 1,000 live births |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births |
| NOM 9.4 - Preterm-related mortality rate per 100,000 live births |
| NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy |
| NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females |
| NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth |

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

### Priority Need

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

### SPM

SPM 5 - Adequate Insurance Across the Lifespan

### Objectives

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

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

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

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

### Strategies

Organize with regional community health workers/promotoras, DOH case coordinators, and navigators to coordinate support for families trying to access insurance from the perinatal period through postpartum and inter-conception periods.

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

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

## 2018 Annual Report

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

**Objectives:**

- *Increase the percentage of primary care providers receiving education and support to assess and treat clients with perinatal mental health disorders to 25% of primary care providers within reach of dedicated programs by June 2020*
- *To prevent the onset of Type II diabetes for women with a history of GDM, increase the percentage of women in the University of New Mexico Hospital's Maternal and Family Planning (M&FP) Clinics completing a post-partum visit and appropriate testing to 80% by June 2020.*

**Strategies:**

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

*Objective- Increase the percentage of primary care providers receiving education and support to assess and treat clients with perinatal mental health disorders, to 25% of primary care providers within reach of dedicated programs by June 2020.*

During Fiscal Year 2018, the Maternal Health Program Manager worked with a committee of Human Services Department staff (Behavioral Health Division), Children, Youth and Families Department (CYFD) staff and other stakeholders to address the introduction of a new diagnostic coding system for infants and toddlers with mental health diagnoses. The system, called Diagnostic Coding 0-5 (DC 0-5), is widely accepted among infant mental health professionals as best practice. It directly addresses the social/emotional development milestones integral to infant mental health, while also acknowledging the needs of the infant caregiver (parents, or other) and their ties to the infant's mental health. The CYFD Infant Mental Health Program leads this work with technical assistance from the national Zero to Three organization.

The goals are:

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

Title V involvement is specific to the first goal through the creation of an inventory of network services that are accessible to referring providers and offer expanded maternal therapeutic support and potential substance use services that are beyond the dyadic therapy offered in the existing infant mental health network. Behavioral support services are limited in many parts of the state, so if a health provider needs to refer a family with a qualifying diagnosis, it is challenging to make an appropriate and accessible referral.

To address provider training needs, a new Project Echo is being launched in July 2019 called, 'Child Behavioral Health ECHO Clinic'. This is a joint venture by two health care systems in Albuquerque using Project ECHO to provide virtual trainings for health providers outside the metro area and for those requiring diagnostic or treatment support. The goals of the project are for healthcare professionals to feel confident in diagnosing, treating and/or referring child and adolescent behavioral health disorders in addition to navigating the legal aspects of their healthcare. The ECHO clinic kicked off a symposium held in May 2019. It was attended by 34 clinical providers.

Several pediatric providers expressed a need to facilitate assessment and support for caregivers, especially during the pediatric visit. Future topics in this series will cover assessment of post-partum mental health and how it affects

children. The sessions will provide case-based clinical discussions and brief didactics to support treatment or referral. The goal is to reach 100 healthcare professionals (doctors, advanced practice clinicians, nurses, counselors, home visiting staff, etc.) by May 2020.

*Strategy- Work in a collaborative partnership to address the prevention of Type II Diabetes Mellitus by addressing barriers to postpartum visit completion.*

MHP and MCH Epidemiology staff continued to work with the NMDOH Diabetes Prevention and Control Program (DPCP) and with the staff of an Albuquerque metro maternity/family planning clinic run by the University of New Mexico Hospital (UNMH) to implement a project to address the appropriate assessment and follow-up of women diagnosed with gestational diabetes (GDM) women at the post-partum visit.

This project was submitted to the MCH Workforce Development Center and accepted as a participating project for their 2018 Learning Institute Cohort. Staff from NMDOH MCH and staff from the UNMH Clinic attended the Learning Institute sessions in Chapel Hill, NC in March 2018. Through participation in the Development Center, the NM team was able to create a clear plan, divided into different phases, to move work forward. Phase one includes improving the post-partum visit follow up scheduling and to identify barriers in preventing women from getting the appropriate follow up blood testing. Phase two includes introducing an evidence-based education for managing diabetes risk for women post-GDM resolution following pregnancy. Phase three includes disseminating the education and methods to a wider-net of providers and phase four includes attempting to create incentive-based initiatives to assure sustainability as well as reach this population in clinics and other settings across the state.

One challenge for this program is using data to identify what barriers exist within the healthcare system itself. Some suspected barriers to attending post-partum visits (PPV) may be created by the healthcare system. For example, there is no clinical database that can easily identify a PPV scheduled at a site external to where the prenatal care took place. It has also been impossible, within the same healthcare system, to measure how many PPV's were actually attended. Through the data that we have been able to pull, we identified inconsistency in appropriate glucose lab testing. This is used to evaluate Type 2 diabetes risk post-partum. Other limitations include the inability to achieve buy-in from all practitioners who could affect our intended outcomes.

In January 2019, a member of the MCH Epidemiology program attended the CDC/Harvard MCH Program Evaluation Practicum. Out of this partnership with the students, through guidance from the state program employees, we created an evaluation plan to further refine stakeholders, activities and outcomes of the initiative. We added a step to our proposed intervention in which we will provide GDM education to pregnant clients who had been identified as being at a higher risk for developing gestational diabetes. This change meant that we could provide health education at an earlier point, and not have to wait until the PPV. This helped to further identify courses of action that could be implemented, such as gathering feedback from the population of interest to guarantee a culturally competent diabetes health education curricula as well as the use of electronic devices to deliver the health education and utilize a survey to measure effectiveness. The evaluation plan was finalized in April 2019.

*Objective- Increase prenatal care utilization in the first trimester. (Access to healthcare and adequate insurance)*

New Mexico struggles with insurance coverage and access to care across all populations, which impacts pregnancy timing and intention, access to family planning and prenatal services, and ultimately affects birth outcomes. The prevalence of insured adults in NM changed positively with Affordable Care Act (ACA) expansion. Statistically significant increases in insurance coverage occurred among all adult women (10.5% increase) and among Hispanic adults (11.1%) from 2012 to 2015. The greatest increase by age was for those under 34 years (NM Behavioral Risk Factor Surveillance System: https://nmhealth.org/data/view/report/1932/). Among women of child-bearing age, this trend appears to have leveled off and while uninsured women (18-49 years) dropped from 24% to 12% in 2015, the prevalence was still 12% in 2017 (NM IBIS- BRFSS).

The existing barriers to insurance coverage for women of child-bearing age carry over to prenatal care where lack of pregnancy recognition, distance to care, and health professional shortages all contribute to delayed entry (NM PRAMS). These challenges impact women residing in border counties and in rural/frontier areas of our state disproportionately.

**Border ColIN- Improving first trimester prenatal care utilization in Dona Ana County**

We built on strategic activities defined through the 2015 Title V 5-year needs assessment:

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

has impacted access and how navigation can be implemented;

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

Title V programs partner with health organizations in the US-Mexico border region to identify and respond to barriers in access to healthcare, health insurance coverage, timely prenatal care and linkages between primary and behavioral/mental health care. There are unique challenges associated with border residence, including rural and urban disparities, geographic distances to routine healthcare, and high concentrations of poverty.

During FY18 Title V staff were challenged by staffing turnover and the termination of case management provided to over 300 families through Healthy Start perinatal case management at La Clinica de Familia in Las Cruces (Dona Ana County). Despite these challenges, we continued to design a web-based resource and app to inform women about community resources and insurance options, with variations depending on their personalized needs and questions. Working through the PCI Border CoIIN with CA, TX and AZ, we brought together Dona Ana County stakeholders to go through an intensive quality improvement innovation pilot.

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

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

The 2018 activities included robust stakeholder input with PCI participation and leadership through our partners at La Clinica de Familia Healthy Start. Participants identified the community of Anthony, NM to receive the focus of intervention. Community members and MCH service providers held meetings to discuss barriers to prenatal care. LCDF Healthy Start staff led the project and worked with a website developer to begin the design process for web-based resources to assist women in their navigation of prenatal care entry. The proposed model of intervention was to:

1. Initiate introduction to a web-based application at the clinical encounter where women presented for pregnancy testing (at NMDOH public health clinics);

2. Coordinate follow up with a health promotions/*promotora* based in La Clinica de Familia and offer resources to women wanting support in insurance, payment or help getting to prenatal appointments, and

3. Verify prenatal care entry in LCDF clinics. With a goal of shortening the time between pregnancy testing/confirmation and clinical prenatal care entry to two weeks, we aimed to pilot the impact of offering the web-based resource application and access to a health promotions navigation support person.

**Barriers to implementation**

Several structural barriers presented themselves during the reporting period. First, La Clinica de Familia staff were informed that they would not be eligible for HRSA funding to continue Healthy Start services and that they would need to transition leadership of the CoIIN to another entity. Secondly, NMDOH staff were geographically and organizationally removed from the population targeted for intervention.

Other challenges were observed in the selection of Anthony, NM as the geographic focus of intervention. For example, input from women on their prenatal and delivery experiences indicated that it would be very challenging to track women's entry to care if they received care in TX. Vital Records data confirmed that most Anthony residents left NM to obtain obstetric care and that there was a consumer preference for OB care offered in TX. The Title V and Healthy Start staff did not have capacity to work with TX clinical sites or to follow up with individual women opting for out of state care.

Finally, while states are offered a small contract to implement and evaluate a pilot project, it does not cover the costs required to conduct a robust evaluation of women receiving an intervention compared to those not receiving an intervention. The Title V staff can utilize population level data in Vital Records and PRAMS with birth certificate and survey information, but they do not have the resources required to conduct case control studies or even simulated

data analysis required to evaluated interventions in a small geographic area. Staff transitioned work plans to reflect these barriers and will establish new goals for the FY2020 plans.

**SPM 5 - Adequate Insurance**

Objectives:

- Reduce the infant mortality disparity ratio between Black/African-American and White Infants by 25% by 2019.
- Improve health insurance coverage among NM women of reproductive age by 5% by 2020.
- Complete an economic impact study and community needs assessment of Paid Family Leave in NM by 2020.

Strategies:

- Organize with regional community health workers/promotoras, DOH case coordinators, and navigators to coordinate support for families trying to access insurance from the perinatal period through postpartum and inter-conception periods.
- Leverage participation in the Infant Mortality CoIINs to improve equity in birthing options and in healthcare utilization before during and after pregnancy.
- Coordinate multi-sector, State (DOH, HSD, CYFD) and tribal health entities, including Albuquerque Area Indian Health Board (AAIHB), Tribal Epidemiology Centers, and Medicaid Managed Care tribal liaisons to improve surveillance and health assessments.

*Objective- Improve health insurance coverage among NM women of reproductive age by 5% by 2020.*

**Midwifery and Birth Worker Workforce Development**

Title V staff seek to increase the adequacy and accessibility of timely maternal care by:

1. improving components of the midwifery workforce licensure processes
2. securing reimbursement for midwife services to allow birthing options in out-of-hospital settings, and
3. expanding the quality and breadth of care to perinatal populations with perinatal mood disorders, gestational diabetes/post-partum care, and oral health needs.

The Title V Maternal Health Program licenses and provides support to midwives attending home births, which can be billed for Medicaid reimbursement. This is a way Title V makes birthing options available to lower-income families, and in conjunction with birth-worker retention funds (to cover malpractice insurance), helps assure that women opting for out of hospital deliveries have adequate insurance for maternity care. However, it is challenging for some midwives to sustain a Medicaid clientele because there are routine claim rejections, and MHP staff have actively helped problem solve this by providing training on billing code procedures. To facilitate better practice in Medicaid billing procedures and successful reimbursement, a training was conducted in conjunction with the Annual Conference of the New Mexico Midwives Association (the professional association for LMs in the state) in February 2018. Title V staff continue to support licensed midwives in this area and have worked with Medicaid leaders to request additional training and guidance for midwives.

Sustaining licensed midwifery as a profession in NM by providing continuing education, training, and living wage assessment are important pieces of Title V oversight, health equity and workforce development. MCH Epi staff work to evaluate and promote access to maternity care and birthing options among low-income, rural residing and minority women. NMDOH Title V Staff partner with statewide advocates and clinicians to broaden awareness about birthing options including access to perinatal doula care and home births.

Complementary work continues to broaden the access and professional development of doulas and midwives of color throughout New Mexico. The Birth Companion Project is a program at the University of New Mexico (UNM) to give Medicaid-covered or uninsured women a birth doula at no cost. The establishment of both the Birth Companion project and the NM Doula Association were important developments, and were led by partnering organizations, including Young Women United and UNM Hospital nurses. The NM Doula Association https://www.nmdoula.org/ was established to mitigate health disparities by increasing access to doula support for families, including rural, tribal, and other underserved communities. The aim is to increase racial, social and geographic diversity in the trained doula workforce.

The leadership from the Doula Association started training doulas in 2018 to prepare them for work in the Albuquerque Metro area in the Birth Companion Project and to train doulas throughout the state to address prenatal

substance use and related behavioral or mental health referrals. NMDOH Title V staff reviewed literature and evidence from other states where Medicaid reimbursement for doula services is legislated and started plans to advance economic impact analysis, building on those state examples. To support training curriculum, MCH Epi staff provided PRAMS data on social context, healthcare utilization and preconception substance use.

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

**Needs Assessments and Multi-Sector Alignment**

Title V staff recognize the need for and support the cross-sector collaboration across government agencies, evaluation assessment and monitoring. As described in the Needs Assessment update, New Mexico Title V serves an important connecting role between clinicians, public health programs and academics. Collaborations include the NM Perinatal Collaborative, the Birth Equity Collaborative, NM March of Dimes, Office of the Medical Investigator, and early childhood programs including home visiting, Early Head Start and other state agencies.

The statewide Home Visiting Collaborative, NM Breastfeeding Task Force, and Tribal Epidemiology Centers partner to conduct community-level needs assessments; statewide population-specific assessments around maternal health, postpartum and child health, adolescent health, and children and youth with special needs or developmental risk; and pre-k school readiness. Title V objectives and strategies are coordinated and monitored with data from population surveys, community focus groups, and fatality review panels.

**Maternal Mortality Review and Severe Maternal Morbidity**

The Maternal Mortality review and analysis of maternal morbidity serve to inform both maternal, birth and infant health outcomes and potential strategies to reduce disparities. Throughout FY2018, the Maternal Mortality Review Committee (MMRC) convened to review 2015 deaths to establish a baseline cohort and build case registry capacity. Case review processes were refined during the reporting period, and the core planning group worked to address the complexity of defining preventable deaths.

Because the NM committee reviews all pregnancy-associated deaths up to one year after pregnancy, the nature of death review calls for multi-disciplinary collaboration. Pregnancy-related deaths, categorized by medical causes such as eclampsia, postpartum hemorrhage, or disseminated intravascular coagulation (DIC), are a fraction of the deaths, and the largest number of reviewed deaths are not directly related to medical circumstances but social or behavioral factors (figure 1.). They include motor vehicle accidents, violent deaths, overdose and suicide fatalities. To address the array of mortality causes, MMRC core members reviewed membership for appropriate expertise and discussed up-stream strategy contributors, such as home visiting, doula support and referrals for counseling or mental health treatment. More information on the definitions of pregnancy-related and pregnancy-associated deaths is available at the CDC Review to Action site: https://reviewtoaction.org/learn/definitions

DOH Title V staff attended CDC Maternal Mortality Review Information Application (MMRIA) database user trainings along with UNM committee members in 2017 and 2018, and two abstractors (OB-GYN and Nurse) have completed populating the case records for 2015. Currently, MMRC abstractors use a local version of MMRIA with no data sharing interface with the CDC. The CDC plans a national web-based platform release, and New Mexico plans to join that platform when the IT and confidentiality specifications are released and then approved by the Department of Health.

A maternal mortality bill was introduced in the 2019 legislative session and signed by the Governor to strengthen the confidentiality protections of the Committee's proceedings, specifically protecting committee members from outside legal interference. The bill also institutionalizes and codifies MMRC proceedings so that they will be sustained through state government changes in leadership and resources over the years. A poster and a fact sheet were created to inform stakeholder agencies and legislators of the progress, proceedings and findings of the MMRC following the first year of its launch. These products were presented at the UNM Women's Health Conference in February 2019, and they will be shared with other CDC maternal mortality review states for input.

Beyond immediate cause of death review, the MMRC and recent legislation included plans to review and to provide statistical analysis of severe maternal morbidity (SMM). MCH Epidemiology staff collaborated with UNM and NM Vital Records staff to analyze a linked birth certificate-hospitalization record file to assess the prevalence and patterns of severe maternal morbidity (SMM) in NM. Employing CDC definitions* of SMM we found that 144 per 100,000 hospitalizations for the 2015 birth cohort (n=27,263 singleton births) involved a severe morbidity between

2014-2016, and sharp disparities were observed by maternal race and ethnicity: The prevalence of severe maternal morbidity (n=439) was about twice as high for AI/AN women (2.69%) compared to non-Hispanic white women (1.35%). For Black women (1.86%) compared to non-Hispanic white women the prevalence was 1.37 times higher, and for Hispanic women (1.53%) it was 1.13 times higher. Work to address pathways to preventability for severe morbidity and mortality will require clinical but also non-medical and preconception/ well-woman interventions around risks such as hypertension, diabetes, obesity and stressful life events.*https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/severe-morbidity-ICD.htm

As a first step in quality improvement for maternal health management, the New Mexico Perinatal Collaborative and NMDOH Title V applied to join an Alliance for Innovation in Maternal Health (AIM)- American College of Obstetricians and Gynecologists (ACOG) bundle to prevent postpartum hemorrhage. NMDOH Title V and NM Perinatal Collaborative members at UNM worked together to plan a launch of the bundle by presenting to hospitals and discussing with colleagues throughout the state. NMDOH staff attended AIM state calls and talked about baseline data and process measures to be used with each participating hospital. Staff planned to leverage the Project ECHO telehealth infrastructure to notify providers and solicit participation in the statewide effort. The 'Improving Perinatal Health' ECHO program uses a tele-mentoring framework in which maternal safety bundle components are presented through brief didactic presentations and reinforced through case-based learning that engages the entire network of participants in problem-solving and sharing of place-based clinical expertise. More about this platform and plans to collect process and outcome measures are found in the FY2020 application section of this report.

**Maternal/Infant Title V-Tribal surveillance enhancements**

*State-Tribal health surveillance and assessment collaboration*

Title V plans from the 2015 statewide needs assessment indicated a need to strengthen DOH-Tribal Epidemiology Center partnerships and institutionalize surveillance of maternal-infant health specific to Native American communities. NMDOH MCH Epi and Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC), and Navajo Epidemiology Center (NEC) established a sampling plan with 26 New Mexico Tribes to conduct a parallel, tribe-specific PRAMS surveillance approved by the Institutional Review Board at New Mexico State University in 2017 and starting with 2018 birth data collection. Agreements and data sharing plans were signed with both Tribal Epidemiology Centers and the Department of Health to assure a long-term, collaborative surveillance plan to builds in capacity sharing, resource/cost sharing, and elements of community participatory research.

AASTEC and NMDOH share responsibility for the surveillance, and AASTEC has agreements in place with all participating tribes. Like the CDC-NM state PRAMS, women must agree to participate in the study, and it is voluntary, but it is important to establish approvals and data sharing agreements with tribes, as well. Tribes have authority over all data pertaining to participants from their communities, and tribe-specific data cannot be released without that agreement for any data request. AASTEC and NMDOH epidemiologists will collaborate to establish data validity at regions or tribal aggregations to provide stable data, when approved. Data will be used for program planning and evaluation for tribal WIC programs, home visiting programs, maternal child health and community health councils and health providers serving Native American women and infants.

In November 2018 the two Tribal Epidemiology Centers and Maternal Child Health Epidemiology staff held the first Tribal Maternal Child Health Symposium in New Mexico. AASTEC, NEC and MCH Epi/Title V presented state PRAMS data on Native American women and infants. Almost 200 participants attended from NM tribes, tribal-serving organizations and health organizations, and there are plans to hold a second symposium when Tribal PRAMS data are available to share.

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

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

The Office of Health Equity and Family Health Bureau/Title V staff collaborate to assess the existing and potential applications of health equity principles in the objectives and strategies advanced through Title V Maternal Child Health partnerships. The broad 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 (rural v. urban, US-Mexico border, Tribal boundaries). New Mexico Title V team members approach the multi-factorial nature of healthcare access by addressing heath inequities related to social environment, determinants of health, and socioeconomic disadvantage.

*Strategy- Leverage participation in the Infant Mortality CoIINs to improve equity in birthing options and in*

*healthcare utilization before during and after pregnancy*

**New Mexico Birth Equity Collaborative**

The NM Birth Equity Collaborative (BEC) was established in February 2018 following two years of community meetings and discussions held between Title V/MCH Epidemiology, Young Women United and the UNM Robert Woods Johnson Foundation Center on Health Equity. After conferencing on complex and historically rooted disparities, an opportunity for the Office of American Affairs and the NM March of Dimes to lead the birth equity work led to a solid and committed coalition of partners determined to change the course of poor maternal and infant outcomes for women of color. From 2015-2017 Black infants in NM were twice as likely to die in the first year of life compared to non-Hispanic White infants (10.5 v. 4.7 deaths per 1,000 live births). Using 5-year rolling averages, the infant mortality rate for black babies has not attenuated in any hopeful way since 1999 (NM IBIS). https://ibis.health.state.nm.us/query/result/infmort/InfMort/InfMortRate5Yr.html

Black women are more likely to experience hypertensive disorders and to report dissatisfaction with prenatal care compared to other NM women (NM PRAMS), and they are less likely to attend prenatal care in the first trimester compared to Hispanic and non-Hispanic White women (57.9% v. 62.7, 70.5% respectively) (NM IBIS, 2017 births).

https://ibis.health.state.nm.us/query/result/birth/BirthCntyPNC/PNCTri1.html

Because African American/Black women bear the highest burden of these health challenges, we came to a consensus that the work should focus on that population, and the concept of Centering Black Women was adopted. Indigenous women and other women of color are working to support this focus, bringing a range of community and medical expertise to the effort. The sustainability of the BEC has been facilitated by AMCHP Infant Mortality CoIIN efforts at the national local levels. Because NM was accepted to participate in two communities of practice, one focused on prenatal care utilization and the other on social determinants of health, we were able to leverage support to the BEC in the areas of provider bias training development and seed funding to make the trainings available within the next two years.

Young Women United, University of New Mexico, and partners including Black Health New Mexico, Office of African American Affairs, Tewa Women United, independent doulas, midwives, DOH Office of Health Equity, Medicaid Managed Care Organizations, and the March of Dimes were able to shift from identifying perinatal outcome disparities (low birthweight, preterm birth, late prenatal care) to focus and mobilize community-level clinical improvements through strategic planning. Strategies in 2018 developed around three primary areas:

**Sister Circles and Story Collection**

- The Sister Circles will be held in Santa Fe, hosted by the New Mexico Health Equity Partnership; in Albuquerque, hosted by Esperanza Dodge (Young Women United); and in Hobbs, hosted by Sabrina Curry (DOH). Additional circles may be offered if capacity and interest permit expansion.
- Circles will be held in four one-hour sessions, once a week for four consecutive weeks
- Sister Circle facilitators will be representative of the women participating, and along with the BEC hosts, ensure that those participating can give input and feedback on the process.
- We will offer a new, geographically-specific community resource at each session, i.e.: yoga, stress reduction techniques, community service resources/calendars.

BEC stakeholders received names of interested women by attending the NM Black Expo in June 2018. A short general survey was used to assess if women were interested in sharing their stories and to understand the usefulness of sister circles. The plans to launch sister circles in three regions of the state coincided with a very busy legislative session and new administration and Governor; however, plans to launch provider bias trainings for medical providers and medical students proceeded through NMDOH participation in an infant mortality collaborative improvement and innovation network (CoIIN) facilitated by the Association of Maternal Child Health Programs (AMCHP).

**Provider Bias Trainings**

Through a small funding opportunity with AMCHP, Title V staff, along with the DOH Office of Health Equity, March of Dimes and Black Health NM, set goals to offer trainings on provider bias. The over-arching goal is to improve health provider education in implicit bias and to minimize differential treatment based on perceived race or ethnic identity. Toward this goal, we established a small contract with Black Health and will describe FY20 plans in the application section of this report. The current goals that have been set include completing a timeline and audiences for training; identifying and convening presenters, national and local experts and clinicians in the process of curriculum

development/adoption; and bringing together stakeholders to review existing plans and build consensus for a provider bias training plan in FY19-20.

The March of Dimes hosted a Birth Equity Summit in December 2018 to bring in health workers, clinicians, medical students and public health stakeholders to learn about how implicit bias and coercion can be identified and addressed in the implementation of birth equity principles. This was followed by a web-based training to support medical students and providers in their self-assessment for bias and inclusion of birth equity principles in their respective course of study or profession. The March of Dimes released birth equity principles and a Birth Equity for Moms and Babies Consensus Statement to help health systems and departments of health navigate tools and curricula on birth equity https://www.marchofdimes.org/professionals/Birth-Equity-for-Moms-and-Babies-Consensus-Statement.aspx Additional tools are available and being shared through the Black Mamas Matter Alliance and the National Birth Equity Collaborative.

**Workforce Development**

NM BEC stakeholders identified the cultivation of diverse (women of color, minority, women) students and clinical/community-based birth providers as a long-term goal. Investing in a representative workforce is a component of health equity requiring fiscal and intellectual investment. To operationalize this activity, NMDOH and UNM have established an agreement to offer women of color and young, parenting or disadvantaged students practica and internships in MCH Epidemiology, behavioral health and health promotion through the NMDOH, UNM, the Perinatal Collaborative, the March of Dimes and Tribal Epidemiology Centers.

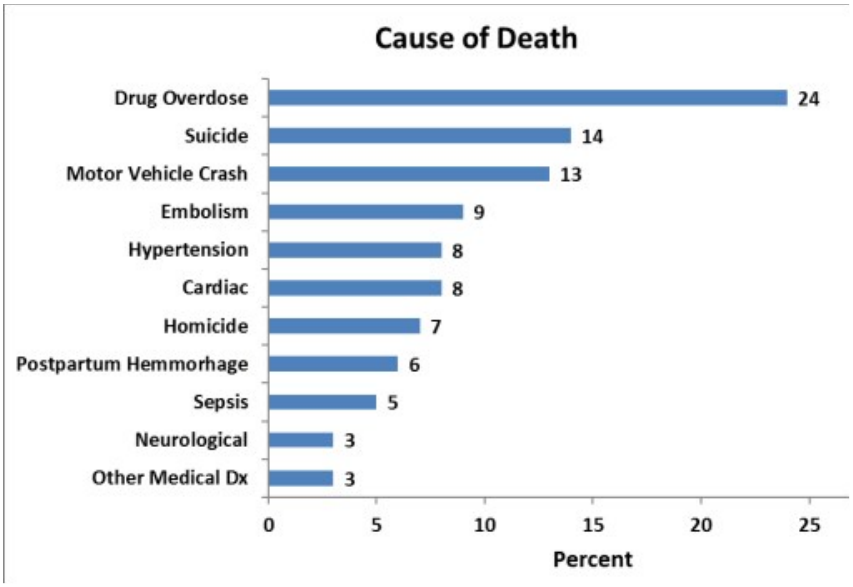
*Objective- Complete an economic impact study and community needs assessment of Paid Family Leave in NM by 2020*

**Infant Mortality CoIIN- Paid Family Leave**

Partnering with the Southwest Women's Law Center, Title V staff and community organizations worked to develop potential policy and practice changes that would advance family-friendly workplace leave policies in New Mexico. Title V staff initially invited presenters from states that had already enacted paid family leave legislation to provide technical information and lessons on economic impact, if known. We convened multi-disciplinary stakeholders to view these webinar presentations and to create a literature repository which can be accessed by the Paid Family Leave policy workgroup, facilitated by the SW Women's Law Center.

The primary NMDOH Title V objective was to support the completion of an economic impact study and community needs assessment related to paid family leave. While economists from the University of New Mexico did complete and deliver an economic impact analysis of implementing paid family leave, NMDOH staff did not receive direct communication in its development, and the report presented to the Paid Family Leave policy workgroup was not well understood nor communicated to state agencies or policy analysts. Ultimately, the bill did not pass because there were changes in leadership of the Paid Leave workgroup and because there was insufficient communication between stakeholder participants and UNM economists. Additionally, it became clear that there was not buy-in from the state agencies identified to manage the fiscal benefits proposed in the legislation. This was a key factor in the failure to pass a bill related to paid family leave. Although members successfully drafted and submitted legislation for paid family leave, it did not pass in 2019. Plans to address this failure and to follow up on community needs assessment are proposed in the 2020 submission of this report.

Figure 1. Causes of Maternal Deaths, 2011-2015, NM MMRC Case Review


Cause of Death
Drug Overdose
Suicide
Motor Vehicle Crash
Embolism
Hypertension
Cardiac
Homicide
Postpartum Hemmorhage
Sepsis
Neurological
Other Medical Dx
24
14
13
9
8
8
7
6
5
3
3
0
5
10
15
20
25
Percent

**Women/Maternal Health - Application Year**

NPM 1 – Percent of Women, ages 18-44, with a preventive medical visit in the past year.

**Objectives:**

- *Increase prenatal care utilization by 10% among women in the targeted impact area(s) (Border Region of the State) through the development of place-based improvement strategies that address the social determinants of health by October 2020*
- *Prevent the onset of the Type II diabetes for women with a history of Gestational Diabetes (GDM). Increase the percentage of women in UNM hospital's Maternal and Family Planning (MFP) clinics completing a postpartum visit and appropriate testing to 80% by June 2019*
- *Percentage of primary care providers who receive education and support for assessing and treating clients with mental health disorders. By June 2020, 25% of primary care providers within the reach of the dedicated programs receive education*

**Strategies**

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

*Objective - Increase early (first-trimester) prenatal care utilization by 10% among targeted impact Areas (US/Mexico Border)*

Title V staff will participate in the Infant Mortality Collaboration Improvement and Innovation Network (IM CoIIN), a network of US- Mexico border states working to improve prenatal care entry in the first trimester. The project went through major staffing and leadership changes, so the FY20 plan is framed to work through important scope of work negotiations and transition to new leadership.

As described in the FY18 Report, the project lead organization, La Clinica de Familia (LCDF), a federally qualified health center (FQHC) administering Healthy Start perinatal case management for over 20 years was not eligible for the new cycle of HRSA funding, and LCDF staff referred families to home visiting and early intervention programs in the vicinity. Title V staff are housed over four hours driving distance from the target population residing in rural areas, and they are working on plans to transition the work begun in the Healthy Start population to a broader consumer target. Geography and interaction with initial stakeholders pose significant challenges to continue work, in part, because the longstanding MCH coalition was led by Healthy Start and has not resumed work since the Healthy Start programming terminated in 2019. Unfortunately, women in these communities still need support in their access and utilization of timely prenatal care. NM Vital Records data indicate that 56.4% of women residing in the communities of Anthony, Berino or Chaparral (small rural *colonias*) had prenatal care within the first trimester (2012-2016 births). This compares to 59.8% of all women in Dona Ana County, and 63.9% in NM. Excluding women delivering a very low birthweight baby (<1500 grams), just 48.7% of those with a low birthweight infant (1500-2499 grams) had prenatal care in the first trimester (NMVR, NM-IBIS). NM PRAMS data point to two primary barriers to timely care in Dona Ana County, the first being recognition of pregnancy and the second, trouble getting prenatal appointments when needed.

To address the need for better and more timely care, Title V staff and Project Concern International (PCI) will work together to assure a transition from Healthy Start- La Clinica de Familia staff to leadership by the University of New Mexico Health Extension Rural Officer (HERO) in Las Cruces and rural communities of Anthony, Berino, Chaparral, including trans-border and floating populations.

Timeline

July- Sept 2019: Start work with the UNM HERO office and re-establish a team charter with revised process and outcome measures.

Continue development on the web-based resource application and determine if the scope of work with WeAREIT developers should be expanded, shortened or modified.

Oct-Dec 2019: Utilize the existing prenatal resource application storyboard to review triage and referral algorithms, pilot the app with convenience sampled women or those at a clinic site selected to participate (pending agreements and potential IRB application). Make final decisions on universal, site-based, or combination app tracking. Personal identifiers will not be collected in the web-based platform, however if women want to be contacted by health promotions staff, they will be given various options for email, telephone or in-person contact.

Jan-Mar 2020: Go live in determined population (clinic-based, universal, or both) to share web-based application and work with NMDOH clinics to link data from clients with positive pregnancy confirmation to track those women in Vital Records or clinic-based data records with approved DUA documents. If only public application use and no site-based tracking, then our efforts will center around media exposure and evaluation. IP addresses can be used to track geographic reach and saturation.

After piloting the web-based application, the next steps are to measure the use of the app and assess change in first-trimester prenatal care rates compared to baseline (2017) in county-wide, rural only, and small-area designations. Assessing change rates with adjustment for maternal population characteristics in Vital Records and PRAMS is the primary evaluation tool.

For additional evaluation we will obtain unidentified data responses on the type of services women seek and the challenges they report with clinical care or insurance coverage. While we do not propose to collect individually-identifiable data, we can ask women to state general characteristics such as residential zip code, where they normally obtain reproductive healthcare (by clinic and provider type), what type of insurance they carry, and their ethnicity and age group categories. These indicators will complement the population-level data and any site-specific data collected.

Findings from all data sources will be shared with community members (including original clinical and family stakeholders) to obtain qualitative feedback and strategic planning based on the results. The final phase of the project will be to contribute to health provider and community health worker/*promotora* trainings to improve timely prenatal care.

*Strategy- Work in a collaborative partnership to address the prevention of Type II diabetes by addressing barriers to postpartum visit completion*

Members of the “GDM Project” with the NMDOH Diabetes Control and Prevention Program and the UNM Maternity and Family Planning Clinic(s) and Title V staff have specific roles in four different work teams – Consumer Feedback, Data and Evaluation, Educational Materials and Post-Partum Visit (PPV) Scheduling. Project members are full-time employees in their respective professional settings and devote in-kind hours to this project. For FY20, work will continue in the two phases of this project:

Phase I: Improve the scheduling, completion and appropriate testing for women with GDM history at their postpartum visit

Phase II: Introduce an evidence-based, tailored counseling and education approach for managing diabetes risk for women with history of gestational diabetes that starts at their postpartum visit

The plans for data management and tracking include establishing a baseline PPV completion rate and rates of appropriate lab testing to establish how assessing post-partum diabetes risk poses issues with variability in definitions and provider practices. Phase I: The Data and Evaluation workgroup, led by the Title V Epidemiologist, will work together to collect baseline data to track during stages of implementation. They will utilize the GDM evaluation plan to guide and monitor activities especially in the area of the project addressing education and counseling to clients awaiting GDM-related testing.

The Education team is gathering GDM patient literature and planning the creation of two videos- one to teach clients on gestational diabetes, and one to orient clients (in a “warm handoff” approach) to the specialty clinic that follows these clients in the latter part of the pregnancy for their GDM care.

The PPV team is working with administrators of the UNM Hospital and Clinic electronic scheduling systems to introduce reminder steps to providers in the post-partum scheduling process. They also plan to build in a reminder

step for patients to reinforce attendance at the visit.

The Consumer Feedback workgroup is actively seeking extra resources to engage with for expert guidance on how to vet the educational materials with consumer groups.

Based on challenges presented over the FY18 reporting period, we are taking the following steps to make the workgroup more productive and efficient. Exploring staffing or student intern support, developing process measures and implementation strategies, identifying a biostatistician at UNM to pull the data required to establish baseline estimates, and considering external strategic planning facilitation through a small direct purchase contract or in-kind staffing over the next two years.

*Objective - Primary care providers receive education and support for assessing and treating clients with mental health disorders*

Strategy: Work through the Perinatal Mental Health Collaborative and partnering agencies to assess behavioral health needs and explore adequate treatment options, for maternal/pregnant populations.

The Perinatal Mental Health Collaborative is currently on hold due to spent funding and the lead faculty at the University of New Mexico (UNM) School of Nursing will desist continued work until funding is available. This effort is described in the FY18 TVBG Annual Report. The MHP manager was invited to join a committee to addressing improvements to infant mental health (IMH) services. However, we will continue to develop capacity among primary health providers to support families in infant mental health screening and treatment or referrals. The vehicle for this work is the Project ECHO series on Child Behavioral Health launching in July 2019. The Maternal Health manager has received commitment from the organizers that pregnant/postpartum mental health topics will be included in the series, and she is supporting the inventory of available referral and treatment services in rural parts of the state. The partnering agencies recognize that mothers as caregivers are integral to an infant's care and social-emotional development, and they are key family members who would benefit from the infant's health care providers' recognizing, assessing and referring the mother for behavioral health services.

In the committee to address improvements in Infant Mental Health services, some activities planned in the "Prevention" sub-workgroup (the MHP Manager is a member) are:

1. Develop a framework for social-emotional training
2. Distinguish between screening and assessment and identify client groups for each step
3. Determine provider groups by priority that would benefit from training

**SPM 5. Adequate Insurance Across the Lifespan**

**Objectives:**

- *Reduce the infant mortality disparity ratio between Black/African American and White infants by 5% in 2019*
- *Improve health insurance coverage among NM women of reproductive age by 5% by 2020*
- *Increase prenatal care utilization in the first trimester (and by adequacy of care index) by 5% by 2020*
- *Complete an economic impact study and community needs assessment of Paid Family Leave in NM by 2020*

*Objective - Improve health insurance coverage among NM women of reproductive age*

*Strategy:* Organize with regional community health workers/promotoras, DOH case coordinators and navigators to coordinate support for families

*Increasing birth equity through birthing options*

New Mexico Title V provides the safety net and inter-agency networks to support broad and equitable access to midwifery care, inter-conception support and insurance options. In addition to leading the policy development and innovations in care, the Maternal Health Program reviews and revises internal procedures to streamline

administrative oversight and support to practicing midwives.

With new Managed Care Organization (MCO) contracts enacted in January 2019, there will be renewed effort to facilitate discussions MCO staff on midwifery practice, birth setting options and improving efficiency in midwife care Medicaid reimbursements. The MHP manager plans to invite a representative from each of the 3 MCOs to the September 2019 Midwifery Board meetings (each midwife group – CNM and LM – have their own quarterly Board meetings) to introduce these organizations to the above topics, and to trouble shoot with the representatives on common reimbursement obstacles. Emphasis at the meeting with the MCOs will be placed on the principles of the Birthing Options Plan, and how to integrate the administrative and claims reimbursement processes at each of the MCOs. A staff member of the NM Human Services Department/Medicaid Division will also be invited as a partner in the effort to improve claims reimbursement for midwifery and out-of-hospital birthing services.

In the 2019 NM legislative session, House Bill 226 was passed and signed by the incoming Governor to amend a section of the NM Drug, Device and Cosmetic Act (Section 26-1-2 NMSA 1978) recognizing "registered lay midwives" as "practitioners to procure, carry and administer drugs that are subject to the same Act. This change was needed to secure the acquisition and use of needed emergency medications by LMs in the home birth setting. This bill enactment will open the LM Rules again for revisions to incorporate the above change. One activity in this area includes a LM Practice Rule review of other needed changes to the rule, which has not been revised since 2001. It is expected this process of rule revision, legal review, hearing for rule changes and promulgation of the revised rule will take a year (2019-2020). These changes help make home birth more accessible to women across the state and more sustainable for the practicing midwives.

We will continue to support a continuum of birthing and perinatal care options for New Mexico women. While NM has a high degree of midwifery integration, the available support for women before during and after birth is not well understood across different delivery systems and modes of care. Promoting traditional, community-based practice is far different than having certified nurse midwife attended births, and Title V assessment gives NM an opportunity to explore models of care.

**Reduce the infant mortality disparity ratio between Black/African American and White infants**

**Strategy-area:** Leverage participation in Infant Mortality CoIINs to improve equity in birthing options and in healthcare utilization before, during and after pregnancy

New Mexico, like other jurisdictions throughout the United States experiences huge disparities in maternal and infant outcomes by race and ethnicity. Because maternal mortality data is not easily reportable for sub-populations, we use infant mortality disparities to measure our progress on maternal and infant outcomes. Nationally, and in NM, we are engaged in conversations about the quality of perinatal care, and how that quality and perception of quality differs across women of varying access to and utilization of care. The Listening to Mothers Survey provides some insight to women's experiences and helps us steer efforts to improve care for all women, but especially for women of color. The third national survey conducted in 2013 provides some insight to help guide some New Mexico maternity support activities. Thirty percent (30%) of surveyed women (n=1072) reported that they had did not ask their providers questions because the provider seem rushed, 22% said it was because their expectation of maternity care differed from the provider's, and 23% held back because they did not want to be perceived as difficult by the provider (Listening to Mothers, III: Pregnancy and Birth (2013).

**Implicit Provider Bias and Health Provider Training**

Through the Birth Equity Collaborative and Social Determinants of Health CoIIN, Title V staff will continue to refine the strategies to advance curriculum development and training materials for New Mexico health providers in FY20. Building on the existing knowledge and body of literature on centering Black/African-American women and other women of color in the United States, we will establish strategic activities. Process measures are already drafted to define the scope of provider training, geographically and by discipline. The FY20 work will focus on implementation and delivery of trainings, pre and post training assessments and institutionalizing the curriculum with university schools of medicine. We will also work with our doula, midwifery, health promotions/*promotores de salud* and traditional birthing partners to expand training of community health workers (CHW), new doulas and lactation specialists and to institutionalize curricula with the NM Department of Health for CHW certification.

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

**Maternal Mortality Review**

The MHP manager is the coordinator for the state's Maternal Mortality Review Committee (MMRC) which relaunched in spring 2018. The MMRC is now completing the review on 2016 mortality cases and will start 2017 case reviews at the August 2019 quarterly meeting. Recommendations are gathered from the ongoing reviews and will be finalized in late 2019 to formally present to the New Mexico Perinatal Collaborative (NMPC) at its October 2019 Annual Meeting. Recommendations will also be shared with NM legislators in the January 2020 session.

New Mexico applied for MMRC funding under the CDC -RFA-DP 19-1908 grant, "Preventing Maternal Death: Supporting Maternal Mortality Review Committees" in early May. Award announcements are due in August 2019. One of the objectives specified in the application is to create a vehicle for sharing MMRC findings and recommendations with consumer groups representing families, communities and birth advocacy/equity voices. The MMRC is seeking membership on the committee of 3-5 professionals representing, or with subject matter expertise, in the areas of social work, mental health, birth justice and equity, family and parenting services (i.e. home visiting), substance use/addiction services, and behavioral health. These members will be recruited and vetted for the MMRC by early 2020.

With CDC funding pending, the following activities were outlined for FY20:

*Strategies and Activities for Year 1:*

Identify deaths to women that occur during pregnancy or within a year of the end of pregnancy on a routine basis no later than 1 year from the date of death; Abstract and enter information about all maternal deaths into the CDC Maternal Mortality Review Application (MMRIA) in preparation for NM MMRC review and no later than 2 years from date of death

Review all pregnancy-associated maternal deaths within 2 years of date of death; Document NM MMRC decisions in MMRIA consistent with CDC;

Analyze multi-year data to provide information on burden, causes, distribution of deaths by age, race, rurality and opportunities for prevention; Prioritize recommendations based on analyses of MMRIA data;

Disseminate information from analyses to internal and external audiences at least once per year; Leverage collaborative partnerships to inform practice and policy changes.

**Severe Maternal Morbidity and the AIM Postpartum Hemorrhage Bundle Initiative**

The Aim Postpartum Hemorrhage Initiative launched in April 2019. Plans for FY20 will address:

- Improved readiness to respond to OB hemorrhage, improved recognition of patients at risk for OB hemorrhage
- Identification and implementation of prevention strategies, improved reporting of outcomes and sustained system changes.

These areas will be covered from April – November 2019 in bi-weekly Project ECHO sessions in didactic presentations and case review. The latter will be presented by staff at participating hospitals (currently 8 have enrolled). The data collection arm of the AIM Initiative will be expanded as more hospitals enroll and get set up for reporting on structure, process and outcome measures to the AIM Dashboard. Outcome data will also be obtained from NM HIDD or Hospital Inpatient Discharge data. The goal is to have approximately 50% of the 30 NM birthing hospitals enrolled by December 2019. In FY20 the Opioid Use Disorder (OUD) Bundle will be introduced and the same facility-level reporting and baseline data procedures will be used as in the OB Hemorrhage Safety Bundle, however the OUD bundle requires more pediatric support and breastfeeding interventions, so the team composition and additional process measures will shift according to the specific requirements of that safety bundle. New Mexico has developed comprehensive support for families struggling with drug addiction and neonatal withdrawals, and two facilities (one in Santa Fe and one in Socorro).

<u>State-Tribal health surveillance and assessment collaboration</u>

The Tribal PRAMS survey (starting in 2018) and the state PRAMS surveillance have been the primary vehicle of maternal-infant assessment collaboration between Title V MCH Epidemiology and the Tribal Epidemiology Centers (Albuquerque Area and Navajo Area). NM PRAMS provides the infrastructure for input from and feedback in planning with tribes and serves as a platform for needs assessment on multiple levels across the state. The activities for FY20 build on that surveillance but also expand beyond the survey. They are divided into three main areas:

*Decolonizing data-*

Decolonizing data is a concept shared with national scholars at the Urban Indian Institute, the Black Mamas Matter Alliance and academics at partnering NM institutions. The process of decolonizing data acknowledges injustice, social justice, and historical structural challenges for women of color. Burdens on birth and maternal outcomes are placed in theoretical frameworks (e.g. black womanism, feminism) and explicitly utilize equity to describe and present health findings which also describe the conditions which created disparity: structural racism, history of injustice. Decolonization also invokes an asset-based and resiliency response to the unjust experiences of women of color.

Title V and TECs, working in concert with the NM Birth Equity Collaborative, Black Health NM and the LANL Pueblo Outreach Project have identified the following objectives for FY20-FY24:

1. In consultation with tribal community members and Black Health NM, identify at least three measures of resiliency not currently measured in PRAMS or the NM Toddler Survey, which may bear on maternal or infant health outcomes
2. Fund and conduct asset-based and lived experience research with community-based, participatory and community led research
3. Invest in the adoption of or development toward health equity assessment tools to evaluate intended and unintended impact of health- related interventions

*Cross-jurisdiction prevention of severe maternal morbidity among AI/AN and Black women -*

With the leadership of the Navajo Nation Epidemiology Center, State Title V programs in NM, AZ and UT and clinical partners, we will meet quarterly to review broad categories of severe maternal morbidity (SMM) experienced by Native American women. Based on this review, and with annual birth-hospitalization data linkage, the participants will draft recommendations to prevent severe morbidity experiences. This group will report summary findings to the NM Birth Equity Collaborative and conduct a parallel review of SMM experienced by African-American women. Findings will ultimately inform provider bias trainings and medical professional curriculum development.

*Measures of discrimination and implicit bias in healthcare -*

While the national IM social determinants of health (SDOH) CoIIN is structured to address trainings aiming to reduce implicit bias and discriminatory healthcare practice, the objective here is to develop or adopt measures to understand the actual experiences of women when they are seeking or receiving healthcare. We seek to implement survey questions in BRFSS, PRAMS and Tribal PRAMS, which can adequately provide baseline information on how well women are respected and treated in their well-woman care, their prenatal and postpartum/inter-conception care. Previous measures have been piloted without success in these NM datasets, and while the performance of some questions can lead us to develop improved questions, we will start with community-based conversations and key informant interviews to more appropriately develop the best ways to ask women about their experiences.

All three areas of work depend on the development of a representative workforce and research team(s) for implementation. To that end, Title V-MCH Epidemiology is rolling out a practicum program with the University of New Mexico to bring in undergraduate and graduate-level minority and young parenting students for 3-month and 6-month internship opportunities at the NM DOH and partnering organizations. Priority is given to students native to New Mexico, and they may be matched with CDC public health fellows or other program interns coming from outside New Mexico. In the first year of the MCH Epidemiology practicum program we will work with students to identify projects and opportunities to support Title V needs assessment and infant mortality collaboratives.

*Objective- Increase prenatal care utilization in the first trimester and by adequacy*

We addressed this objective in the prenatal care/Border CoIIN and will defer replication or amplification of statewide plans until we complete the 2020 statewide needs assessment.

*Objective- Complete an economic impact study and community needs assessment of Paid Family Leave*

The objective to complete an economic impact study was met during the FY18 reporting period, however the community needs assessment will be the focus for FY20. The lead organization, Southwest Women's Law Center, established a group of stakeholders to design messaging and education for people and businesses to understand what paid family leave would do or not do. The activities for FY20 are to inform the NM legislature with a summary of:

Evaluation of maternal and infant outcomes associated with paid and unpaid work leave.

Opinions shared by small and large business owners

Examples of cost savings related to paid family leave from other states

Evaluation

Title V staff will provide PRAMS analysis of women's experiences who work during pregnancy and whether they have paid, unpaid or no leave at all. Outcomes may include breastfeeding, maternal depression, food security and access to health insurance. Title V and UNM Health Science Center staff will collaborate to provide at least one internship with a UNM MPH student to analyze and present findings to the Paid Family Leave Coalition.

Opinions of business owners

Working with Family Friendly NM, the Paid Leave Coalition and chambers of commerce, we will survey businesses about their fears or concerns about paid family leave. The work group will develop talking points and media to explain how family leave works and how employees pay into their benefit fund and what allows them to draw down on the benefit.

Examples of cost savings

Title V staff will re-start their meta-analysis and resource sharing of literature and evidence from states where paid family leaves legislation was enacted. Beside cost-benefits at the population level, other state examples provide feasibility and logistics studies to learn what will work best for New Mexico.

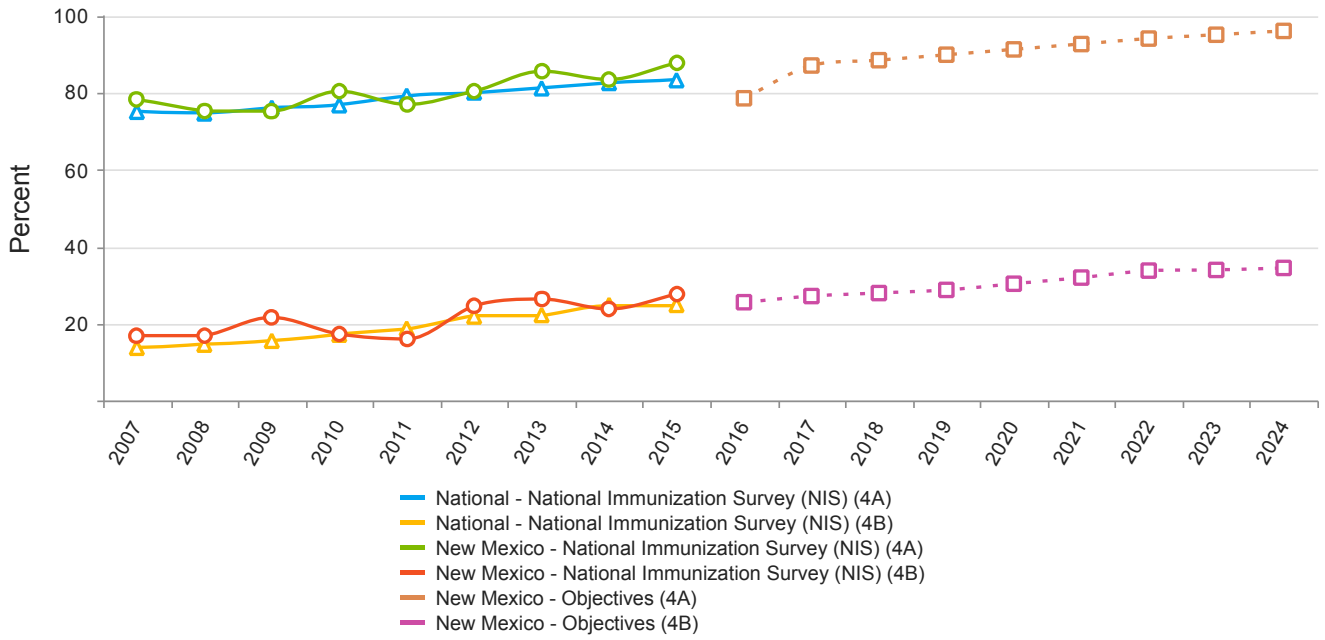
**Perinatal/Infant Health**

**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 9.1 - Infant mortality rate per 1,000 live births | NVSS-2016 | 6.2 | NPM 4 |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births | NVSS-2016 | 1.8 | NPM 4 |
| NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births | NVSS-2016 | 68.8 | NPM 4 |

## National Performance Measures

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




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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | 78.5 | 87 | 88.4 |
| Annual Indicator | 85.5 | 83.2 | 87.7 |
| Numerator | 21,270 | 20,438 | 21,834 |
| Denominator | 24,890 | 24,563 | 24,910 |
| Data Source | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 |

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | 78.5 | 87 | 88.4 |
| Annual Indicator | 91.1 | 88.9 | 89.2 |
| Numerator | 20,885 | 19,734 | 18,951 |
| Denominator | 22,926 | 22,196 | 21,242 |
| Data Source | NM PRAMS | NM PRAMS | NM PRAMS |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 89.8 | 91.2 | 92.6 | 94.0 | 95.0 | 96.0 |

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | 25.6 | 27.2 | 28 |
| Annual Indicator | 26.6 | 24.0 | 27.6 |
| Numerator | 6,319 | 5,708 | 6,648 |
| Denominator | 23,784 | 23,807 | 24,076 |
| Data Source | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 28.8 | 30.4 | 32.0 | 33.8 | 34.0 | 34.5 |

**Evidence-Based or –Informed Strategy Measures**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | 29 | 30 |
| Annual Indicator | 27.2 | 28.2 | 27 |
| Numerator | 5,679 | 5,574 | 4,924 |
| Denominator | 20,855 | 19,734 | 18,240 |
| Data Source | NM PRAMS | NM PRAMS | NM PRAMS |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 31.3 | 33.0 | 35.0 | 37.0 | 39.0 | 35.0 |

**State Performance Measures**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | 80.3 | 80.9 |
| Annual Indicator | 75.4 | 78 | 79.2 |
| Numerator | 17,707 | 17,558 | 16,845 |
| Denominator | 23,487 | 22,517 | 21,271 |
| Data Source | NM PRAMS | NM PRAMS | NM PRAMS |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 81.5 | 83.1 | 85.7 | 86.5 | 87.2 | 87.2 |

**State Outcome Measures**

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 82.0 | 84.0 | 86.0 | 88.0 | 90.0 | 91.0 |

**State Action Plan Table**

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

## Priority Need

To maintain and increase breastfeeding initiation and duration

## NPM

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

## Objectives

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

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

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

## Strategies

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

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

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

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

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

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

| NOMs |
| --- |
| NOM 9.1 - Infant mortality rate per 1,000 live births |
| NOM 9.3 - Post neonatal mortality rate per 1,000 live births |
| NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births |

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

### Priority Need

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

### SPM

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

### Objectives

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

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

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

### Strategies

Create an incentive program to award hospitals with Safe Sleep certification

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

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

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

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

### Priority Need

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

### SOM

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

### Objectives

Increase crib or bassinet sleeping environments for infants

### Strategies

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

## 2018 Annual Report

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

**Objectives:**

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

**Strategies**

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

**Safe Sleep/ Sudden Unexpected Infant Death - SUID Prevention**

*Background* **-** *Definitions and program activities informing the current report*

Sudden Unexpected Infant Death (SUID) includes deaths of infants which are either unexplained after thorough case investigation (i.e. SIDS ICD-10 R95, Unknown ICD-10 R99) or explained by Accidental Suffocation or Strangulation in Bed (ICD-10, W-75). All cases are reviewed in field investigation and autopsy to assess sleep environment-related risks and prevention factors. New Mexico joined the Centers for Disease Control and Prevention (CDC) Sudden Unexpected Infant Death (SUID) Registry in 2009, and in 2011 the NMDOH Office of Injury Prevention and MCH Epidemiology began formally planning and implementing safe sleep prevention plans. Since 2011 SUID rates initially decreased slightly in 2012-2013 but resumed to about 1 death per 1,000 live births through 2017. Rates are about twice as high among male infants compared to female. By ethnicity, rates are 2.3 per 1,000 for Black/African American infants, 1.0 per 1,000 among Native American infants and .8 per 1,000 among non-Hispanic white babies (NM-IBIS, 2009-2017).

To address disparate outcomes requiring complex interventions, and to provide education to health and home visiting providers, we offered webinar trainings for perinatal case management, midwifery, and WIC nutrition programs starting in 2012. These trainings informed initial strategies to work with perinatal clinicians and hospital staff responsible for policy development and regulations at clinical or facility settings. We developed those trainings in collaboration with Dr. Michael Goodstein, a nationally recognized neonatologist and board member of Cribs for Kids, who we later contracted to train New Mexico hospital staff in safe sleep hospital policy and procedure development (Oct. 2014).

We initiated a 2012 NMDOH web-page devoted entirely to safe sleep resources and trainings with links to National Institute of Child Health and Human Development (NICHD) https://safetosleep.nichd.nih.gov/ and American Academy of Pediatrics (AAP) safe sleep information https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-child-care/Pages/Safe-Sleep.aspx. We developed a state-specific brochure with Injury Prevention staff contact information for local safe sleep education support and to connect parents or health providers with education and referral resources. We offered ongoing webinars and in-person trainings for community health workers and *promotoras* with Doña Ana County, tribes, Indian Health Service pediatric health promotions, and for nonprofits offering home visiting services, Head Start, Early Head Start, and Families FIRST perinatal case management staff, as well as providing direct training to parents and grandparents.

From 2014-2016 FHB MCH Epi program partnered with the NM Children Youth and Families Department (CYFD) Home Visiting Program (MIECHV) to make cribs and safe sleep training materials available to home visiting clients,

statewide. However, changes in leadership and in early childhood priorities altered the focus of the collaboration. We met in early 2017 to discuss culturally resonant ways to improve the promotion of breastfeeding and safe sleep in an integrated way. NMDOH WIC program staff also modeled safe sleep education through the CDC Breastfeeding Peer Counselor program to integrate both (breastfeeding and sleep environment) AAP recommendations. This peer support model is being explored as a home visiting and perinatal case management approach in a pilot program through Durham Family Connects (Welcome Baby Program). Family Connects is a universal (not income or risk-targeted) community-wide nurse home visiting program for parents of newborns, and it bridges the gap between newborn-parent needs and community resources right after delivery. NM DOH Public Health Division is piloting the program in one area of Albuquerque, using the evidence-based Durham model and funded by private foundation funding. The MCH Epi program is providing evaluation support to the project.

**Safe Sleep Products**

Home Visiting program staff in CYFD researched safe sleep products in 2017-2018 and determined that the most versatile product would be the Munchkin BRICA travel bassinet https://www.munchkin.com/fold-n-go-travel-bassinet.html. Travel bassinets or baby boxes, and co-sleepers/ in-bed sleepers, are portable and may be easier to manage for mobile or homeless families, and they can also be used for camping. Alternatives are presented to families who do not have access to or cannot afford to purchase any of these products. Plastic tubs, clothing drawers, laundry baskets and other no-cost or low-cost sleep surfaces are promoted in situations where families need something fast or unexpectedly.

Many Mothers, a volunteer-staffed case management program serving families in Santa Fe and Rio Arriba Counties, provides prenatal and postpartum support to pregnant women, stay-at-home fathers, and families with a new baby six months or younger. The program started offering Baby Boxes or Travel Bassinets to promote safe sleep with clients beginning in 2018. Many Mothers also partners with Tewa Women United Doula Program in Española to provide baby boxes to families prenatally or at delivery. The doula program's experience with Baby Box products has been positive among Latino and Native American families, and doula staff also encourage clients to view short video trainings to obtain more information and resources on safe sleep. However, there have been no evaluation plans among partnering organizations to assess the use of baby boxes or bassinets, and that is a gap in the program activities which will be addressed in the NM Safe Sleep Statewide Strategy Plan.

Some communities continue to decline distribution of the boxes, since they may seem uncomfortable for sleep or culturally inappropriate, as with the Navajo Nation service area or Navajo Area Indian Health Service (IHS) families. Prenatally, and at delivery, families receive safe sleep and breastfeeding education/promotion in the Navajo IHS service area, but they are not offered a specific sleeping product. Families are encouraged to place their infants on firm mattresses in a supine position, and this is aligned with cradle boarding and cultural practices. Breastfeeding is strongly encouraged by health promotion and lactation staff in IHS hospitals, which were also the first facilities in New Mexico to achieve Baby-Friendly Hospital Initiative (BFHI) breastfeeding designation.

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

NMDOH Office of Injury Prevention (OIP) and MCH Epidemiology collaborated to expand a scope of work for hospital safe sleep education and continue the work through a contract with the UNM Prevention Research Center. Theresa Cruz, PhD, is the Project Director who initiated trainings with University of New Mexico delivery and nursing staff in 2017. The contract was expanded to include two facilities by the end of 2019. Based on the projected timeline for hospital training, this would double to at least six birthing facilities in 2020. It may not be possible to reach the objective of 15 hospitals, as originally proposed; however, we are exploring implementation of a hospital safe sleep incentive program through the NM Pediatric Society and NM March of Dimes. The program would be modeled similarly to the Baby-Friendly Hospital initiative and plans for 2020 describe this pilot effort.

To address the need for coordinated efforts to increase safe sleep education, Title V staff completed a statewide, multi-sector Safe Sleep Strategic Plan. Evaluator Nicholas Sharp drafted the strategy, which will continue to be refined and vetted in 2019. The NM Children's Cabinet was re-established and will be consulted for support in the implementation of the statewide plan.

*Objective- Transition at least five (5) NM birthing facilities to report standardized statistics for Shaken Baby Education to the NMDOH in 2019*

The legislation for Shaken Baby Syndrome (SBS) was enacted during the report year, and it mandated that every birthing facility in New Mexico educate families about SBS prevention before discharge. The law was based on strong evidence from a nationally researched model, locally replicated at the University of New Mexico. The 2018

SBS education law requires DOH-approved education for staff and families delivering at every birthing facility, but the rules providing guidance and appropriate curriculum have not yet been approved or published in administrative code. Therefore, no data have been collected from hospitals on their SBS prevention education statistics.

While Family Health Bureau (FHB)/Title V staff are eager to advance the education and support evaluation of hospital compliance, we will not be allowed to collect data from facilities until rules from the Department of Health are promulgated. We are working with the Office of Policy and Performance to obtain updates on the status of that legislation for future submission with partners at the March of Dimes and the University of New Mexico. Evaluation design will be contingent upon the specific rules and requirements written and delivered to birthing hospitals. It is not clear whether Title MCH staff or Office of Injury Prevention staff will be required to perform an evaluation, but it is goal to provide impact evaluation for the education provided to families at delivery.

FHB/Title V staff analyzed a 2018 bill introduced on safe sleep education which closely resembles the current SBS education law; however, the safe sleep bill did not pass in 2019. If the bill is submitted again for the next legislative session, we will recommend that the Governor and the NM Children's Cabinet be consulted on the proposed legislation and that it be tied to the SBS prevention education already conducted at the same birthing facilities (both hospitals and birthing centers).

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

NMDOH OIP Health Educator, John McPhee developed a Train-the-Trainer education model for safe sleep and general home safety for families interacting with Child Protective Services, starting in 2017. The trainings were incorporated into workshops statewide, resulting in the training of approximately 600 staff members. CPS used electronic web-based trainings to continue safe sleep education for all staff throughout 2018, with approximately 600 additional staff trained in safe sleep, shaken baby prevention and safe home trainings via e-learning modules. NMDOH MCH Health Educator, Sabrina Curry, supports early childhood screening and safe sleep education efforts through home visiting, Early Head Start, and case management staff trainings. Ms. Curry and Mr. McPhee (OIP) have joined efforts to provide safe sleep and shaken baby syndrome trainings to CPS and perinatal case management staff throughout the state.

The panel for the NM Sudden Unexpected Infant Deaths (SUIDS) Registry is managed by the NM Office of the Medical Investigator. The panel is active and included ongoing representation from OIP and NMDOH throughout 2018. Dr. Lori Proe, Office of the Medical Investigator (OMI) pathologist, led the death review panel with participation from lead field investigator, Rebecca Tarin. The team was rounded out by NMDOH staff to develop recommendations for the annual child fatality review. Christina Brigance, the Title V MCH Epidemiologist, participates in the SUID panel and has contributed to the recommendations for policy or program applications. She and John McPhee provide guidance to the development of program practice and prevention messaging in the Family Health Bureau.

The SUID panel drafted their 2018 prevention recommendations based on death review findings. Title V staff and OIP staff worked together to align Title V strategies and objectives with the findings applied to the recommendations. They are also incorporated into the Safe Sleep Strategic Plan. Primary areas of recommendation are found here:

1. Ongoing and expanded safe sleep education for parents and caretakers.
    a. Legislation should require birth hospitals to provide one-on-one instruction on safe sleep to all birth, foster, and adoptive parents prior to a newborn's discharge from the hospital.
    b. Birth hospitals, Ob-Gyn providers and pediatricians should be linked with state, county, or community resources that can provide free "baby boxes" bassinets, cribs, or other safe sleep surfaces when needed *prior to the newborn going home*.
2. Increased statewide participation in home visiting programs.
    a. Ob-Gyn providers, birth hospitals, and pediatricians should be the first points of contact for referrals to home visiting services.
3. Improved/expanded ability and opportunity for mandated reporters and community providers to initiate a face-to-face response from CYFD Protective Services when there are concerns about unsafe sleep or related risk factors.
    a. Under a differential response track, circumstances leading to assessment and follow-up from the agency could include:
        1. Caregivers whose infants are discharged from a birthing hospital with a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act as amended by the Comprehensive Addiction and Recovery Act of 2016 who do not follow through on appointments, services, or

treatment as described in their Plan.

4. Revision of procedures and practices around safe sleep for foster care and respite care providers, per CYFD Protective Services Division.
    a. All CYFD field staff; licensed placement agency staff; prospective foster parents, adoptive parents, and respite care providers licensed through CYFD or a CYFD-regulated private agency should participate in annual safe sleep training based on American Academy of Pediatrics recommendations.
5. Strategies to improve investigation of SUID deaths and remove barriers to thorough data collection are implemented.
    a. All Field Deputy Medical Investigators should be routinely trained in SUID death investigations, including tribal police partners.
    b. Translation services should be available for parents/caregivers whose first language is not English, to complete thorough interviews and doll reenactments with law enforcement and Field Deputy Medical Investigators.

These strategies and recommendations will inform FY20 plans to continue progress on the Title V safe sleep objectives and strategies described in the corresponding application plans.

**2018 Annual Report Perinatal-Infant**

NPM 4: A) Percent of infants who are ever breastfed
B) Percent of infants breastfed exclusively through six months

**Objectives:**

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

**Strategies**:

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

Title V and WIC staff collaborated to set data and analysis goals for activities related to WIC client data and breastfeeding outcomes measured in PRAMS, the New Mexico Toddler Study and NM Vital Records. We also collaborated to evaluate the CDC Breastfeeding Peer Counselor Programs, cultural competence in lactation support and training for home visiting programs, and hospital breastfeeding data, and to develop new metrics for provider

knowledge. Over the reporting period we interacted to monitor objectives and strategies to increase breastfeeding duration and encourage safe infant sleep practices with community partners.

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

**Community Advisory Board and NMDOH Collaboration**

NMDOH Title V staff participate in and provide professional consultation through the NM Breastfeeding Community Advisory Board and collaborate with CAB partners to improve provider competencies and increase support to women to achieve longer breastfeeding duration.

The NM Breastfeeding 'Community Advisory Board' (CAB) assesses provider knowledge of breastfeeding competencies and confidence in educating women on key predictors and support services associated with longer breastfeeding duration. The CAB developed and implemented a 2016 survey of health providers (n=77) designed to measure the knowledge, attitudes, and practices (KAP) of outpatient providers around breastfeeding promotion and support. This outpatient provider survey focused on the opportunities for supporting continued breastfeeding at well-child and pediatric visits. In 2017 and 2018 the CAB members published findings, and then shared results in clinical Grand Rounds and at local and national breastfeeding conferences. Almost half (44%) of responding providers reported a lack of confidence in discussing home visitation program referrals, 29% were not confident in their counseling on feeding options for hepatitis-positive mothers, and 72% incorrectly responded that those women should not breastfeed. Almost 14% said babies should stop breastfeeding when they are 12 months old, despite AAP and WHO guidelines suggesting the benefits of longer duration if mutually desired by mother and infant. Just over half of providers *strongly* agreed that early supplementation with formula can result in insufficient breast milk supply; 17.0% *somewhat* disagreed with this statement. As an early predictor of breastfeeding duration, it is concerning that some clinicians may be misinforming or not fully educating women on the importance of exclusive breastfeeding. Additional findings on predictive breastfeeding factors indicated that:

- Fewer than 3/4 (72.4%) of providers *strongly* agreed that babies do not need any food or drink other than breast milk for the first 6 months of life.
- Under half of providers strongly disagreed that babies should be able to sleep through the night by 2 months of age; 25.3% somewhat disagreed and 28.0% somewhat agreed with this statement.
- About half of providers strongly disagreed with the statement that mothers who are Hepatitis C should never breastfeed; 21.9% somewhat disagreed, 19.2% somewhat agreed, and 9.6% strongly agreed with this statement.

The provider-level data collection was supported through a WK Kellogg Foundation grant for a one-time survey and was not conducted after 2017, so the results could not be updated beyond that point. However, the results indicate the need for more provider education, and that led to NM Telehealth presentations and specialized subject matter presentations at the annual in-person Breastfeeding Summit. Additional evaluation efforts to appraise provider confidence continued in 2018 in telehealth offerings through Envision NM and in two NMDOH-UNM collaborative projects, the Breastfeeding Evaluation Study and the Retrospective WIC Peer Counselor Study.

With the leadership of OB-GYN Sophie Peterson, MD (Principal Investigator) and Heidi Fredine, MPH the Breastfeeding Evaluation Study (bEST) began in 2016, but they approached NMDOH Title V staff to share complementary population data (PRAMS and NM Toddler Survey) and expand the scope of the Breastfeeding Evaluation Study (bESt), an outpatient survey of women with a 6-week postpartum clinical visit in two urban outpatient sites in the Presbyterian Health Services system. The short survey asks women a variety of questions at six weeks postpartum to address their duration of breastfeeding, support received and barriers to continuation. While it does not survey health providers, the survey was developed by OB-GYN, Pediatric and Family Provider staff to measure the clinical prevalence of breastfeeding duration at six weeks and to inform the impact of current clinical practice. 2017-2018 findings show that many women are struggling to breastfeed as early as one week after delivery (dropping from 96% at initiation to 85% at one week and 66% by two weeks), and this is instructive to our efforts to increase clinical provider competence and intervention.

Since the survey asks women, not providers, about their support to breastfeed (or barriers to continuation) the clinical provider training will be built from the results analyzed from 2017-2018 data collection.

**WIC clinic and peer counselor staff training**

New Mexico's Women Infant and Children program (NM WIC) trains all new staff within the first year of employment on breastfeeding promotion and education through a full 2-day workshop 'Using Loving Support to Grow and Glow in WIC'. This training is required by the United States Department of Agriculture (USDA) in all states receiving WIC funding, and was presented in both the northern and southern areas of the state. NM WIC also participates in an advanced 4-day Lactation Training Program, presented by the Childbirth and Postpartum Professional Association (CAPPA), which is available for all WIC Nutritionists after one year of employment. In 2018, WIC expanded use of the Hug Your Baby Training, a series of 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 expanded the reach of the Breastfeeding Peer Counselor (BPC) program with 70 active BP Counselors. BPCs provided one-on-one breastfeeding counseling support via telephone calls, home and hospital visits, even after WIC clinic hours, to WIC participants within 65 WIC sites/communities and 11 hospitals of the 29 maternity care hospitals statewide participating. WIC focused BPC training expansion on SE & SW regions of the state whose breastfeeding initiation rates are the lowest and whose lactation resources remain scarce or non-existent. In 2018 we added one hospital in the SE region and three hospitals in the SW region and collaborated with Tribal health promotion organizations and Navajo Breastfeeding Coalition in the NW region to expand support in their hospitals. This exchange of place-based staff expertise led to improvements across the state for WIC and community breastfeeding coalitions.

*Objective- Increase the degree of cultural specificity and awareness in the breastfeeding education/training with at least two home visiting programs by 2019.*

New Mexico Title V staff worked through the PRAMS steering committee and the NM home visiting collaborative to address cultural and programmatic variation in the way breastfeeding information is presented to women receiving home visiting services. WIC, Title V and the NM Breastfeeding Task Force also collaborative on this objective by offering tele-health consultations and by providing didactic learning with Envision NM and other partnering organizations in the Community Advisory Board. The cultural specificity and adaptations have been in progress in several areas of the state, and we are building off those efforts to tie in home visiting personnel for training or subject matter expertise.

**Breastfeeding on the Border Project**

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

The BBP partners with the Binational Breastfeeding Coalition's website https://www.borderbreastfeeding.org/ to provide the "Look Who's Talking" Lactation Educational Series to Southeast and Southwest NM regional health care professionals and families. The series is open to the public and makes it easier for families and consumers to ask questions or give input to the content experts in English and in Spanish. Not only are lectures free, but they include very low-cost continuing health and health education credits to participants. The series are advertised in the communities where they will be offered and online https://www.borderbreastfeeding.org/new-events/2018/4/18/look-whos-talking-breastfeeding-lecture-series-lecture-1

**Community Health Worker/*Promotora*-Home Visitor Trainings**

The NM WIC Breast Peer Counselor Program collaborated with DOH Community Health Workers Program to develop curriculum and delivery of lactation trainings for community health workers being certified through the NM Department of Health. This expands breastfeeding resources throughout the state and engages with two home visiting programs to assure vetting and cultural competency components in the trainings offered for certification.

Cariño Home Visiting, serving predominantly Spanish-speaking families in Las Cruces and surrounding rural communities, and Native American Parent Professional Resources, Inc. provided professional input for the lactation and early intervention trainings for certification. NAPPR, which provides early head start and perinatal home visiting services for Native American families, worked with WIC breastfeeding peer counselors, the NMDOH northern Tribal and Community Liaison and Title V staff to update language and materials to be shared with CHWs and the families they will serve independently and through home visiting programs.

WIC BPC program staff also began lactation support consultations with a pilot home visiting program 'Family Connects', focusing on the South Valley area of Albuquerque. This evidence-based program is part of the national Family Connects out of Durham, NC, and will link families to community resources and early intervention through 1 to 3 nurse home visits after delivery. Because the program only connects with families in one or more early postpartum encounters, it relies on professional lactation referral sources and in-home support to optimize those opportunities to help women meet their breastfeeding goals and challenges.

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

The New Mexico Breastfeeding Task Force (NMBTF) continued to expand efforts to increase the number of New Mexico hospitals births in Baby-Friendly USA designated facilities. Nine hospitals were designated Baby-Friendly by 2017 and NMBFTF is working with eight hospitals on the pathway to this designation. No facilities were designated in 2018. Title V and WIC staff interacted with 20 Community Support Groups community lactation support groups statewide and served as a resource for hospitals seeking Baby Friendly designation to help them meet the Step 10 requirement of fostering the establishment of breastfeeding support groups and referring mothers to them upon discharge. They also expanded three breastfeeding support groups by equipping community partners and community health workers trained in basic lactation to transition from a Peer Counselor-led breastfeeding support group to a community-led breastfeeding support for sustainability. This helps extend the reach of baby-friendly practices beyond delivery and initial WIC or peer counselor interactions for longer-term impact.

The Baby-Friendly steps most closely corresponding to the PRAMS survey indicators include the following:

1. Inform all pregnant women about the benefits and management of breastfeeding
2. Help mothers initiate breastfeeding within one hour of birth
3. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants
4. Give infants no food or drink other than breast-milk, unless medically indicated
5. Practice rooming in - allow mothers and infants to remain together 24 hours a day
6. Encourage breastfeeding on demand
7. Give no pacifiers or artificial nipples to breastfeeding infants

In addition to these, the CDC PRAMS standard baby-friendly indicators include provision of a phone number for lactation support and not allowing infant formula gift packs in the hospital. Envision NM, in collaboration with the NMBTF, University of NM, Nuestra Salud, LLC and other breastfeeding stakeholders, organized the 4th Statewide Hospital & Clinics Maternity and Infant Care Summit. There were 83 attendees in fields ranging from IBCLCs, RNs, BPCs, MDs, Midwives and other hospital staff. The PRAMS data were presented showing comparisons by ethnicity and region regarding provision of Baby-Friendly practices, self-reported in PRAMS.

**Data collection and analysis**

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

We used PRAMS (Pregnancy Risk Assessment Monitoring System) survey results to compare prevalence of baby-friendly indicators with facility designation coverage. Because NM Vital Records restricted hospital identifying information from the PRAMS dataset starting with 2015 births, we could not do this at the facility level; however, we conducted several analyses to explore the proportion of NM women reporting a baby-friendly experience as defined above. We found that the statewide prevalence increased from 12.5% in 2012 to 27.0% in 2019 and that when excluding the indicator on pacifier use, the prevalence was significantly higher, rising from 18.4% in 2012 to 31.9% in

2017 (dropping off from ~34% in 2016). This suggests that many hospital staff may offer pacifiers with variability.

Baby-friendly experiences (excluding the pacifier indicator) were very similar across maternal ethnicity populations (ranging between 28-31%) and only geographically disparate for the SE region of the state (8% v. 28%, statewide). Rates were highest in the NW quadrant of the state, corresponding with breastfeeding initiation and duration gains among Native American (principally, Navajo and Zuni) women in New Mexico. Because I.H.S facilities in New Mexico were the first to achieve baby-friendly designation, we expected improvements in breastfeeding initiation and duration, but we recognize that multiple efforts by breastfeeding coalitions, supportive workplace policies and WIC + WIC breastfeeding peer counselor programs all contributed.

Deeper analysis (PRAMS, 2012-2014 births) found that the three most predictive baby-friendly indicators for breastfeeding duration to eight weeks were: 1. breastfeeding within one hour after delivery, 2. only feeding the infant breastmilk, and 3. breastfeeding while in the hospital. We also found that these indicators were variably predictive for different sub-populations (Sebastian R, Coronado E, Otero M, McKinney C, Ramos M https://rdcu.be/bhvmT ). However, when modeled for maternal ethnicity subpopulations, findings were conflicting and divergent. For instance, while non-Hispanic White women and non-Hispanic Native American women were likely to keep breastfeeding >8 weeks if they breastfed before delivery discharge, this was not predictive for Spanish-Speaking Hispanic women. And breastfeeding within the first hour after delivery was associated with decreased odds of duration for Native American and Spanish-speaking Hispanic women (adjust odds 0.42, CI 0.35–0.50, 0.62, CI 0.48–0.80). This finding is not well understood by the authors, and some qualitative data collection and focus groups are being conducted to help answer questions about why the first hour of feeding is a negative predictor. For all women in the study, being encouraged to breastfeed on demand was positively associated with longer breastfeeding duration, so focus groups will explore the difference between supportive encouragement and more restrictive or time-limited approaches.

Findings from these FY18 analyses indicate that while baby-friendly hospital staff are increasing their provision of breastfeeding-supportive practice, at least 50% of the birth population should be reporting these experiences, and we are under 30%, as a state. To improve monitoring at the facility level, PRAMS began asking women where they delivered with the 2017 birth cohort. Findings will be used to drive more direct quality improvement in the next fiscal year.

2. Subpopulation analyses in PRAMS

NM PRAMS supported NM Breastfeeding Task Force Goals to improve breastfeeding support women whose infants are hospitalized in the Neonatal Intensive Care Unit (NICU). PRAMS data indicated that 58% of women with infants in the NICU breastfed more than two months compared to 65% of all other women (2014-2015). More analysis is planned to explore breastfeeding support with program partners working in home visiting and NICU referrals to infant mental health or maternal behavioral health and case management.

Glenda Hubbard, PRAMS analyst, shared results exploring baby-friendly experiences by payer of care and maternal age sub-populations. The findings were used to help guide lactation support provided in School-Based Health Centers and at federally qualified health centers with sites trained in the management of reproductive and perinatal health. MCH Epidemiology/Title V hosted an MPH program graduate student to explore more global (beyond baby-friendly) factors and risks for breastfeeding initiation and duration, and her final paper will be synthesized for a Title V monitoring report and data dashboard in development.

3. Longitudinal data collection and data linkage improvement

Data collection for the longitudinal follow-up to PRAMS in the NM Toddler Study/PRAMS-2 continued and descriptive data were shared with breastfeeding subject matter experts participating in the PRAMS/Toddler Study Steering Committee and with the NMBFT Community Advisory Board, academic epidemiology research consultants and early childhood service and breastfeeding program staff. Data analysis of 2015-2016 births (with two-year old results) is summarized for unweighted data, and the linked PRAMS-Toddler Study dataset will be released in September 2019.

Development of the Toddler Study surveillance is a high priority for Title V and Maternal Child Health Epidemiology. We are seeking continued private foundation grants and increased our Medicaid revenue in 2018 to support the surveillance. The PRAMS and Toddler Study Coordinator is in the process of revising the survey tool to meet long-term objectives to measure the impact of baby-friendly experiences to early breastfeeding duration and their relationship to ongoing (after 10 weeks) breastfeeding duration.

## 2020 Application Year Report

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

**Objectives:**

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

**Strategies:**

*- Support the passage of legislation mandating hospitals to provide and support Safe Sleep certification for their birthing center staff.*
*- Develop and track a data collection protocol for Shaken Baby Education at NMDOH; tie use of protocol to certification to incentivize hospitals.*
*- Participate in an evaluation of Shaken Baby and Safe Sleep Education delivered by NMDOH.*
*- Draft and present a statewide, multi-sector Safe Sleep Strategy Plan to the Cabinet Secretaries of DOH and CYFD and the NM Children's Cabinet.*

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

For the upcoming year, 2020, we will continue to work with partners in DOH Office of Injury Prevention, Health Systems Bureau and at the Office of the Medical Investigator/Center for Disease Control (OMI/CDC) Sudden Unexpected Infant Death (SUID) registry, Tewa Women United, NM birthing facilities, Navajo Nation and Indian Health Service (IHS) health promotion and home visiting programs. The Child Health Program health educator, funded out of Title V, will continue to provide safe sleep and SBS trainings for parents, child care workers and home visitors statewide.

Our work will continue to focus on promoting combined breastfeeding and safe sleep education for NM families, following national guidelines. In 2020 activities in New Mexico will include joining partners in conducting an environmental scan of program practice and policy across New Mexico. We will use this scan to further develop a Statewide Safe Sleep Strategic Plan and promote evaluation of statewide capacity around safe sleep education. From there, we will develop and share the resulting logic model and the plan to draft process measurements and tasks for team review. This process involves partnership with Children, Youth and Families Department (CYFD) home visiting programs, tribal home visiting sites, Families FIRST case management, Public Education Department (PED), Office of African American Affairs, Many Mothers, NM Graduation Reality and Dual Role Skills (GRADS) program, NM Hospital Association, March of Dimes (MOD), Indian Health Services providers, community doula programs, and the WIC breastfeeding counselor program. It is our goal to use the Statewide Strategic Safe Sleep Plan to align and coordinate disparate safe sleep efforts in the state and promote consistent messaging.

Another activity that will help us reach our new objective involves convening existing stakeholders from the Child Fatality Review (central OMI); University of NM; NMDOH; NM CYFD; Tribal Organizations; home visiting programs; NM Breastfeeding Task Force; Voices for Children; and the March of Dimes to begin the strategic planning process. Utilize quarterly inter-agency meetings (CYFD-DOH). In the upcoming year we will start holding quarterly interagency strategy and communication meetings between NMDOH and CYFD programs (to include CYFD Home Visiting staff), MOD, PED, clinicians and community health workers, and Human Service Department/Medicaid staff.

Through our partnerships, we also plan to combine child protective and calming techniques in trainings and evaluate cultural adaptability and suitability for different community settings. We will work with Tribal Epidemiology Centers, UNM and the NM Pediatric Society to assess approaches to safe sleep products and education and media-

messaging. We also plan to work with Many Mothers, Young Women United, and Tewa Women United to evaluate Baby Box distribution and recommend next steps.

Preliminary plans will start with the development of regional messaging and cultural adaptability with consultants in Albuquerque and rural communities and specifically include breastfeeding promotion in messaging efforts with a focus on minority populations disproportionately impacted by SUID and lower breastfeeding rates (e.g. African-American and Native American families). We will simultaneously utilize Title V and partner participation in the Infant mortality CoIIN safe sleep strategy network, the social determinants of health/health equity CoIIN strategy network, and other partnerships to develop a transition from perinatal education to early childhood/infant health and safety collaboratives. In addition, reviewing current national campaign materials (National Institute of Child Health and Human Development - NICHD) to increase safe sleep awareness and media messaging on CYFD and DOH websites and community resources for families will enable us to keep up to date on current practices.

Lastly, in order to get NM birthing facilities to report standardized statistics for SBS to NM DOH by 2020, we plan to expand the number of DOH and state agency Child Fatality Review participants and stakeholders. This will help to develop recommendations with actionable strategy items for families and regions most at risk for SUID/SBS.

**Objective.** *Increase the number of NM birthing facilities trained by the NMDOH in safe sleep education protocols from 3 to 8 by 2020.*

For the Title V program to be able to increase the number of programs and facilities with both SBS and Safe Sleep trained staff, our first strategy will be employing the results of the strategic plan and environmental scan, formative evaluation plans, logic model, and local engagement strategy plans. The work moving forward will be facilitated through multi-sector engagement with the March of Dimes program service committee in safe sleep strategies by communicating invitations to representatives from state agencies, NM Hospital Association, NM Voices for Children and Federal MIECHV and tribal home visiting sites. Inter-agency meetings will convene to implement the first phase of the strategy plan beginning in 2020 and will assess ways to integrate breastfeeding promotion with safe sleep curricula in different clinical and program service settings.

Other ways that we can advance this work is through supporting regional and local efforts (Child Protective Service (CPS) trainings and hospital protocols) to continue expanding e-learning modules in development with CPS. Expanding the e-learning offerings to Early Head Start, pre-school, daycare and home visiting programs will also serve this purpose as will working with the NM Hospital Association and NM Pediatric Society, Medicaid Managed Care Organizations, and NM Breastfeeding Task Force to consider an incentive program for hospitals and birthing centers successfully demonstrating both safe sleep and breastfeeding promotion with families. To incentivize hospital participation, the Title V funded Child Health Program in FHB is planning to purchase safe sleep books for hospitals to give to every baby born in NM in 2020.

**Objective.** *Transition at least five NM birthing facilities to report standardized statistics for Shaken Baby Syndrome (SBS) Education to the NMDOH in 2020.*

To work towards completing this stated objective in the upcoming year, one step we can take is to combine legislative language already enacted for shaken baby education with introduction of safe sleep prevention at the same birthing facilities. The NM DOH Injury Prevention Bureau is responsible for promulgating rules around SBS education and data reporting, which will hopefully be complete in the next six months. We will also incorporate data collection and reporting specifications in NMDOH rules to track numbers of families trained in both safe sleep and SBS prevention education. One of our specific goals is to report annually on statewide education occurring at birthing facilities. Additionally, we intend to contribute to the analysis of NM SUID registry data and publication as well as staff a full-time position in MCH Epidemiology or in the Office of Injury Prevention to support SBS and SUID analysis.

**2020 Annual Plan Perinatal-Infant**

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

B) Percent of infants breastfed exclusively through six months

**Objectives:**

- *Increase the proportion of birthing facilities with Baby-friendly designation and corresponding self-reported experience in PRAMS by 50% by 2020.*
- *Increase the degree of cultural specificity and awareness in the breastfeeding education/training with at*

*least two home visiting programs by 2019.*

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

**Strategies:**

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

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

**Community Advisory Board, NM Breastfeeding Taskforce and NMDOH Title V Collaboration**

The NM Breastfeeding 'Community Advisory Board' (CAB) assesses provider knowledge on breastfeeding competencies and confidence in educating women on key predictors and support services associated with longer breastfeeding duration. NMDOH Title V staff will continue to participate in and provide professional consultation to the NM Breastfeeding Community Advisory Board and collaborate with the New Mexico Breastfeeding Taskforce to improve provider competencies and increase support to women to achieve longer breastfeeding duration. FY20 plans fall into three programmatic areas:

1. Develop 2020 NM Telehealth web-based presentations and specialized subject matter presentations with the Envision NM, UNM Department of Pediatrics, Tewa Women United, the Navajo Breastfeeding Coalition and the NM Birth Equity Collaborative. Appraise provider confidence through pre and post-test telehealth offerings by Envision NM and in two NMDOH-UNM collaborative projects, the Breastfeeding Evaluation Study and the Retrospective WIC Peer Counselor Study.
2. Expand the Breastfeeding Evaluation Study (bEST) data collection to two additional sites. The bEST study is an outpatient survey of women with a 6-week postpartum clinical visit to measure duration of breastfeeding, support received and barriers to continuation. We will present findings of the Breastfeeding Evaluation Study (bEST) to clinical staff in clinical Grand Rounds and develop strategies to address varying barriers to breastfeeding duration at one, two and six weeks, post-partum. Clinical provider training will be built from the results analyzed from 2017-2018 data collection.
3. Incorporate lactation support competency areas into the DOH Community Health Workers Program to expand the delivery of lactation trainings for Community Health Workers (CHWs) and home visiting staff seeking certification through the NM Department of Health. This expanded breastfeeding curriculum was developed and piloted with the NM WIC Peer Counselor Program, bilingual *promotoras,* Community Health Representatives and tribal home visiting staff. Expansion and acceptance of the curriculum requires additional stakeholder input and adaptation for different programs across the state.

*Objective- Increase the degree of cultural specificity and awareness in the breastfeeding education/training with at least two home visiting programs by 2019.*

**Breastfeeding on the Border Project**

The Breastfeeding on the Border Project (BBP) is a binational effort to increase breastfeeding rates in US/Mexico border communities, funded by the NM Office of Border Health. FY2020 goals of the BBP include increasing breastfeeding rates in three rural border communities in New Mexico through three objectives: 1) Build on the Hospital Baby-Friendly Initiative (BFHI) by providing a resource for referral for lactation support after hospital discharge (BFHI step 10); 2) Support the 2011 US Surgeon General's Call to Action to Support Breastfeeding; 3) Bridge health and racial disparities along the US/Mexico border through forming binational partnerships and equipping partners and health promoters in basic lactation to increase accessibility to bilingual health services and resources. To meet the objective 3) the BPP will hold a community-wide event hosted in rural border communities (Anthony, Chaparral, Sunland Park) to introduce them to local breastfeeding coalitions and connect health organizations and family members, and then to offer a NMDOH Community Health Worker training, using the *CDC Loving Support* peer counselor 12-hour curriculum (English and Spanish). Once complete, the health workers can apply for a lactation consultant certificate with NMDOH.

The BBP will continue to partner with the Binational Breastfeeding Coalition https://www.borderbreastfeeding.org/ to provide the "Look Who's Talking" Lactation Educational Series to regional health care professionals and families. This series will be offered to home visiting staff and will engage specifically with health promotions staff/ *promotores* and providers working across multiple systems of care. *Cariño* Home Visiting, serving predominantly Spanish-speaking families in Las Cruces and surrounding rural communities works with Ngage New Mexico, a non-profit which serves as a backbone organization for an early education initiative called SUCCESS! Partnership in Doña Ana County. This partnership uses a collective impact framework to support families through resource leveraging and continuity of services, and we are working through the statewide Home Visiting Collaborative to bring more health services support to these existing partnerships. In FY20 NM Title V staff and WIC staff will provide technical assistance and cultural bridging to offer bilingual lactation support training and resource alignment between cross-referring home visiting, nutrition services and perinatal case management partners.

Ben Archer Healthy Start, Families FIRST case management and WIC will continue to coordinate with local delivery hospitals (Mountainview and Memorial) to provide post-delivery, bilingual support and referrals to women who wish to continue breastfeeding their infants. Through WIC and Breastfeeding on the Border lactation support, women residing in areas outside Las Cruces are reached through home visits or community-based locations. For women participating in WIC, Healthy Start or Families FIRST perinatal case management, referrals are made to Breastfeeding 'Sisters' who are certified lactation heath workers to provide peer counseling support after delivery.

WIC peer counselors provide both breastfeeding and safe sleep assessment and education with their clients, however, individual home visiting programs practice different models of care. The Sisters on the Border approach builds on the WIC peer counselor structure with *promotoras* (lay health workers) to provide breastfeeding education and one-on-one support to women in rural communities where transportation, language and insurance access make it very challenging to access lactation, health or medical care services. FY20 plans focus on exclusive breastfeeding support because Black and Hispanic women have the highest rates of formula supplementation within two days of birth (Perez-Escamilla 2019 and Chapman, Perez-Escamilla 2012 https://www.ncbi.nlm.nih.gov/pubmed/22332107). Efforts to change this pattern require collaboration and coordination across different sectors, and Sisters on the Border successfully models that in New Mexico communities. Exclusive breastfeeding is recommended for the first six months of life, and while NM enjoys high initiation rates, we struggle with duration and especially duration of exclusive breastfeeding. Women of color, low-income and monolingual Spanish-speaking women have lower access to healthcare, and the challenges they face in breastfeeding continuation are greater in magnitude compared to the aggregate birth population.

**Food Sovereignty/First Foods**

Navajo Breastfeeding Coalition and Zuni Breastfeeding Coalition are building unique and robust community-based spaces and policies to encourage and normalize and reclaim breastfeeding. Five Sandoval, Eight Northern Indian Pueblos and Santo Domingo WIC among other tribe-serving organizations have addressed breastfeeding promotion in innovative and self-determining ways. Because tribal nations have a colonial history of rationed and processed foods forced upon their people, breastfeeding promotion carries a reclaiming of feeding traditions and resistance to continued marketing and saturation of unhealthy or suboptimal nutrition products, such as infant formula. Tribal home visiting programs serving San Felipe Pueblo, Tiwa Babies Program (Taos) and Native American Parent Professional Resources (NAPPR) each has a unique approach to breastfeeding reclamation, and

Title V partners support these communities upon request. We do not have an explicit Title V FY20 strategy plan for this work because it is not our role to lead. But, through the statewide Home Visiting Collaborative, MCH Epidemiology and the Title V Director participate in data provision, evaluation and policy development to support and share resources with home visiting programs. We will partner with the Albuquerque Area Southwest Tribal Epidemiology Center, Navajo Epidemiology Center and the LANL Pueblo Outreach Program to share research techniques and follow community-led and sovereign data collection processes.

**Breastfeeding Friendly Workplace Development**

Title V and the NM Breastfeeding Task Force will continue collaboration to promote family-friendly and breastfeeding-friendly workplace policy and practice in New Mexico. The areas of focus for FY20 are:

1. Promoting family-friendly workplace awards and recognition with Family Friendly NM and the Southwest Women's Law Center Paid Family Medical Leave Coalition; support employer survey development, PRAMS maternal work leave analysis and evidence-based recommendations;
2. Research family-friendly and breastfeeding-friendly laws passed in other states and provide data briefs, economic impact summaries and recommendations to the NM Southwest Women's Law Center Paid Family Leave Coalition;
3. Both Title V and the NMBFTF plan to support FY20 strategies with the NM Birth Equity Collaborative (NMBEC), Nuestra Salud, LLC and Envision New Mexico to incorporate health equity principles and training topics in hospital summits and web-based or provider education (implicit bias and social determinant medical coding) objectives. Building on existing telehealth offerings through the NM Breastfeeding Task Force and the NMBEC, this will strengthen inclusion of national experts including Jennie Joseph (The JJ Way®) in FY20. Joseph, a British-trained midwife is a nationally-recognized speaker and trainer on patient-centered care which places value on listening to mothers in care, creating perinatal safe spots (support circles and referral agency homes) and giving women tools and methods for self-advocacy in their care.

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

The New Mexico Breastfeeding Task Force (NMBTF) continues to expand efforts to increase the number of New Mexico hospitals births occurring in Baby-Friendly USA designated facilities. San Juan Regional Medical Center is the most recent NM hospital to achieve Baby-Friendly designation. WIC staff support 20 community lactation support groups statewide and serve as a resource for hospitals seeking Baby-Friendly designation or refresher trainings.

**Data collection and analysis**

a. Comparison of Baby-Friendly designated hospitals or regions with prevalence of baby-friendly indicators in PRAMS.

Findings from these FY18 analyses indicate that while baby-friendly hospital staff are increasing their provision of breastfeeding-supportive practices, at least 50% of the birth population should be reporting these experiences, and we are under 30% prevalence as a state. To improve monitoring at the facility level, PRAMS began asking women where they delivered with the 2017 birth cohort, but analysis will require 2018 data to make any inferences. Findings will be used to drive more direct quality improvement in the next fiscal year. In FY20 we will be using a calculated variable to analyze breastfeeding data by Baby-Friendly v. Other hospital designation. This will not require individual hospital identification, and we will not publish facility-level data, but we will make those estimates available to facilities upon request.

b. Subpopulation analyses in PRAMS

NM PRAMS supported NM Breastfeeding Task Force goals to improve breastfeeding support to women whose infants were hospitalized in the Neonatal Intensive Care Unit (NICU). More analysis is planned to explore breastfeeding support with program partners working in home visiting and NICU referrals to infant mental health or maternal behavioral health and case management. Dr. Peggy McLean, PhD, is a psychiatrist in the UNM Department of Pediatrics who directs the HATCH (Helping Families to Come Home) program. The program offers families of hospitalized newborns social support and transition to home visiting programs when their infant is released from the NICU. Because breastfeeding is one therapeutic approach to soothe premature (at appropriate gestational ages), low birth-weight and substance withdrawing infants, UNM has developed a program promote wrap around services and support for families of those infants. NMDOH case coordination and CYFD home visiting

programs coordinate with HATCH to help identify early and ongoing social and medical needs for mothers, families and their infants. Title V/MCH Epidemiology staff will support this project with PRAMS and Toddler Survey data analysis and by soliciting input for the 5-year statewide needs assessment in FY20.

Title V will include in needs assessment and data analysis plans ways to evaluate doula service impact on breastfeeding initiation and duration. Because there are innovative and culturally-specific doula programs in NM, we will work with program staff to support their client, Vital Records and PRAMS aggregate analysis needs, one-on-one. The NM Birth Companion Project http://hscnews.unm.edu/news/laboring-together serves a large delivery volume urban hospital in Albuquerque with diverse, changing needs, and Tewa Women United's Yiya Vi Kagingdi Community Doula Training was developed through diverse communities in Northern New Mexico from years of doula programming and community/academic research. Breastfeeding is multi-factorial, personal and complex, and doula programs providing holistic services are crucial to understanding factors leading to success for each woman's infant feeding choice.

MCH Epidemiology/Title V will host at least one MPH program epidemiology graduate student to explore more global (beyond baby-friendly) factors and risks for breastfeeding initiation and duration. This will build upon FY18-19 student work which included sub-population analyses for WIC recipients and for women who worked during pregnancy and had to make decisions about paid or unpaid family medical leave and how to support their families while they were out of work. The final paper (2019) will be synthesized for a Title V performance monitoring report, website, and data dashboard, which is in development.

c. Longitudinal data collection and data linkage improvement

We completed 2016 birth data collection for the longitudinal follow-up to PRAMS in the NM Toddler Study/PRAMS-2. We completed year three of the three-year WK Kellogg Foundation grant and will apply for a grant extension to assure that the data are properly weighted with statistical adjustments for the birth population, so we can publish valid estimates and release indicators over the next year. Provisional unweighted data indicate that in the 2016 birth cohort, 57.6% breastfed for at least 6 months (n=531) and that 32.6% breastfed exclusively for at least 6 months. Over 75 indicators for 2015-2016 births (with two-year old and maternal health results) are summarized for provisional, unweighted data, and the linked PRAMS-Toddler Study dataset will be ready for complex survey analysis in September 2019.

Further development of the Toddler Study surveillance is a high priority for Title V and Maternal Child Health Epidemiology. We are seeking continued private foundation grants and increased our Medicaid revenue to support the surveillance. The PRAMS and Toddler Study Coordinator is in the process of revising the survey tool's long-term objectives to measure the impact of baby-friendly experiences on early breastfeeding duration and their relationship to ongoing (after 10 weeks) breastfeeding duration.

**Data Visualization and Dissemination**

New Mexico Title V began feasibility exploration for Title V and Maternal Child Health data repositories and web-based data visualization. Over the years, faster, more easily accessible data have been in high demand. Birth registration and CDC statistical weighting of survey data are becoming more timely and will help us to meet the growing demand. To keep up, the program has tested different software options and continues to consult with partnering academic and community organizations.

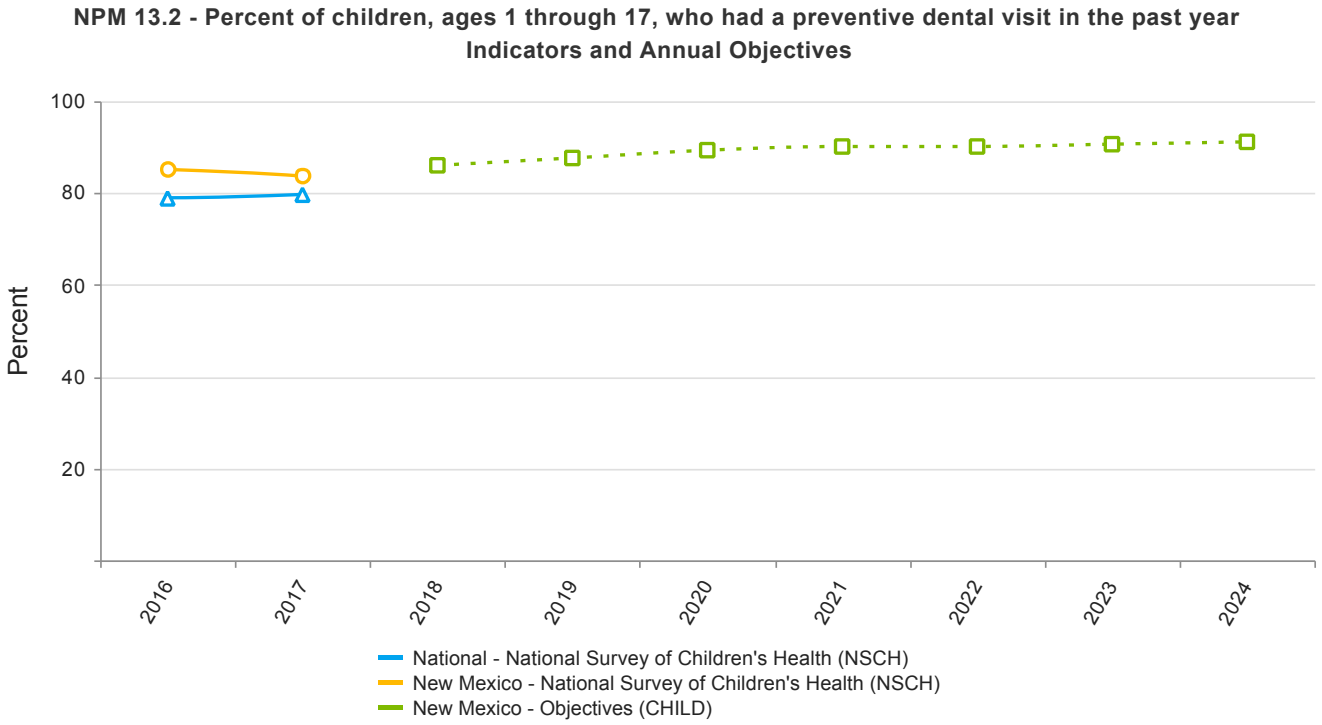
This is a priority area for FY20 to support all Title V domain areas, and we will employ two primary platforms to achieve this goal. We will utilize LiveStories, an e-reporting platform and Tableau (or similar) software for data dashboarding. We will house these and other Title V priority area products in a maternal child health website which allows staff to perform real-time updates, news briefs and information gathering over the next five years.

**Child Health**

**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year | NSCH-2016_2017 | 13.9 % | NPM 13.2 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2016_2017 | 91.2 % | NPM 13.2 |

## National Performance Measures




### NPM 13.2 - Child Health

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 85.9 |
| Annual Indicator | | 85.0 | 83.7 |
| Numerator | | 386,111 | 384,606 |
| Denominator | | 454,417 | 459,720 |
| Data Source | | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 87.5 | 89.2 | 90.0 | 90.0 | 90.5 | 91.0 |

**Evidence-Based or –Informed Strategy Measures**

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

| Measure Status: | | | | | | Active |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 43.1 | 44.1 | 45.1 | 47.0 | 48.0 | 49.1 |

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

| Measure Status: | | | | | | Active |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 18.0 | 23.0 | 28.0 | 33.0 | 38.0 | 40.0 |

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

| Measure Status: | | | | | | Active |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 9.0 | 11.0 | 13.0 | 15.0 | 17.0 | 17.0 |

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

| Measure Status: | | | | | | Active |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 9,353.0 | 14,353.0 | 19,353.0 | 24,353.0 | 29,353.0 | 29,353.0 |

**State Action Plan Table**

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

| Priority Need |
| --- |
| To increase and improve access to preventive dental care in pregnant women and children |

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

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

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

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

NOMs

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

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

## 2018 Annual Report

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

**Objectives**:

- *Increase by 10% the number of children aged 1 to 17 who have had a dental visit, and who participated in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, by June 20, 2020.*
- *Increase by 10% the number of children receiving an application of a dental sealant or fluoride varnish by June 30, 2020.*
- *Increase by 5% the number of pregnant women who have had a dental visit during pregnancy by July 2019.*

**Strategies:**

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

The NM Department of Health (DOH) has identified 12 priority health indicators to address that would improve the health status of New Mexico residents, oral health being one of these indicators. The Office of Oral Health's (OOH) mission is to reduce the incidence of tooth decay and other disease through prevention. Program strategies to improve the oral health status of New Mexicans include: promote oral health, provide preventive services to preschool and school-aged children, increase the number of dental providers serving the uninsured and low-income populations, and increase the consumption of fluoridated water.

One major program activity is a mobile prevention initiative. State staff and contractors travel throughout the state to provide oral health education (hygiene instructions, proper brushing of teeth, use of dental floss, eating healthy, drinking water) a dental examination, application of dental sealants/fluoride varnish, and dental case management services to selected pre-school programs, elementary, and middle schools. OOH also contracts with dental providers to serve uninsured and low-income adults and children (prevention/treatment services). Additionally, OOH conducts an oral health education campaign promoting oral health, identifying risk factors to prevent disease, and making healthy eating recommendations.

The New Mexico CMS 416 Annual EPSDT Report for FY 2017 (the most recent available) reports that 416,295 children and adolescents were eligible to participate in EPSDT services. Over 208,072 individuals received preventive services (e.g. cleaning or fluoride mouth rinse or jel) and over 25,708 received a sealant on a permanent molar. Presently there is no reimbursement code for fluoride varnish. In 2016, 413,935 individuals were eligible to participate in the program with 204,757 receiving preventive services and 26,539 receiving a dental sealant on a permanent molar.

During the 2017-18 school year, OOH staff screened 6,314 preschool and elementary school children. 4,812 children received fluoride varnish applications and dental sealant applications. Each visit consisted of a dental assessment, oral health education, application of the preventive agent, parental notification of the oral health status of the child, and dental case management services. The Dental Case Manager assisted 99 preschool children in securing treatment services and a dental home.

An estimated 7,000 preschool and elementary school children at school health fairs received oral health education by OOH state staff. In addition, state contractors provide preventive and treatment services to over 5,083 children. OOH experienced some difficulties during the year, including staff retirements and the fact that private dentists are

now applying dental sealants. Federally Qualified Health Centers' dental components are required by the Health Resources and Services Administration to promote the application of dental sealants, and reduced parent consent forms, especially from immigrant families, have impacted the school-based prevention program.

OOH collects data on each school or Head Start location, including: the number of children eligible to participate in the program (usually the total number of students enrolled in a school), the number of children screened (parental consent required and received), the number of children receiving dental sealants/fluoride varnish application (three times a year), and data assuring parental notification and dental case management services were provided for all children diagnosed with decay. During the same school year OOH and contractors provided 1,958 preschool aged children with 3 applications of fluoride varnish. In addition, 250 pre-K children received a dental screening.

During the same academic year, OOH staff also provided oral health education (English and Spanish), toothbrushes, toothpaste, and referrals to the Women Infants and Children program (WIC) clients in the Santa Fe, Española, Albuquerque, Anthony, Chaparral, Southern Park and Las Cruces. The educational materials address the importance of oral health for moms during pregancy and their children at all stages of life. OOH state contractors are unable to collect data on the number of pregnant women/adolescents they serve because the electronic health records do not identify if a patient is pregnant.

Former Governor Susan Martinez proclaimed February as "Children's Oral Health Month" in 2017 and 2018. OOH conducted oral health Public Service Announcements (PSA) during "February Children's Oral Health Month" via KOAT TV (English and Spanish) and conducted a "Smile Campaign". The campaign was a partnership between NM Delta Dental, Hearst Corporation and NM OOH. The PSA promoted the importance of oral health and provided oral health tips. The campaign included spot announcements by KOAT TV anchor staff and ads on Facebook, Twitter, and Instagram. The 2018 campaign had 2,721 entries with 3 individuals winning the prize funds provided by New Mexico Delta Dental.

Over 3200 individuals visited the KOAT.com websites (oral health tips) and over 1 million individuals visited the contest web site. The Department of Health website had 85,993 visits by individuals viewing the Oral Health web site. The significance of this social marketing campaign is that New Mexico residents heard news anchor staff promote oral health and the children's smile campaign via their news broadcast. Also, oral health messages were posted on KOAT TV web sites and the NM DOH web site – and a significant number of viewers read an oral health message for the day at each site.

On July 1, 2018, the Albuquerque Water Utility Authority began fluoridating its water systems. Over 600,000 individuals can drink fluoridated water. The next project for the Community Fluoridated Water (CWF) coalition and OOH is to promote consumption of fluoridated water. The Association of State and Territorial Dental Directors awarded the Utility a Certificate of Accommodation for its efforts in fluoridating its system. The city of Santa Fe continues to provide over 68,000 individuals with fluoridated water. In the city of Santa Fe OOH has begun promoting consumption of fluoridated water via the NM Nurses Association news letter and a local state newspaper. It is hoped that promoting Community Fluoridated Water in these two communities will increase the consumption of fluoridated water rather than bottled water and reduce the consumption of sugar water-based drinks. Increased consumption of fluoridated water will contribute to the reduction of tooth decay, especially among children.

During the school year 2017-18 the OOH, the Office of Nutrition and Physical Activity and the Child Health Program partnered with the University of New Mexico Lier Corporation (UNM Lobo promoters) for the children healthy living campaign. The campaign promoted physical activity, oral health, and improving reading capacity. The campaign was conducted in Albuquerque through the auspices of the ABQ Public School system. Elementary schools were encouraged to participate in the campaign, over 325 students participated in the program and one southside school was selected as a winner. Each student received awards and a certificate from OOH along with being introduced at one of the UNM Lobo football games.

OOH continues to partner with the NM Oral Health Coalition (37 members), State Title V/MCH, the Office of Physical Activity and Nutrition, NM TUPAC (a smoking cessation program), the UNM Pediatric Advisory Committee, the NM State Head Start Regional Office, the state Children Youth and Family Department (CYFD), DentaQuest Foundation, NM Pregnancy Risk Assessment Monitoring System (PRAMS), UNM Lobos, and a local news station, KOAT TV. The partnerships provide various avenues to promote oral health, preventive diseases, healthy eating, physical activity, and reduction of risk factors that contribute to tooth decay and other childhood chronic disease such as diabetes and obesity.

## 2020 Application Year Report

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

**Objectives:**

- *Increase by 10% the children aged 1 to 17 who have had a dental visit, who participated in the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program by 2021.*
- *Increase by 10% the children receiving an application of a dental sealant or fluoride varnish, by June 30, 2021.*
- *Increase by 5% the pregnant women who have had a dental visit during pregnancy by July 2021.*

**Strategies:**

- *Provide oral health education to pregnant women and children through promotion of state-wide campaigns, dental screening, fluoride varnish applications, dental sealants, health fairs and public service announcements.*
- *Promote Dental Case Management practices by dental and medical providers and other health care agencies.*
- *Promote the development of interagency partnerships championing and promoting oral health programs and initiatives through the work of the New Mexico Oral Health Coalition and other advocacy or school related organizations. OOH will add the NM Delta Dental to the coalition membership.*

In FY20, OOH will work with the New Mexico Human Services Department to improve oral health access and services to existing Medicaid eligible children and increase the number of eligible children enrolled in Medicaid. The New Mexico Legislature has recognized the importance of oral health, especially among Medicaid-eligible children. The Legislature in 2019 directed the Office of Oral Health (OOH) to form a Task Force and examine the current services provided to children and what could be improved. OOH will be advocating for the establishment of Convergent Medical Terminology (CMT) Codes for Fluoride Varnish reimbursement and for Silver Diamine fluoride (SDF) – a new procedure; less invasive treatment of caries; and increased reimbursement rates for oral health, with the hopes of increasing the number of New Mexico Medicaid dental providers.

OOH will continue to conduct the mobile prevention program by conducting dental sealant/fluoride varnish program throughout the state (including the collection of data). OOH will renew year 2 of the oral health contractors on July 1, 2019. Contractors will be completing the second year of their contract. OOH continues to educate contractors regarding promoting oral health among pregnant women and their children. An additional dental provider will be secured for FY 20, which will increase the number of children receiving fluoride varnish and dental sealant applications.

OOH will promote CAMBRA among Federally Qualified Health Center (FQHC) Dental Providers. CAMBRA – caries management by risk assessment – is an evidence-based approach to preventing and managing cavities at the earliest stages. Developed at University of California San Francisco (UCSF) in the early 2000s, CAMBRA considers a patient's health and lifestyle risk factors, such as the presence of harmful bacteria, low levels of saliva, or poor diet, and weighs them against protective factors like living in a community with a fluoridated water supply, using fluoride toothpaste and antibacterial mouth rinses, and adequate saliva flow. OOH is hopeful that the CAMBRA approach will reduce the number of no-shows among private Medicaid providers.

OOH will continue promoting oral health and overall health via department and other social media marketing activities. OOH, KOAT TV (Hearst Corporation) and sister station Television (Spanish speaking TV station), and NM Delta Dental will conduct our fourth social media campaign in February 2020. OOH will promote oral health by meeting with the NM School Nurses Association, the NM School Health Alliance, the NM Oral Health Coalition, and via other NM media avenues.

OOH, in partnership with The Oral Health Forum and three other states is applying for a HRSA Grant: Networks for Oral Health Integration within the Maternal and Child Health Safety Net. Should the partnership be successful, funding will be provided for five years to increase the number of School Based Health Centers with a dental component in each of the four states. The target populations are middle school and high school students.

OOH will continue to work with our partners. We will work with our sister programs in the Family Health Bureau, including WIC and MCH, to continue promoting oral health, healthy living, awareness of risk factors and prevention; work with the NM Oral Health Coalition to develop a "State Oral Health Plan"; continue our membership in the Santa Fe Head Start and Albuquerque city Head Start advisory committees; and promote the consumption of fluoridated water in the city of Albuquerque and county of Bernalillo County residents and Santa Fe County. In partnership with the NM Office of Physical Activity and Nutrition, we are promoting consumption of fluoridated water among preschool and elementary school children. A poster has been developed prompting drinking water via a cartoon lunch engagement. The poster will be distributed to school nurses throughout the state and WIC offices. OOH will continue to work with the NM Tobacco Control Cessation Program in our mutual efforts to reduce the use of tobacco and other products among elementary, middle, and high school students.

OOH staff and contractors will continue to provide Dental Case Management services to those students served by our respective programs. DCM assists families without a dental provider secure treatment services and complete a treatment plan.

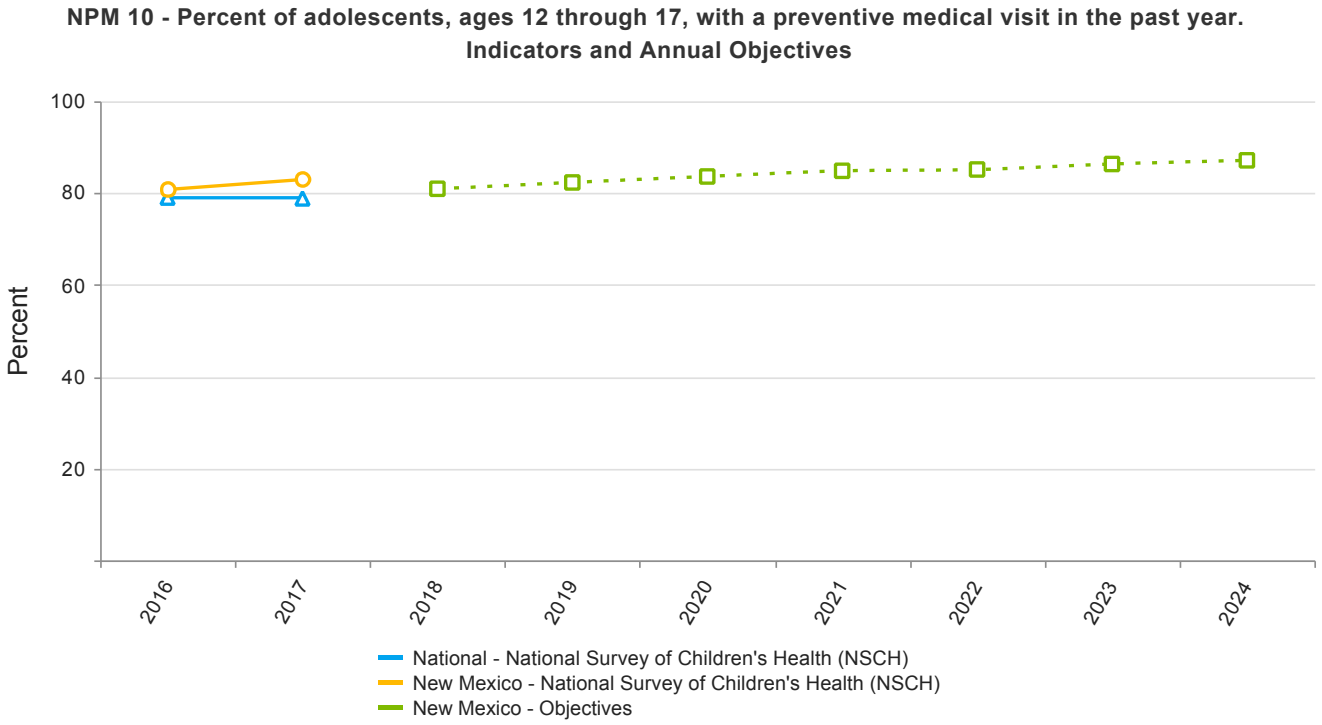
NM has an approved Community Health Worker (CHW) program. The state office provides training, certification of programs, and certifies CHWs. OOH has developed an "Oral Health Specialty Track" for CHWs. This year we will pilot the "Track" among several Native American CHWs. Once the pilot is competed the "Track" will be available to all CHWs. CHWs will improve their oral health literacy and assist local communities' literacy, hygiene, prevention and referrals. OOH will also inaugurate the oral health training of the St. Joseph's Catholic Health Initiative (CHI) home visitors. Educational material and oral health incentives have been purchased and will be provided to the home visitors.

**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-2017 | 42.3 | NPM 10 |
| NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 | NVSS-2015_2017 | 14.4 | NPM 10 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 | NVSS-2015_2017 | 20.9 | NPM 10 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling | NSCH-2016_2017 | 50.9 % | NPM 10 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2016_2017 | 91.2 % | NPM 10 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | NSCH-2016_2017 | 15.1 % | NPM 10 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | WIC-2014 | 12.5 % | NPM 10 |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) | YRBSS-2017 | 15.3 % | NPM 10 |
| NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza | NIS-2017_2018 | 62.3 % | NPM 10 |
| NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine | NIS-2017 | 66.9 % | NPM 10 |
| NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine | NIS-2017 | 85.5 % | 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-2017 | 78.0 % | NPM 10 |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females | NVSS-2017 | 27.9 | NPM 10 |

**National Performance Measures**




| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 80.8 |
| Annual Indicator | | 80.5 | 82.9 |
| Numerator | | 140,946 | 137,803 |
| Denominator | | 175,148 | 166,150 |
| Data Source | | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 82.2 | 83.5 | 84.7 | 85.0 | 86.2 | 87.0 |

**Evidence-Based or –Informed Strategy Measures**

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 50.0 | 75.0 | 100.0 | 125.0 | 150.0 | 175.0 |

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 1.0 | 2.0 | 3.0 | 4.0 | 5.0 | 6.0 |

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 70.0 | 95.0 | 110.0 | 135.0 | 150.0 | 175.0 |

**State Performance Measures**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | 31.6 | 28.8 |
| Annual Indicator | 34.2 | 29.4 | 27.6 |
| Numerator | 2,307 | 2,000 | 1,889 |
| Denominator | 67,519 | 68,117 | 68,324 |
| Data Source | NM Vital Records | NM Vital Records | NM Vital Records |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 26.1 | 23.4 | 20.7 | 18.2 | 17.6 | 17.6 |

**State Action Plan Table**

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

### Priority Need

To improve access and quality of comprehensive well exams for adolescents

### NPM

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

### Objectives

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

### Strategies

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

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

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

| ESMs | Status |
|---|---|
| ESM 10.1 - The number of policies/or practices implemented at a clinical system, that helps improve access to or quality of the adolescent well visit. | Inactive |
| ESM 10.2 - Percent of Patients ages 10-17 reporting they are satisfied or very satisfied with their well visit/ clinical encounter | Inactive |
| ESM 10.3 - Percentage of Well visits ages 10-25 for Medicaid patients | Inactive |
| ESM 10.4 - Number of youth and adults who are trained using the Youth Health Literacy Toolkit. | Active |
| ESM 10.5 - The number of clinics that respond that they have increased their youth friendliness practices by at least two points according to the pre and post surveys given after the Know Your Health Toolkit presentations. | Active |
| ESM 10.6 - Number of people attending Know Your Health Toolkit presentations | Active |

| NOMs |
|---|
| NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000 |
| NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 |
| NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health |
| NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) |
| NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza |
| NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine |
| NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine |
| NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine |
| NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females |

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

### Priority Need

To reduce birth rates among teens 15-19

### SPM

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

### Objectives

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

### Strategies

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

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

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

## 2018 Annual Report

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

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

**Strategies:**

- *Utilize the New Mexico (NM) Youth Health Literacy toolkit in schools near the clinics that are piloting the Know Your Health toolkit (KYHT).*
- *Collaborate with the clinics and public health offices that are 'Know Your Health' Pilot sites to implement the youth-friendly services and environment assessments.*
- *Spread the KYHT to various adolescent health stakeholders in New Mexico to highlight the importance of adolescent and young adult health and the importance of annual well exams.*

**Adolescent Well Visits**
The NM Department of Health (DOH) Office of School & Adolescent Health (OSAH) has worked to increase annual adolescent well-exams using three different initiatives: 1) the NM Adolescent & Young Adult Health (AYAH) Collaborative Improvement & Innovation Network (CoIIN), 2) Youth Peer-to-Peer Helper Programs (P2PH), and 3) SBHCs.

OSAH initiated the NM AYAH CoIIN in 2016. The NM AYAH CoIIN continues to strive toward their project aim of increasing the percentage of adolescent and young adults that receive preventive care such as annual well exams, also referred to as Early & Periodic Screening, Diagnostic & Treatment (EPSDT) services. The project goal is for all NM adolescents and young adults to be healthy and engaged in self-care and community care. Adolescence is defined as age 10-25. However, we refer to ages 18-25 as young adults, as this is the title they prefer.

In 2017, the NM AYAH CoIIN partnered with local and national partners, including youth and young adults, to develop the NM Know Your Health Toolkit (KYHT). This toolkit addresses the importance of annual adolescent well exams and is a resource for healthcare providers and staff to utilize in promoting and empowering adolescents and young adults. The goals of the toolkit are to increase youth-friendly services and environment, preventive and high-quality health care services, and youth health literacy.

The KYHT was submitted for internal review and was approved for use by the NM DOH leadership. The KYHT provides a comprehensive approach to promoting adolescent and young adult health and includes the following three sections:

- Section I: Training & Educational Material for Healthcare Providers & Staff - Get everyone within your health office or clinic to be on the same page when working with young people. Foster respect & youth-adult partnership so young people feel comfortable & want to come back to the clinic.
- Section II: Assessments, Surveys & Questionnaires - Assess how youth-friendly the clinics' services and environment are. Use a holistic approach to assessing young people's health and promoting preventive services. Ensure youth have a voice in their health!!
- Section III: Know Your Health Campaign Materials - There are several resources (posters, memes, Piktocharts, handouts, resources) to promote youth health literacy and a safe and youth-friendly environment.

A remarkable feature about this toolkit is that healthcare clinics can work on implementing all three sections, choose just one section to implement, or just utilize specific resources within the toolkit to improve how they work with young people. We know healthcare providers are busy providing patient care and don't have a lot of time to be doing research on new and innovative training opportunities and youth-friendly materials and resources.

In September of 2018, the NM AYAH CoIIN started working with the University of New Mexico's Envision NM to develop an evaluation and pilot site plan for implementing the KYHT starting January 2019. Unfortunately, Envision NM's budget was cut and the two employees working with us had to be let go. Therefore, they were unable to continue their partnership with us to help with the evaluation and pilot plan. Another barrier during this same time was that OSAH went from seven employees to three employees due to staff retiring and finding other jobs. This put a strain on the remaining three employees as they had to perform their usual work duties as well as cover other position's duties.

OSAH decided to continue the AYAH CoIIN work, just at a slower pace. The NM AYAH CoIIN team set up a meeting with Apex Evaluation, a current contractor who assists with OSAH's school-based health center and peer-to-peer helper program evaluation, to see if they would work with us on the KYHT evaluation. Apex agreed to work with us on the KYHT evaluation tools this coming fiscal year July 2019-June 2020. Due to the financial difficulties, lack of staff, and staff covering multiple positions, the pilot project and Youth Health Literacy trainings have been put on hold for now. Our focus at the beginning of this coming fiscal year is to complete the KYHT evaluation process and tools.

OSAH also advocates for youth to get an annual adolescent well exam as part of their self-care. We funded 32 NM Youth P2PH Programs across the state to promote peer-to-peer education and youth-adult partnership. These programs are required to incorporate strategies based on the evidence-based Positive Youth Development Approach (PYD) and the Natural Helper Program. The program is based on the premise that when young people have problems, they most often turn to friends whom they trust for help, and that every school has an informal "helping network." The program sponsors at each school seek to identify this informal network of young people who represent the different subgroups within their school and provide training and support to those who are already serving as helpers.

Main objectives for the P2PH program are for peer helpers to increase their knowledge of effective ways to help and support their friends and peers, positive ways to take care of themselves, and ways to contribute to creating safe and supportive school and community environments. Approximately 600 youth peer helpers statewide were trained in youth suicide prevention, positive youth development, peer helping skills and self-care.

The importance of annual adolescent well exams was discussed during the self-care portion of the training. The peer helpers brainstormed various way to incorporate self-care in their lives. If annual well exams were not identified as important by youth, the facilitator started a discussion about why they are important and explained the difference between an annual well exam and the type of physical exam that is required for youth in sports. Each P2PH program also planned and implemented one service learning and one health promotion project based on the needs of their school and/or community.

In the 2017-2018 school year, OSAH provided supplemental operational funding to 48 school-based health centers (SBHC) around the state to ensure delivery of a model of care that includes integration of primary (physical) and behavioral healthcare. OSAH-funded SBHC provided 56,566 visits to 18,609 patients. Twenty-one percent of those visits were for well exams.

While SBHC are uniquely positioned to provide healthcare in rural areas of the state, 68% of SBHC are open three or less days per week and most don't offer hours in the summer or during school holidays. The operational hours of SBHC can be a barrier to providing well exams for students on Medicaid in New Mexico as the "treatment" component of the Medicaid EPSDT visit is not always manageable with limited hours and availability. An additional barrier is that many students already have medical homes where they are receiving, or would prefer to receive, well exams and only use the SBHC for episodic or behavioral health care.

OSAH has made a strong push in recent years for more local and regional medical organizations to sponsor SBHC. Currently, eighty-six percent of OSAH-funded SBHC are operated by Federally Qualified Health Centers or University medical groups. This affiliation connects students and families to larger medical organizations which can serve as medical homes and improve continuity of care.

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

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

**Strategies:**

- *Ensure teens receive confidential services including access to a broad range of contraceptive methods.*
- *Fund, monitor, and evaluate the implementation of evidence-based unintended teen pregnancy prevention education programming in communities across the state.*
- *Promote the use of social media to increase awareness about and availability of birth control and to r*educe unintended pregnancies (BrdsNBz, digital media campaigns).

**Teen Birth Rates**

Between October 2017 and September 2018, New Mexico Family Planning Program (NM FPP) continued to use a two-pronged approach to decrease the unintended teen birth rate in NM through clinical services and educational programming. NM FPP promotes three population-based strategies: service learning and positive youth development programs, adult/teen communication programs, and comprehensive sex education programs. These strategies complement clinical family planning services to prevent unintended teen pregnancy and bring about meaningful and measurable reductions in teen births. Between 2012 and 2017, the teen birth rate for teens aged 15-19 decreased from 46.8 per 1,000 to 27.6 per 1,000, which is a 41.03% decrease (New Mexico's Indicator-Based Information System [NM-IBIS, 2018]) (See Chart 1).

**Ensuring Teens Receive Confidential Services**

The state Title V program collaborates with the Family Health Bureau/Family Planning Program (the state Title X program) to implement activities related to reducing unintended teen pregnancy in NM. NM FPP works with 44 Public Health Offices (PHOs), including three PHO outreach sites, and 19 primary care clinics and school-based health centers (SBHCs) through Contracts and Provider Agreements. In 2018, FPP provided reproductive health services to 18,720 unduplicated clients (17,190 females and 1,530 males), which accounts for a 24.5% increase in client count. Statewide activities include clinical services with on-site provision of methods including the most effective (implants, intrauterine devices [IUDs]) or moderately effective (i.e., injectables, oral pills, or ring) methods of contraception and community-based education for unintended teen pregnancy prevention.

Over 70% of teen clients (15-19 years) at risk of unintended pregnancy received a most effective (implants, IUDs) or moderately effective (injectables, oral pills, or ring) contraceptive method. The percent of clients less than 20 years old who were provided a long-acting reversible contraceptive (LARC) method (implants or IUD) was 30% (a 66% increase from 2017). Confidential services are provided through NM FPP's Title X program for any client who requests it, regardless of age or marital status. The long-term impact is to reduce unintended teen pregnancy. (See Chart 2 and Chart 3)

Clinical services are enhanced through the provision of training opportunities through site audits, webinars, on-site mentoring, and Project ECHO (Extension for Community Healthcare Outcomes, a guided practice model through the University of NM (UNM) that transforms medical education and improves workforce capacity to provide best-practice specialty care and reduce health disparities). The Reproductive Health arm of Project ECHO (RH ECHO) convenes twice-monthly training webinars with a focus on family planning and reproductive health services. Topics include reproductive health services for teens, teen sexuality, contraception, sexual coercion, emergency contraception, and motivational interviewing for contraceptive methods. Individuals from various state government agencies, educational agencies, managed care organizations, and community health centers participate across the state.

NM Department of Health (DOH), Family Health Bureau participates in the Long-Acting Reversible Contraception (LARC) statewide working group, a multi-stakeholder group working to increase awareness and accessibility of IUDs and implants. The convener is Young Women United, a reproductive justice organization, with NM DOH, NM Human Services Department, UNM, the American Civil Liberties Union (ACLU), the Southwest Women's Law Center, Planned Parenthood, and others as collaborators. The LARC Mentoring Project (LMP) is a collaboration between NM DOH, the UNM, and the NM Perinatal Collaborative. The goal of the LMP is to increase accessibility of LARCs through training and mentoring of providers, including school-based health centers (SBHCs), federally-qualified health centers (FQHCs), and hospitals.

**Fund, Monitor, and Evaluate Programming**

Educational programming is provided to teens across the state by local non-profits that are contracted with NM FPP. These organizations provide the evidence-based educational programs, Wyman's *Teen Outreach Program* (*TOP*®)

and *Project AIM* (Adult Identity Mentoring). *TOP*® promotes positive youth development by incorporating community service learning and curriculum-based activities in a program to decrease unintended teen pregnancy and increase school success. Community service learning allows the teens to select a project within their community that helps them feel engaged and incorporates a reflection component that fosters a sense of purpose. *Project AIM* encourages at-risk youth to imagine a positive future and discuss how current behaviors can impact a successful adulthood through interactive and small-group activities, group discussions, and role-plays.

In State FY18, there were 362 teens completing either the *TOP*® or *Project AIM* programming. Evaluation is done through matched pre- and post-tests to determine the change in knowledge, attitude, and behaviors post-programming. After educational programming, no students reported getting or causing a pregnancy, compared to 1% before educational programming.

NM FPP promotes the use of the *From Playground to Prom: Talking with Your Child about Sexuality* curriculum, designed to increase parent-child communication, with the parents of teens who participate in *TOP*® or *Project AIM*. Evaluation is done by post-surveys to determine parental ability to talk about sexual health with their teens. In addition to educational and experiential programming, NM FPP continues to provide funds to support the BrdsNBz warm-line text service that provides medically accurate, age-appropriate sexual health and behavior answers to teens who text questions.

NM DOH also contracts with 14 providers (including five faith-based organizations) in 12 counties who offer sexual risk avoidance education programming across the state. The Success with Adolescent Goals (SWAG) program is a sexual risk avoidance program which promotes abstinence and strives to help students delay sexual initiation while covering topics such as peer pressure, healthy relationships, and drug and alcohol prevention as methods to avoid sexual risks. In addition to student programming, parents play a critical role in helping their teens with healthy decision-making. This programming helps promote positive family relationships and increased family participation in family planning and healthy decision-making. The *From Playground to Prom* curriculum is now also being incorporated into the NM DOH SWAG program. In February 2018, 25 individuals were trained and certified as facilitators by NM FPP staff, including 23 contractors who work with the NM DOH SWAG program.

The NM DOH Office of School and Adolescent Health (OSAH) and the NM DOH Family Health Bureau (FHB) also support Positive Youth Development (PYD) programming through the Peer-to-Peer Helper Program. In this program, the PYD approach reduces risk factors such as teen pregnancy, youth suicide, teen dating violence, and substance abuse by increasing resiliency factors such as the 40 Developmental Assets (https://www.search-institute.org/our-research/development-assets/developmental-assets-framework/).

The principles of this approach are 1) asset-based (focusing on strengths and supports); 2) place-based and reflective of local cultural assets; 3) holistic and developmentally-appropriate (heart, mind, body, and spirit across ages); 4) youth-informed for youth/children and by youth/children; and 5) inclusive of broad stakeholder input and support. The PYD approach encourages peer-to-peer helping skills and youth-adult partnerships. It is a way of living, breathing, and interacting with young people every day in personal and professional settings. These efforts encourage youth to take charge of their own health, help others, and recognize they are the leaders of today and the future. Healthy and engaged youth become healthy and engaged adults.

Another way NM is working to reduce the teen birth rate is through provision of services at SBHCs. SBHCs can provide a broad range of sexual and reproductive health services directly or via referral. In NM, 83% of SBHCs provide reproductive health services to their patients, with 58% of those providing hormonal contraceptives and 50% of those providing LARC. In School Year 2017-2018, 21% of SBHC patients received sexual or reproductive health services, with 66% of those services being for contraceptive management. Two hundred and twenty-five SBHC patients received a LARC in the same school year. Additionally, OSAH collaborates with the LMP to offer LARC insertion training to SBHC and adolescent medicine providers. Approximately 50 adolescent medicine providers were trained in school year 2017-2018.

The NM Public Education Department (PED) also provides support to pregnant and parenting teenagers through the NM Graduation Reality and Dual-Role Skills (GRADS), a school-based pregnant and parenting teen program. It provides services and programming for males and females in multiple high-school settings, including traditional, charter, and alternative schools. The GRADS site usually is co-located with a SBHC so that the participants can easily receive physical health services, including family planning services, at a location that is easily accessible. In the 2018-2019 school year, there were 21 GRADS sites across the state. In 2018, the repeat teen pregnancy rate for

GRADS students was 5.2%, compared to 15% for students who didn't participate in GRADS (http://www.nmgrads.org/, retrieved on 4/30/2019).

**Promote Awareness about and Availability of Birth Control**

Strategies utilized by NM FPP for unintended teen pregnancy prevention include a social media campaign about birth control and where to find services. This campaign has been funded by a grant from a local foundation (the Brindle Foundation) that supports children's issues. Digital ads on Facebook and other websites directed females aged 13-19 to age-appropriate websites that contain information on contraceptive choices available to teens. Teens aged 13-17 years were directed to http://stayteen.org/sex-ed/birth-control-explorer, while teens aged 18-19 years were directed to http://www.whoopsproof.org/nm. NM FPP analyzed the rate of use of implants in public health offices (PHOs) on a quarterly basis through the NM DOH electronic health record system, before the intervention and during the intervention, where the use of implants and IUDs in teens increased by 39%.

Community education and outreach (CE&O) activities are primarily provided by Public Health Office (PHO) staff. The CE&O activities are done to promote the availability of family planning/reproductive health services and provide community education on topics related to family planning. Information on the following topics were provided during outreach activities conducted by PHOs: contraception, sexual responsibility, intimate partner violence, adult/teen communication, sexually-transmitted diseases, and accessing family planning services. Pamphlets related to those topics are approved by an Information and Education (I&E) Committee, which consists of members from various state government agencies and from communities across NM. Membership reflects the diverse cultures of NM.

Chart 1

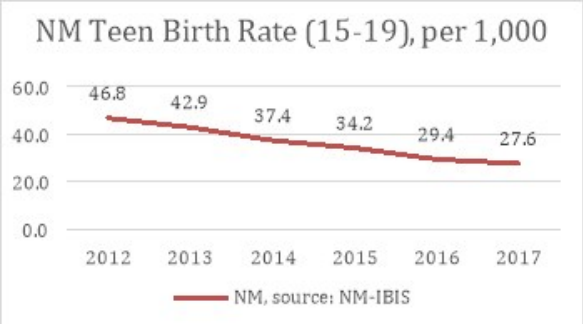



Chart 2

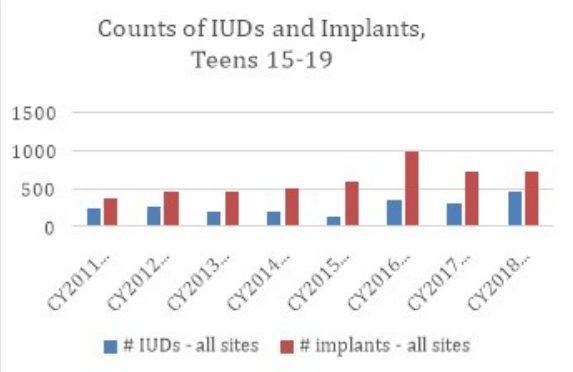
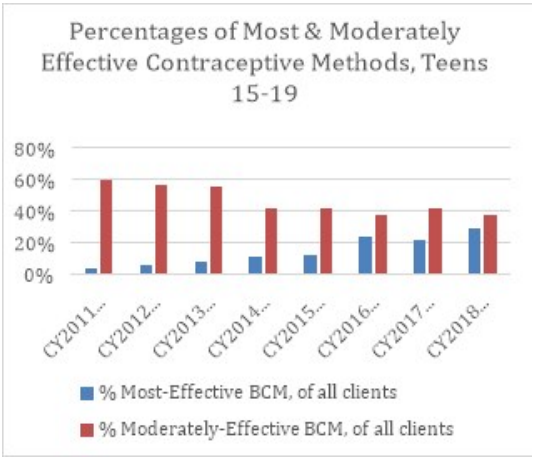



Chart 3


Percentages of Most & Moderately Effective Contraceptive Methods, Teens 15-19
80%
60%
40%
20%
0%
CY2011...
CY2012...
CY2013...
CY2014...
CY2015...
CY2016...
CY2017...
CY2018...
% Most-Effective BCM, of all clients
% Moderately-Effective BCM, of all clients

## 2020 Application Year Report

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

**Objective:**

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

**Strategies:**

- *Utilize the NM Youth Health Literacy toolkit in schools near the clinics that are piloting the Know Your Health toolkit (KYHT).*
- *Collaborate with the clinics and public health offices that are 'Know Your Health' Pilot sites to implement the youth-friendly services and environment assessments.*
- *Spread the KYHT to various adolescent health stakeholders in New Mexico to highlight the importance of well exams.*

**Adolescent Well Visit**

In FY20 the NM Department of Health(DOH) Office of School & Adolescent Health (OSAH) will continue to promote increasing annual adolescent well exams utilizing three programs they fund: the NM Adolescent & Young Adult Health (AYAH) Collaborative Improvement & Innovation Network (CoIIN), Youth Peer-to-Peer Helper (P2PH) Programs, and School-Based Health Centers (SBHCs).

By January 2020, the NM AYAH CoIIN in partnership with Apex Evaluation should have the KYHT evaluation tools completed and accessible to be filled out online. Details of the KYHT and barriers for implementing it sooner are in the 2018 annual report. The next steps from January 2020 to June 2021 are to: 1) print and gather all the youth-friendly posters and clinic materials that will be utilized by clinics; 2) recruit 3-6 primary care clinics and/or SBHCs to pilot sections of the toolkit; 3) identify and recruit schools near the pilot sites to implement the Youth Health Literacy workshop (which promotes annual adolescent well exams) with their youth, hang up youth-friendly posters in the school, and provide information about the clinics near them; 4) collect data quarterly for 6-12 months; 5) analyze the evaluation data and make improvements to the KYHT and the evaluation process if needed; 6) develop a KYHT plan to implement at more clinics in NM; and 7) share results with various partners and potential funders. OSAH will also continue to fund the Youth P2PH Programs and advocate for the importance of annual adolescent well-exams as a form of self-care, as explained in the 2018 annual report.

State Fiscal Year 2019 will mark the end of another four-year contract cycle with our school-based health center sponsors. A new RFP was released in April 2019 and new contracts will begin July 1, 2019. Attention will be given to SBHC sustainability to ensure adolescents have access to the right care, in the right place, at the right time. Sustainability entails each school-based health center having a medical sponsor in place to coordinate the provision of services and improve continuity of care. At least five new medical organizations are providing proposals to operate SBHCs in rural communities.

All SBHCs contracted with OSAH are required to select two performance measures from a menu of seven measures to actively work and report on quarterly. Increasing well exams is one of the seven performance measures. OSAH is also working with the state Medicaid office and managed care organizations (MCOs) to improve their well-exam Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS is a national health performance improvement data set that is used by health insurers to show that their members are getting appropriate care. For more information go to https://www.ncqa.org/hedis/measures/.

We will be sharing data with the MCOs to identify current SBHC student users who have not had a well exam in the last two years. Since students may also be receiving well exams in their medical home, we are also encouraging the state Medicaid office to share well exam data on SBHC users so we can reduce duplication of services and ensure well exams are completed on those students who need them. Collaborative efforts to increase partnerships with stakeholders and community health care providers improves sustainability and ultimately increases the number of visits, including well exams, provided by school-based health centers.

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

**Objective:**

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

**Strategies:**

- *Ensure teens receive confidential services including access to a broad range of methods.*
- *Fund, monitor, and evaluate the implementation of evidence-based unintended teen pregnancy prevention education programming in communities across the state.*
- *Promote the use of social media to increase awareness about and availability of birth control and to reduce unintended pregnancies (BrdsNBz, digital media campaigns).*

**Teen Births**

New Mexico's teen birth rate for ages 15-19 declined 63% since the peak year (1991) and 14% since 2015. Between 2012 and 2017, the teen birth rate for teens aged 15-19 decreased from 46.8 per 1,000 to 27.6 per 1,000, which is a 41.03% decrease (New Mexico's Indicator-Based Information System [NM-IBIS, 2018]). New Mexico (NM) is currently ranked seventh nationally, an improvement from fourth highest in the previous year, with a decline of 14% from 2015 to 2016, the second greatest decline in the nation.

The New Mexico Family Planning Program (NM FPP) will continue to fund, monitor, and evaluate the implementation of the *Teen Outreach Program* (TOP®) and *Project AIM* (Adult Identity Mentoring) evidence-based programs to prevent unintended teen pregnancy. As a result of a Request for Proposal (RFP) for Youth Development Programs to Prevent Unintended Teen Pregnancy and the awarding of contracts in State Fiscal Year 20 (FY20), *TOP*®, *Project AIM*, and *From Playground to Prom* will be offered at sites across NM.

In State FY20, *TOP*® will be implemented in eight counties at 11 sites statewide by eight different organizations. *Project AIM* will be implemented in three counties by two different organizations. NM FPP will continue to work with community organizations and provide technical assistance and oversight to ensure curricula are implemented with fidelity. The parents and trusted adults who complete the adult-teen communication curriculum, *From Playground to Prom*, will help with teen pregnancy prevention as adult-teen communication is a strong protective factor.

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

The state Title V program will continue to collaborate with NM FPP to implement a statewide, comprehensive, and coordinated plan focusing efforts on unintended teen pregnancy prevention/reduction. Components of the plan will include:

1. Funding, monitoring, and evaluating the implementation of evidence-based programs to prevent unintended teen pregnancy;
2. Assuring continued delivery of safety net family planning services through the strategic alignment of contraceptive services;
3. Ensuring teens receive confidential services in a youth-friendly environment, including access to a broad range of contraceptive methods;
4. Addressing the reproductive and other health needs of hard-to-reach and vulnerable populations through community education and outreach;
5. Implementing social media campaigns to increase awareness about birth control and where to find services; and
6. Providing training for clinic staff (including site audits, webinars, Project ECHO [Extension for Community Healthcare Outcomes] and on-site mentoring opportunities).

The long-acting reversible contraceptive (LARC) mentoring project (LMP), led by Envision NM, is a collaboration between NM Department of Health (DOH), the University of NM (UNM) and the NM Perinatal Collaborative. The goal of the LMP is to increase accessibility of LARCs through training and mentoring of providers, including school-based health centers (SBHCs), federally qualified health centers (FQHCs), and hospitals. During the 2019 Legislative session, DOH was allocated $1.1 million for LARC training and mentoring. The LMP is currently contracted to do this work following an RFP process in 2018, so they will continue to expand their training with new sites in 2019-2020. The new funding will begin July 1, 2019 and run through the state fiscal year through June 2020. Clinical staff in some public health offices will also provide mentoring for providers in their area.

The public health offices are one of the largest providers of LARC in the state and public health staff are a great resource for mentoring other providers, especially in the rural areas. Unfortunately, this is a very limited resource, because there are several vacant positions and difficulties in recruiting, especially for MDs, and two more MDs may be retiring in the next year. The Public Health Division is working on ways to address the projected staff shortage.

**Children with Special Health Care Needs**

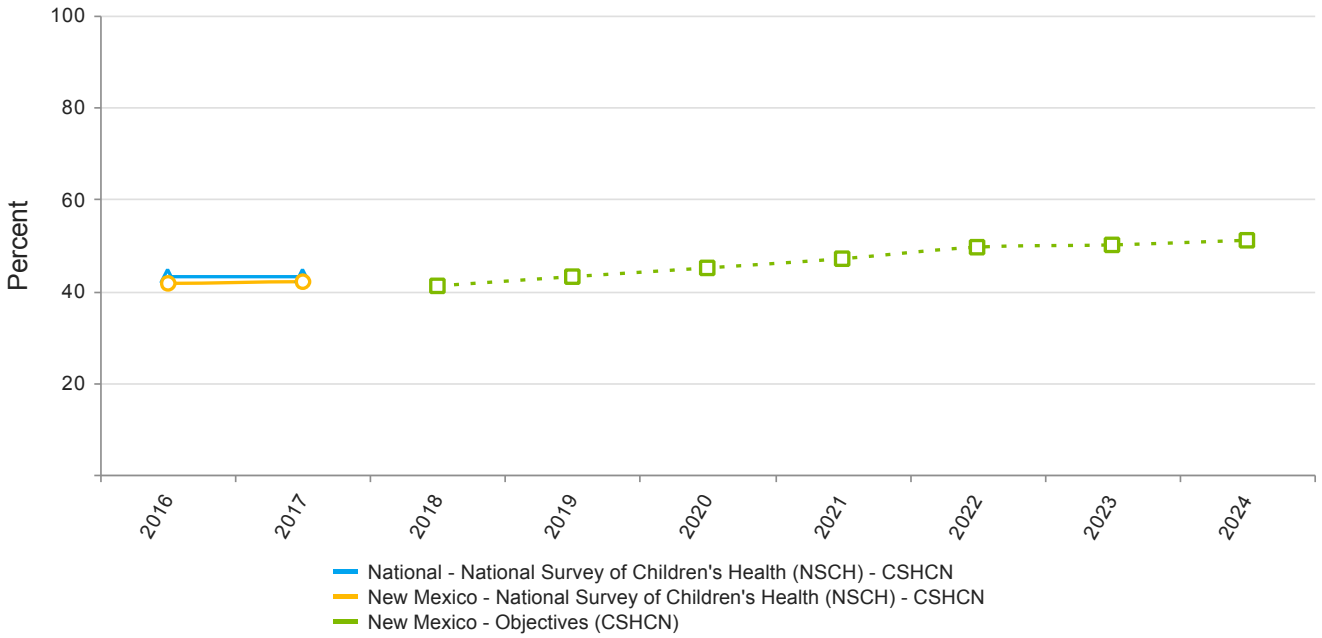
**Linked National Outcome Measures**

| National Outcome Measures | Data Source | Indicator | Linked NPM |
|---|---|---|---|
| NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system | NSCH-2016_2017 | 21.9 % | NPM 11<br>NPM 12 |
| NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling | NSCH-2016_2017 | 50.9 % | NPM 11 |
| NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health | NSCH-2016_2017 | 91.2 % | NPM 11 |
| NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year | NSCH-2016_2017 | 4.2 % | NPM 11 |

## National Performance Measures

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

**Indicators and Annual Objectives**




**NPM 11 - Children with Special Health Care Needs**

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 41.1 |
| Annual Indicator | | 41.6 | 42.1 |
| Numerator | | 40,839 | 39,424 |
| Denominator | | 98,104 | 93,717 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 43.1 | 45.0 | 47.0 | 49.5 | 50.0 | 51.0 |

**Evidence-Based or –Informed Strategy Measures**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | | 10 |
| Annual Indicator | 4 | 4 | 0 |
| Numerator | | | |
| Denominator | | | |
| Data Source | CMS Training Roll | CMS | CMS |
| Data Source Year | 2016 | 2016 | 2018 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 5.0 | 8.0 | 11.0 | 14.0 | 17.0 | 20.0 |

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

| Measure Status: | Active |
|---|---|

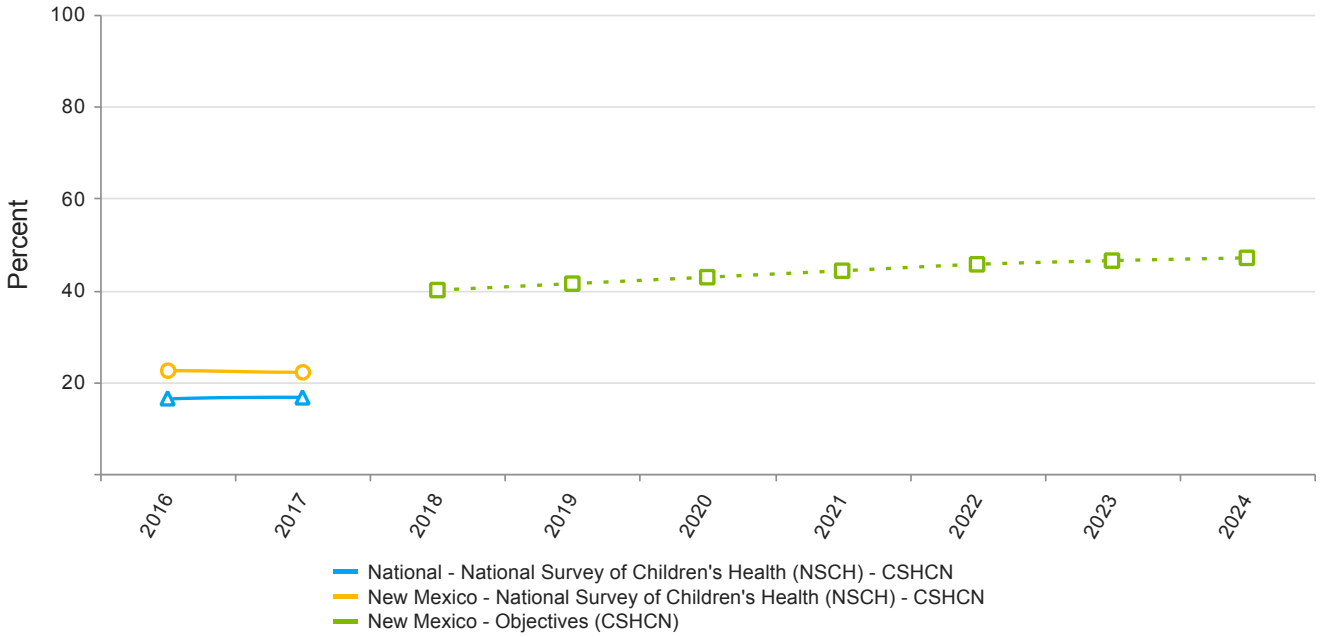
| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 4.0 | 5.0 | 7.0 | 9.0 | 11.0 | 13.0 |

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

| Measure Status: | Active |
|---|---|

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

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




**NPM 12 - Children with Special Health Care Needs**

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 40 |
| Annual Indicator | | 22.5 | 22.1 |
| Numerator | | 8,575 | 8,571 |
| Denominator | | 38,131 | 38,736 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 41.4 | 42.8 | 44.2 | 45.6 | 46.4 | 47.0 |

**Evidence-Based or –Informed Strategy Measures**

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

| Measure Status: | Inactive - Completed | |
|---|---|---|
| **State Provided Data** | | |
| | **2017** | **2018** |
| Annual Objective | 2 | 2 |
| Annual Indicator | 2 | 1 |
| Numerator | | |
| Denominator | | |
| Data Source | Family Health Bureau - Title V | Medicaid |
| Data Source Year | 2017 | 2018 |
| Provisional or Final ? | Final | Final |

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 2.0 | 2.0 | 3.0 | 4.0 | 5.0 | 6.0 |

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 1.0 | 2.0 | 3.0 | 4.0 | 5.0 | 5.0 |

**State Action Plan Table**

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

### Priority Need

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

### NPM

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

### Objectives

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

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

### Strategies

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

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

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

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

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

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

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

### Priority Need

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

### NPM

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

### Objectives

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

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

### Strategies

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

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

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

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

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

## 2018 Annual Report

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

**Objectives:**

- *Increase by 2% the number of families who have access to a pediatric clinician with effective medical home practices in place by July 2019.*
- *Increase by 2% the number of families who have access to patient and family centered care coordination by July 2019.*
-

**Strategies:**

- *Develop trainings and strategies with the New Mexico (NM) Child Health Improvement project for pediatric providers to improve care integration and cross-provider communications using evidence-based tools such as the shared plan of care.*
- *Develop strategies with the NM Child Health Improvement project to provide training to pediatric providers on care coordination and how to integrate the Title V Children and Youth with Special Health Care Needs (CYSHCN) care coordinators into their practice.*
- *Collaborate with the Family to Family Health Information Center to recruit family leaders to provide input to Medicaid and the Managed Care Organizations (MCO) to the overall system of care, specifically care coordination and family-centered care.*
- *Promote use of the Medical Home portal by primary care providers, families and other interested stakeholders by providing relevant and timely content and community resources to improve the care for CYSHCN and their families*.

### System of Care for Children and Youth with Special Health Care Needs

The focus of the state action plan is to improve the system of care for Children and Youth with Special Health Care Needs (CYSHCN) with a focus on Medical Home. Children's Medical Services (CMS) has continued to provide leadership around care coordination that is family-centered and culturally competent for CYSHCN. According to the National Survey of Children's Health, in New Mexico while more CYSHCN have at least one health care provider and a place they usually get health care they face significant disparities in other areas of the medical home model. Ninety-seven percent of CYSHCN have health insurance but far more, 61% are insured through public plans such as Medicaid and Indian Health Services where nationally this number is 47%. Twenty-seven percent of CYSHCN had at least on annual visit to an emergency room compared to 18% of children who are not; 31% of CYSHC reported having problems getting health care referrals versus 14% of non-CYSHCN. New Mexico CYSHCN also face greater economic hardship than non-CYSCHN with 54 % of these children living with families with incomes under 200% FPL as opposed to 48% nationally.

CMS employs licensed medical social workers trained in the provision of care coordination for CYSHCN from birth to age 21 in New Mexico, helping to bridge the gaps in the healthcare system and link families to needed services. This coordination of care across settings leads to an integration of services, which decreases health care costs, reduces fragmentation of care, and improves the experience for the patient and family. In rural areas CMS is seen as the only program that addresses the needs of CYSHCN. The CMS program, with its revenue source from Medicaid billing, focuses efforts on maintaining staffing in all regions of the state and defending the necessity and value of the work the social workers do in their communities. With increased staffing this year, we were able to resume outreach activities to underserved communities in rural frontier areas and within tribal communities and increase the number of our pediatric specialty outreach clinics.

In addition to working on medical homes, CMS social workers and CMS management continued to work to improve three of the core outcomes for all CYSHCN clients. These outcomes are: 1) families partner in decision making and are satisfied with the services they receive; 2) families of CYSHCN have adequate private and/or public insurance and financing to pay for the services they need; and 3) services for CYSCHN are community based and culturally and linguistically competent.

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

**Insurance Coverage and Adequacy**

New Mexico has benefited from the Affordable Care Act (ACA) as a Medicaid expansion State. This has helped close the gaps in health care access for youth age 18 and older who had historically transitioned into a system with limited health care financing. In 2018, Medicaid implemented the revised 1115 Waiver and awarded contracts to three managed care organizations (MCOs). Key components of the 1115 Waiver include: care coordination delegation and enhancements, cost sharing, patient-centered medical homes, and integrative behavioral/physical health homes. The Title V program had developed key partnerships with the MCOs several years ago and this provided the perfect opportunity to provide input into policy development around key elements such as care coordination, medical home, and transition.

The interagency workgroup met several times and agreed on recommendations that were formally delivered to Medicaid during the public comment period. Comments were centered around care coordination for CYSHCN and the need to maintain contractual partnerships with community agencies such as CMS, which has expertise in the provision of care coordination for this population, and utilization of evidenced based practices as cited by the "Got Transition" and the six core elements to assure a successful transition for youth with special health care needs into adulthood. CMS continues to monitor the Medicaid activity, as the MCO a CYSHCN is enrolled in can significantly affect access and ability to have health care needs met.

Although the uninsured rate in NM has dropped significantly with the ACA, approximately 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 therefore requires continuous monitoring by the Title V program.

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

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

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

One important goal of the project with the CDD was to produce information that can be used by CMS staff to promote the program when speaking with senior staff of the Department of Health (DOH); policymakers, including legislators; and funders, including federal agencies and MCOs. Reports prepared will incorporate results from each project component. Data was sought that addresses the cost-effectiveness of CMS services, including cost-avoidance. At this point, little is known about what data is available that meets the criteria listed above.

The first project component was to assess what relevant data is available, develop an analysis plan based on the best available data which will be approved by CMS, implement the analysis plan, and prepare one or more written and/or oral reports. Another piece of the project was requesting that the CMS staff participate in a study of what the work of care coordination entails. This time tracking was completed and the results were analyzed and reported to the program. An abstract was submitted and accepted for the annual Association of Maternal and Child Health Program conference and the New Mexico Public Health Association Annual meeting. The presentation was well received at both venues and a second contract will be developed to further analyze the data and outcomes.

In November 2018, the CMS program held a statewide conference for all staff. It had been several years since the program was able to do this and the focus was on skills building and care coordination. Topics included; adverse childhood experiences and resiliency; immigration and legal advocacy; angioma and the common Hispanic mutation; pediatric epilepsy; and structural family therapy. The conference promotes cohesion and a sense of community within the program and an awareness of core Title mission and values.

**Access to Specialty Care**

Another responsibility of the CMS program is the Newborn Screening program (NBSP). The program screens for 32 conditions, including critical congenital heart defects, congenital hearing loss, and a variety of blood tests for metabolic and hematologic disorders. The program assures that all newborns receive these screens prior to discharge and have access to follow-up and treatment in coordination with the Medical Home. In 2018, there were several activities designed to improve this coordination and support families.

The Newborn Hearing Screening program was engaged in a multi-year statewide learning community focused on Sandoval County, which consists of rural, urban and tribal communities. The goals of the project were to: (1) measure improvements in patient/family care consistent with evidenced-based approaches to referral, access to care and care coordination at the local and state level for infants with hearing loss; (2) improve response to child and family health care and community needs consistent with evidenced-based approaches based on tenets of the patient-centered medical home; (3) obtain measurable improvements in parent and family engagement; (4) develop a model for building capacity for quality improvement (QI) within the leadership of the target community and (5) measure positive changes in knowledge, attitudes, and provider practice in the content area of newborn hearing screening, referral to services, and follow-up. This past year the learning community has been successful in recruiting and training participants in the QI process and have engaged in activities that are moving the agenda forward.

The Newborn Genetic Screening program is part of the Mountain States Regional Collaborative and is participating in the second year of Underserved Populations Project (UPP) which was undertaken to develop strategies to increase access to genetic services for individuals in rural, Hispanic, and American Indian communities in the Mountain States. The New Mexico team consists of the Title V program, Trish Thomas from Family Voices, Navajo Nation, Parents Reaching Out, and Dr. Dale Alverson from the University of New Mexico office of Telehealth.

The purpose of the project was to support the outreach efforts of Ms. Sandoval, who interviews families on the Navajo Nation about access to genetic services. These families have children with genetic conditions, and she provides the families with educational materials, services, and community supports so that the team can understand the gaps and opportunities to improve resources and information for families. Ms. Sandoval left the project this year and the team began to expand its membership to include more families as well as genetic specialists from the University of New Mexico Health Sciences Center. With these changes, the focus of the project began to shift to exploring the use of telehealth as a way to improve access to genetic services.

New Mexico is a largely rural state with most pediatric specialists located in Albuquerque at the University of New Mexico Health Sciences Center (UNMHSC). High poverty rates, lack of transportation, and other socio-economic conditions can make accessing specialty care prohibitive for many families outside of the Albuquerque metro area. In partnership with UNMHSC, CMS facilitated over 160 multidisciplinary pediatric specialty clinics in rural areas of the state including cleft palate, nephrology, endocrinology, pulmonary, neurology, and genetics. CMS medical social workers follow CYSHCN through the multidisciplinary pediatric specialty outreach clinics, as well as assuring that specialists' recommendations are communicated to the local (community-based) primary care providers. Without these specialty clinics many CYSHCN would not be able to access this care.

**Family Partnerships**

Parents Reaching Out (PRO) and the NM Title V CYSHCN program are committed to provide support for New Mexico families of children and youth with special health care or education needs, especially those who have challenges accessing current systems. Within our vast state, the aim is to reach all families, especially those who may be isolated due to language, citizenship status, or geographic location. We work with populations that are diverse culturally, ethnically and linguistically, and populations with varying citizenship status residing within the state of New Mexico. The parents and partners with whom we work reflect New Mexico's demographic makeup, which is majority Hispanic with significant Native American representation.

Organizations with whom we partner include: Education of Parents of Indian Children with Special Needs (EPICS), Hands & Voices, Growing in Beauty (Navajo), the Mescalero Apache Early Childhood Program, and the Asian Family Resource Center. CMS sponsored and participated in the annual PRO and EPICS Family Leadership conferences. Each conference attracts over 400 participants and consists mostly of families who have children with special needs. Participants from across the state come for mutual support and education about a range of topics that support the core outcomes for family professional partnership.

CMS continued its partnership with the state's lead agency for child welfare, the Children, Youth and Family Department (CYFD). The CYSHCN/Child Protective Services project aims to provide CYFD staff with an efficient means to improve overall care of children with chronic medical conditions on their caseloads. CMS social workers provide consultation and co-management for this population as they are specially trained in care coordination for children with chronic medical conditions. In this partnership, the social workers provide the link between specialty care-patient-primary care offices and dental practices in the local communities.

CMS social workers work with the clients until they turn 21, which serves to provide both continuity of care for those CYFD clients who are aging out of their system at 19, as well as intensive work around youth transition in all areas (healthcare, educational and vocational). The social workers also work with foster families to teach them about the medical needs of the child, how to navigate the specialty healthcare system, and how to assure a medical and dental home.

New Mexico needs sustained family leadership and advocacy, especially regarding 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 to obtaining the information they need to navigate the complex managed care system. The Title V program supports the existing family networks to be fully prepared, mentored, and connected to meaningful opportunities of program and policy partnership and ensures that the Managed Care Organizations (MCOs) are guided by patient and family voices. In 2018, PRO enlisted CMS to be part of a State Team to address this issue. Through a training grant from Family Voices, the New Mexico team developed a list of advisory/stakeholder committees that should have or do require consumer/family participation and will be utilizing the Family Leadership conference to recruit parents who are interested and prepared for this leadership role.

The ECHO™ financing clinic at the NM Family to Family Health Information Center (F2F) at Parents Reaching Out continued to address health care financing issues and access to care for CYSHCN. This model uses the "hub" and "spoke" approach to addressing health care needs. The "hub" in this case are experts from Medicaid, the MCOs, the disability community, Title V, and others. The "spokes" are care coordinators and families in rural communities who meet in local Public Health offices. This project had staff turnover and was not as robust as in the prior years and CMS will continue to support and encourage the continuation of the project.

**Care Coordination**

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 was completed in spring of 2018. The program hoped to continue this partnership but due to a change of leadership, ENM changed focused and direction and was no longer aligned with the needs of the CMS program. A request for proposals was issued in the fall of 2018 to continue the quality improvement project related to Title V performance measures, and the New Mexico Quality Improvement partnership was selected. Due to lengthy contracting procedures, the contract was not expected to be finalized until late into the fiscal year, delaying this project. The contract will be for three years, so it does give some longevity to the project.

The MCH Epidemiology program continued its partnership with the DOH Asthma Epidemiology program to address unmet needs of children with moderate to severe asthma. The asthma program uses surveillance data to provide MCH Epidemiology with a list of children who have been hospitalized or had an Emergency Department visit due to

asthma. 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 prioritizes that the child has a Medical Home. An evaluation component will be developed in 2019.

The Birth Defects program continued surveillance and outreach to families with birth defects. With funding for the Zika Virus ending, the DOH in New Mexico Birth Defects program focused on the 12 core Birth Defects. The program began developing educational materials around each of the diagnoses. Resource and referral information was also developed on topics such as: behavioral health, substance abuse treatment, and pediatric specialty care. The coordinator participated in numerous outreach events across the state over the year to disseminate this information.

The coordination of services will continue with all babies and children (birth to 4 years) identified with a birth defect being referred to CMS. Contact is being made with families who are not linked to services. Families identified through Newborn Hearing Screening will also be contacted if the Hearing Screen results indicate further need of services and/or multiple medical diagnosis are identified. These families are referred to CMS social workers for care coordination and linkage to the Medical Home.

Babies identified with a Neonatal Abstinence Syndrome (NAS) code were reported to the Birth Defects Surveillance program from the birth hospitals in the State. Even though NAS is not a birth defect, it was added to the birth defects surveillance because of the high prevalence in NM. For example, many babies who are born exposed to substance in utero have a higher incidence of a cardiac condition such as ventricular septal defect. Submucosal Cleft Palate is another birth defect that can be linked to smoking and potential poly-substance use as well.

CMS is partnering with CYFD in developing and implementing the state plan for Comprehension Addiction and Recovery Act (CARA) 2018. This is part of a statewide effort to address the opioid epidemic and involved a multi-agency task force that met monthly to develop the response and assist CYFD to meet the requirements of the program improvement plan. The Birth Defects Coordinator took the lead in developing the Safe Plan of Care template and the training materials that will be used.

**Medical Home Portal**

CMS continues to support and promote the use of the Medical Home Portal (MHP) maintained at the University of Utah as a useful resource for families and providers to obtain accurate information on pediatric medical conditions. It also links families to community resources to address psychosocial needs as well. The community resources page is kept up to date in partnership with the University of New Mexico Center for Development and Disability Information Network. The CMS Program Manager participates in the Medical Home Portal Advisory committee that began meeting quarterly to review portal metrics and usefulness and to provide input into additions that would be helpful for New Mexico families.

The MHP got considerable attention this year from the NM Pediatric Society and the Early Childhood Comprehensive Systems-Act Early (ECCS-AE) State Team. These groups decided to embrace the MHP as the "go to" for their respective stakeholders. A New Mexico team was formed to provide input to the MHP staff in Utah. At the annual NM Pediatric Society conference, a brief survey was made available to pediatricians to elicit level of knowledge and interest of the MHP. The results demonstrated enough interest that the Pediatric Society invested resources from an Association of Maternal and Child Health Programs (AMCHP) grant to develop promotional materials that are being distributed to all pediatricians statewide to encourage use of the Portal.

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

**Objectives:**

- *By July 2019, increase by 2% the number of pediatric and pediatric specialty care practices who report that they have a written health care transition policy and/or process to help youth with special health care needs prepare and plan for transition to the adult physical and behavioral health care systems.*

- *By July 2019, establish a baseline of youth and their parents/guardians in the Title V Children and Youth with Special Health Care Needs (CYSHCN) program, Children's Medical Services (CMS), who report that they have the knowledge and tools to talk to their doctor about transition and be engaged in the planning process.*

**Strategies:**

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

**Transition Training and Quality Improvement**

In 2018, Children's Medical Services (CMS) continued to enhance foundational program activities to improve medical transition for Youth with Special Health Care Needs (YSHCN). According to the National Survey of Children's Health 22.2 % of New Mexico YSHCN reported having received services for transition to health care compared to the national average of 12.6%. Since 2002, CMS has had an established transition program for YSHCN. Transition guidelines and transition plans were developed by the CMS Transition Team over several years, and CMS staff in all five regions of the state utilize the Transition Plans. The transition plans have been reviewed by several CMS social workers and YSHCN to assess effectiveness. The plans have been helpful in raising issues such as employment, secondary school, medical management of their chronic health condition and inspiring youth to think about transition. They also assist teens in identifying their own needs.

CMS social workers are required to use this plan for transitioning youth aged 14-21, ideally as part of the CMS renewal process. We recommend that transition planning occur every other year for youth aged 14-17 and that the written plan be updated every year for those 17 and older, at the discretion of the social worker. The transition plan is designed to be reviewed and discussed in person with the client as a tool for promoting conversation about transition topics.

CMS social workers complete a transition assessment for youth starting at age 14. This assessment addresses youth knowledge and ability to manage their medical condition, use of health care services, daily living activities, what areas they continue to need assistance with or anticipate needing assistance with, living arrangements, transportation, recreation, social relationships, and future education and/or employment planning.

For medical transition, CMS social workers work with the youth to identify adult providers that will assume care from the pediatric providers during the transition process and assist in addressing health care financing. NM participates in the Affordable Care Act (ACA) Medicaid expansion, and this has been very beneficial to YSHCN who are 18 because it enables many of them to move onto the expansion coverage when they age out of Medicaid/Children's Health Insurance Program (CHIP). For youth that are not eligible for Medicaid ACA or private insurance, the social workers transition these YSHCN onto the NM High Risk Pool at age 21. The High-Risk Pool offers a low-income premium plan that offers monthly premiums based on a sliding scale fee.

Behavioral health care has been identified as an increasing need for CMS clients, so the transition plan was updated this year to include questions around behavioral health such as depression, substance use, and suicidality. The CMS social workers also participated in a one-day training at the Head-to-Toe Conference, an annual conference for school personnel. The training, called ASPYR (Alliance for Suicide Prevention and Youth Resilience), focused on screening and assessment for suicide, building safety plans, and enhancing youth coping skills. This was in response to a recognition that depression, suicidality, and other mental health disorders can have a great impact on

YSHCN, and staff requested assistance in becoming more effective and prepared to manage these issues.

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

CMS social workers continued to receive training and support around transition planning with youth. The data system, CACTUS, has integrated the transition assessment and includes a care plan that is co-developed with the social worker and the youth to highlight areas of work that need to be focused on to assist with a successful transition. Regional staff meetings that occur monthly continue the focus on different aspects of transition and social workers earn CEU's towards their social work licenses by attending these meetings.

The CMS Management team continues to review the materials from Got Transition, the national center that supports evidenced-based transition methodology and other transition resources, and to incorporate questions and processes into the transition plan. As a best practice, the CMS statewide program manager attends webinars and trainings that are sponsored by Got Transition and shares this information with the CMS Management team. In addition, a CMS all-staff meeting was held in November 2018; transition for YSHCN was included in the curriculum.

CMS has contracted with Envision New Mexico for several years to assist with quality improvement activities and help the program address Title V performance measures. The contract for the third year with Envision was not renewed due to some changes in their leadership and a shift in their priorities and focus. A Request for Proposal (RFP) was issued in the fall of 2018 to continue the work that had been requested and the New Mexico Quality Improvement Partnership (NMQIP) was selected. Unfortunately, due to delays in contracting, the work is not scheduled to be started until May 2019, but this will be a three-year contract so there will be some longevity in the work.

**Statewide/Policy Activities**

The New Mexico Action Learning Collaborative (ALC) with the Association of Maternal and Child Health Programs (AMCHP) and the National Academy of State Health Policy (NASHP) set a goal in 2017-18 to review the Six Core Elements of Transition (policy, tracking, readiness, planning, transfer, and evaluation) and other state examples and submit recommendations to NM Medicaid during the public input phase of the Medicaid 1115 waiver renewal. The Six Core Elements were integrated into the written comments that were submitted to Medicaid on behalf of the ALC, as transition was a focus of the waiver application.

From this process, transition was identified by the MCOs and Medicaid as an essential component of care that needs to be addressed. The definition of transition in the waiver was quite broad and incorporated transitions such as juvenile justice, transition from hospital to home etc. It did not specifically include youth transition to adult health care. Our goal was specifically to introduce the concept of medical transition as a best practice for YSHCN. This is especially important for Medicaid and the MCOs considering that NM has expanded Medicaid benefits and many of these young people will be transitioning their Medicaid eligibility status at age 18. Ultimately, in 2018 the recommendations regarding transition for youth were incorporated into the Managed Care policy manual section 5.7.

CMS also continued to support the work of the Medical Home Portal (MHP) through participation on the advisory committee. The MHP does house information on transition and acts as a resource statewide. The MHP has received a lot of attention this year from early childhood stakeholders and the NM Pediatric Society. This has led to considerable efforts around outreach events in many communities to promote the use of the Medical Home Portal.

**Collaboration and training with the Family to Family Health Information Center**

A transition track at the annual family leadership conference sponsored by Parents Reaching Out (PRO) the NM Family to Family Health Information Center (F2F) was supported through funding and professional presentations to

train families who have children and youth with special health care needs to be advocates for their children and improve understanding of the health care system. A second conference in Las Cruces, in the southwestern part of the state, was sponsored this year as well as the main conference in Albuquerque. Families throughout New Mexico and some CMS staff members attend this conference. CMS presented on transition using the Six Core Elements at the PRO conference in Las Cruces this year, which was well received by families in that region.

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

Several years ago, CMS developed a DVD entitled “What Comes Next” which follows three YSCHN through the transition experience and highlights the need for interagency collaboration, which is still relevant today. A curriculum guide accompanies the film and creates a springboard for interaction and discussion with conference participants. The DVD and audience discussion during the presentation continues to raise numerous issues that parents had on issues such as guardianship and the role of their youth’s primary care physician in initiating transition planning. This feedback is helpful in planning subsequent training sessions.

In 2018, CMS again utilized 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 Project ECHO Clinic participants consist of a cross-section of providers and partners across the state including Children, Youth and Families Department, the MCOs, Medicaid, parents, advocates, the Center for Law and Poverty, legislators, medical providers, therapists, early intervention providers, behavioral health providers, among others. CMS social workers and other staff have presented transition-related cases to the ECHO participants to highlight the needs of YSHCN and seek input. There have been some personnel changes at Parents Reaching Out this year which has affected the regular scheduling of these clinics.

## 2020 Application Year Report

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

**Objectives:**

- *Increase by 2% the number of families who have access to a pediatric clinician with effective medical home practices in place by July 2019.*
- *Increase by 2% the number of families who have access to patient and family centered care coordination by July 2019.*
-

**Strategies:**

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

**System of Care for Children and Youth with Special Health Care Needs**

Children's Medical Service (CMS) will continue to support the medical home concept in New Mexico through discussions at professional meetings and conferences and continuing work on the Medical Home Portal (MHP), which provides accurate and comprehensive information on health information and community resources for families in English and Spanish. The CMS Program Manager will continue to participate in the Medical Home Portal Advisory committee. This committee will be meeting to review portal metrics, usefulness and to provide input into additions that would be helpful for New Mexico families.

To support updates to the portal resources, CMS will enter a contractual relationship with the Center for Development and Disability (CDD) Information Network for three years. The CDD Information Network provides information and referral, tip sheets, library materials, and other resources to individuals with disabilities, families, physicians, educators, and other professionals in New Mexico. The CDD Information Network maintains a database of over 4,000 resources, each including agency/program names, contact information, website, what services they provide, eligibility information, etc. This data is stored in an information and referral software known as ReferNet. Updates for each service provider and/or program are requested and made regularly.

Since 2013, the CDD Information Network has shared its resource data with the Utah MHP, which has extracted a subset of those services to be included in the MHP's services database. The MHP provides information, tools, and other resources for physicians, families, and others who care and advocate for children with chronic and complex conditions. The Utah MHP has developed a tool to facilitate importing and updating data maintained within the ReferNet software used by the CDD Information Network. This partnership assists CMS to continue making information available about New Mexico community services for Children and Youth with Special Health Care Needs (CYSHCN) to families and the healthcare providers who care for them through the MHP. A series of PEDX talks sponsored by the NM Pediatric Society will occur over the next year to promote use of the MHP with pediatricians across the State. These activities address the strategy to promote the use of the MHP.

**Care Coordination and Quality Improvement**

CMS will be entering into a contract for a second year with the Center for Development and Disability (CDD) at the University of New Mexico Health Policy Program to expand the first-year work around care coordination. The first component of the project will focus on identifying Health and Other Disparities for CYSHCN by analyzing existing data. The goal of this component of the project is to identify information from existing data sources which can be used to document health and other disparities faced by CYSHCN by analyzing data from the combined 2016-2017 National Survey of Children's Health (NSCH). Activities will include preparing an analysis plan to identify the data that will be used in the analysis and conducting appropriate analysis on the NSCH.

The second component of the project will be to collect self-reported data on the impact of CMS**.** The goal of this project component is to augment the data collected in the first component with self-reported quantitative and/or qualitative data from CMS clients, their families, CMS staff and others identified by CMS. This data will address the perceived impact of CMS services on health-related and other quality of life indicators. Activities will include developing a client impact survey to be sent to families that will be available in both hard copy and online formats; analyzing data from the survey; and developing a needs assessment survey instrument for parents that will be disseminated on a statewide basis.

The final component will be to provide additional analysis of the encounter data**.** The goal of this component is to undertake additional analysis of the dataset captured in FY2019 on encounters by CMS Social Workers. Activities will include entering data on race, ethnicity, gender, county, and age supplied by CMS in the de-identified dataset and analyzing the data to identify health and other disparities based on these variables. This analysis will assist to further define the role of care coordination for CYSHCN and the value that the Title V program brings to the medical home. It will also assist in laying some groundwork for the upcoming needs assessment.

CMS will continue to closely monitor the impact of the 1115 Medicaid Waiver. Some of these changes include: care coordination enhancements, patient-centered medical homes and integrative behavioral/physical health homes, changes to eligibility, and cost sharing. With a new administration, there could continue to be changes and updates, which may affect care for CYSHCN. Feedback on the impact of the waiver will be obtained directly from families that the CMS staff work with and through the family organizations CMS partners with who collect data from stakeholders through their outreach and education events on access to medical care and services. The Managed Care Organizations will continue to play a key role in terms of access to care, especially specialty care for CYSCHN.

To address care coordination for CYSHCN in the overall state system, the New Mexico Quality Improvement Partnership will initiate improvement activities regarding coordination of health care and social services for children in New Mexico who have disabilities and chronic medical conditions. Uncoordinated, fragmented care is a contributing factor to poor health outcomes in the pediatric population of children with special health care needs. There is an increased demand for services for CYSHCN and families at all levels, necessitating health care from multiple organizations and programs. Initiatives for this multiyear project include improving the coordination of care across service providers for CYSHCN in partnership with the medical home, and improving the transition of youth with special health care needs from pediatric to adult care in accordance with the National Training Center "Got Transition" evidenced-based practices. Activities will include:

- A plan to increase the percentage of patient/family engagement receiving care consistent with the American Academy of Pediatrics (AAP) Bright Futures Guidelines for evidenced-based approaches to care coordination and to provide input to affect the state plan for coordinated services for CYSHCN in the medical home;

- A plan to increase primary care physician (PCP) engagement with CMS social workers and youth with special health care needs and their families as part of the care team around the transition from pediatric to adult medicine based on evidenced-best practice, as referenced in the National Consensus Framework for Systems of Care for Children and Youth with Special Health Care Needs (*cyshcnstandards.amchp.org*);

- Establishment and maintenance of a care coordination consortium to be a source of information, resources, tools, expert advice, and peer learning and support for pediatric and family practice staff, managed care organizations, Medicaid, family organizations, Title V staff and other service providers who focus on coordinating care for children, with an emphasis on those with chronic conditions and special health care

needs and the family- and patient-centered medical home approach.

An initiative for the Newborn Hearing Screening program designed to reduce loss to follow-up of newborns who do not pass their hospital screen is also included in this project. This initiative will focus on 1) increasing health professionals' engagement with and knowledge of the Early Hearing Detection and Intervention (EHDI) system; 2) improving access to Early Intervention (EI) services and language acquisition; and 3) improving family engagement, partnership, and leadership within the EHDI programs and EI systems. The Newborn Hearing Screening program is utilizing a Learning Community model in Sandoval County New Mexico to test changes that can be utilized statewide in hospitals, audiology offices, and primary care provider practices. The Newborn Hearing (NBH) and Newborn Genetic Screening (NGS) Programs will continue to include the medical home during follow-up when an infant is identified through newborn screening.

The NGS program will continue its work with the Mountain States Regional Genetics Collaborative (MSRGC) project that is assessing access to resources and care for families that have a child with a genetic condition and live on tribal lands. This project is parent-driven and targeted at families from underserved regions of the state. The annual MSRGC conference will be held in Albuquerque in the fall of 2019, and the work of the NM State team will be highlighted. There has been a focus on using telehealth to improve access to genetic services for families in rural areas and especially tribal lands and the goal for this upcoming year is to pilot a metabolic outreach clinic in the northwest part of the state utilizing telehealth.

CMS was asked to participate in the first cohort of an Action Learning Collaborative (ALC) with the National Resource Center for Patient/Family Centered Medical Home. The goals of the ALC are to: strengthen systems of services in states; increase cultural competency; and increase health equity in vulnerable and underserved populations of CYSHCN. The state team consists of the Title V CYSHCN Director, AAP representative, a pediatrician, a family representative, and a Medicaid representative. The ALC will begin in the summer of 2019 and last 10-12 months.

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

CMS is also participating in an Integrated Care for Kids grant application, due in the summer of 2019. If we get this grant it will enable us to demonstrate a new model of care that should hopefully increase access to care for all children in northern NM, while integrating physical and behavioral health and raising the visibility of the CMS program and the work of the medical social workers.

The Birth Defects program will continue it surveillance and outreach to families with birth defects on the twenty-three core birth defects identified by the CDC. The program will continue to work on developing educational materials around each of the diagnoses as well. Families are linked to community services, CMS social workers, and primary care.

Babies identified with a Neonatal Abstinence Syndrome (NAS) diagnosis code will continue to be reported through Birth Defects Surveillance from all birthing hospitals. Even though NAS is not a birth defect, it is an increasing problem in NM that puts babies at potential risk for birth defects and medical complications. CMS will continue its partnership with Children, Youth and Families in implementing the state plan for Comprehensive Addiction and Recovery Act (CARA )2019, which includes training on Care Plans for all newborns and tracking of these care plans. This is a multi-agency statewide effort to address the needs of children with NAS and to improve the statewide system for children born exposed to substances.

The Title V program will continue to strengthen the existing family networks to help families with CYSHCN be fully prepared, mentored and connected to meaningful opportunities of program and policy partnership and ensure that the Managed Care Organizations (MCO), Medicaid, and state polices that can affect CYSHCN are guided by patient and family voices.

Best practice for care coordination of CYSHCN involves collaborative patient and family-centered care. To continue to address these principles, CMS will sustain family participation in the Maternal and Child Health (MCH) Collaborative, NM Interagency Coordinating Council (ICC), Newborn Hearing Screening (NBHS) Advisory Council, Early Hearing Detection and Intervention (EHDI) meeting, and Association of Maternal and Child Health Programs (AMCHP) Conference. CMS will maintain contracts with family organizations to ensure that families partner in decision-making at all levels; the scope of work includes participation in local, state and national meetings/conferences, training for staff/families, and an advisory role regarding policy.

CMS will continue to meet with family organizations to discuss ways to improve efforts to ensure that families partner in decision-making at all levels and are satisfied with their care. Parents Reaching Out (PRO) and the NM Title V CYSHCN program are committed to supporting New Mexico families with children and youth with special health care or education needs, especially those who may be isolated due to language, citizenship status, or geographic location.

We work with diverse cultural, ethnic, and linguistic populations with varying citizenship status within the state of New Mexico. Organizations with whom we partner include: Education of Parents of Indian Children with Special Needs (EPICS), Hands & Voices, Growing in Beauty (Navajo), and Navajo Family Voices. The Navajo Family Voices contract will include support for Navajo families to participate in various activities to promote traditional wellness and resiliency. Trainings specifically around cultural competence entitled “Cultural Signals” will be provided to CMS staff at various locations in the state to assure that all staff receive this training.

CMS will continue to provide funding to PRO to support the family leadership training meeting which will be held both in Albuquerque and in Las Cruces to improve access to families in the southern region of the state. Funding is also provided to EPICS for their family leadership training conference, which focuses on Native American families and attracts over 400 participants annually. The Hands & Voices chapter in NM will also continue to be funded for family-to-family support during early identification of hearing loss in infants. In the summer of 2019 the CARE project will be in New Mexico. The project is a family retreat that is organized and funded by CARE for up to 10 families who have a child, birth to age 4, who is deaf or hard of hearing. The retreats are 2-3-day experiences of informational seminars, family to family bonding time, social activities and break-out groups for moms, dads, siblings and children that are deaf or hard of hearing to build community, advocacy and resiliency.

CMS will also continue its partnership with the state’s lead agency for child welfare, the Children, Youth and Families Department (CYFD). The CYSHCN/Child Protective project aims to provide CYFD staff with an efficient means to improve overall care of children with chronic medical conditions on their caseloads. CMS social workers provide consultation and co-management for this population as they are specially trained in care coordination for children with chronic medical conditions. In this partnership, the social workers provide the link between specialty care, patients, primary care offices and dental practices in the local communities. CMS staff in the Regions will continue to provide education and outreach to local CYFD staff to maintain this partnership as there is frequent staff turnover. The CARA collaboration at the state level also provides opportunities for joint trainings and has greatly improved inter-agency communication.

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

**Objectives:**

- *By July 2019, increase by 2% the number of pediatric and pediatric specialty care practices who report that they have written a health care transition policy and/or process to help youth with special health care needs prepare and plan for transition to the adult physical and behavioral health care systems.*
- *By July 2019, establish a baseline number of youth and their parents/guardians in the Title V Children and Youth with Special Health Care Needs (CYSHCN) program Children’s Medical Services (CMS) who report that they have the knowledge and tools to talk to their doctor about transition and be engaged in the planning process by July 2019.*

**Strategies:**

- *Provide training on transition and the Six Core Elements to a successful transition to CYSHCN and their families at the annual parent leadership conference sponsored by Parents Reaching Out (PRO) and EPICS (Educating Parents of Indian Children with Special Needs) and with youth with special health care needs (YSHCN) in the CMS program.*
- *Collaborate with the Family-to-Family Health Information Center to recruit family leaders to provide input to Medicaid and the Managed Care organizations to the overall system of care for CYSHCN around transition to adult health care.*
- *Develop quality improvement projects with the NM Child Health Improvement project to engage pediatric providers to increase their understanding of transition and implement processes into their practices based on the evidenced-based model developed by Got Transition.*

**Transition Training and Quality Improvement**

For FY20, CMS social workers will continue to initiate a transition assessment and develop a plan of care for youth starting at age 14 to address youth knowledge and ability to manage medical conditions. This plan also includes education around the use of health care services, daily living activities, what areas they continue to need assistance with or anticipate needing assistance with, living arrangements, transportation, recreation and social relationships and future education and/or employment planning.

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

Activities related to assisting youth transition to an adult health care provider can still be challenging in many areas, so this will be an ongoing project to work on. The contract with the New Mexico Quality Improvement Partnership (NMQIP) will assist the Title V program with the strategies identified to meet the objectives for improving transition process for youth. The contractor will conduct a needs assessment with CMS staff and providers this year to identify barriers, successes and other areas were improvements could be made when transitioning YSHCN to adult medical care. Part of the goal with this new project will be to work on partnering more closely with the adult providers (either medical home or specialist) through a warm handoff or other strategies to be identified through a Plan, Do, Study, Act (PDSA) approach. This focus on individual community needs is the basis of a successful transition.

CMS had been working on revising a tool that the social workers have been using for many years called the CHUMS. It is wallet sized and holds several inserts where the youth can document their medical conditions, medication, emergency contact numbers, doctors etc. It can be easily updated and brought to appointments to facilitate information transfer from the youth to the providers. It has been very popular with families. In the upcoming year, the CHUMS prototype will continue to be tested and revised. It has also been translated into Spanish, so that version will be tested also. There have been requests for different formats of CHUMS that will be worked on as well in 2020. The transition booklets that CMS gives to youth have been updated and this year we will update the Spanish version.

CMS social workers will continue to receive training and support around transition planning with youth, which includes a focus on utilizing the transition care plan in the CACTUS data system to develop specific tasks with timelines and persons responsible for completion for transitioning youth. Our goal is to see better utilization of the care plan by CMS social workers and youth and inclusion of behavioral health needs as well as physical health needs. Trainings on the data system occur monthly and are facilitated by the CMS training specialists along with super users among the staff.

CMS will continue to support the work of the Medical Home portal which does house information on transition and which will be shared with partners and stakeholders as a resource statewide. A PedX talk sponsored by the NM Pediatric Society is being planned for fall 2019 to introduce the Medical Home Portal to pediatricians during their monthly lunch time training meetings.

**Partnerships/Family organizations**

A transition track at the annual family leadership conference sponsored by the NM Family to Family Health Information Center/Parents Reaching Out, in Albuquerque and now in Las Cruces, will continue to be supported through funding and professional presentations to train families who have CYSHCN. Transition training is also part of the annual family leadership conference sponsored by EPICS, 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 helps the program serve as a liaison to Native American families in New Mexico. CMS is developing a relationship with the newly formed Navajo Family to Family Health Information Center/Navajo Family Voices and will enter a contractual relationship with them this upcoming fiscal year. A focus will be integrating transition best practices into their curriculum and their work with families and YSHCN on the Navajo Nation. This is an exciting new partnership as we know that there is a dearth of resources and support for families with CYSHCN on the Navajo Nation.

CMS will continue to utilize the Project ECHO Health Care Financing clinics to address challenging issues related to transition. This will be done to highlight the needs of transitioning youth and elicit feedback on policies and practices that have been effective. CMS social workers and other staff will present cases to the ECHO participants to highlight the needs of YSHCN and seek input on solutions.

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

**Cross-Cutting/Systems Building**

**Cross-Cutting/Systems Builiding - Annual Report**

No content was entered for the Cross-Cutting/Systems Building - Annual Report in the State Action Plan Narrative by Domain section.

**Cross-Cutting/Systems Building - Application Year**

No content was entered for the Cross-Cutting/Systems Building - Application in the State Action Plan Narrative by Domain section.

**III.F. Public Input**

In New Mexico, we have a centralized Health Department based in Santa Fe that houses the Public Health Division Director, two Deputy Directors, and other staff that serve the entire Division. The state is divided into four public health Regions, each with their own Regional Director; but our Public Health Regions are rural, expansive and diverse, both geographically and demographically and include sovereign tribes and nations. It is therefore paramount that we continue to interact with tribal leadership and regional leadership to align our goals and objectives across jurisdictions. Public input includes the continuous engagement with Navajo Nation, Albuquerque Area Indian Health Board, and family advocacy groups, including those not always in our usual stakeholder communications. Health Promotion staff in the regions attend local community meetings and participate in local Health Councils to continually receive input and feedback on community needs and priorities.

This year, our Title V program is excited about updating our mechanisms and technology for obtaining public input for the block grant. One of the barriers to obtaining public input is the lack of understanding among the general public, and even some of our partners, as to what Title V is. To address this, we have elected to create a series of animated videos to explain the block grant in general, as well as by domain. These videos will allow us to break down the grant into smaller pieces to facilitate comprehension of the overall purpose of Title V. We will still distribute the actual grant and Executive Summary as well, so that the transparency is built into the process, but now we will be able to provide a quick and visual overview as an introduction.

In addition, the Maternal Child Health Epidemiology program will be creating a webpage to display a data dashboard. The purpose of this is dashboard is to have MCH data all in one place in a way that is easily accessible and understandable. This will also serve to provide further context for the Title V priority areas in New Mexico, helping to link data and program efforts in a visual way for the public and professional workforce. This webpage will be used as another source for feedback on Title V data and activities on a year-round basis.

More information about public input from family organizations is written in detail in the Family Partnership narrative. These organizations are an important part of how we gain feedback. Family organizations are invited to provide input into the CYSHCN Program activities and the Title V Block Grant during scheduled MCH Collaborative meetings. The MCH Collaborative is a partnership model in which Title V funded programs such as MCH, LEND and the Pediatric Pulmonary Center all meet together quarterly with family organizations such as Parents Reaching Out (PRO) and Family Voices. This provides a regular forum for discussion and input. Input is also obtained when CMS makes direct referrals to family support organizations for family-to-family connections. The Cleft Palate clinics specifically 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), the Early Childhood Comprehensive Systems/Act Early (ECCS-AE) work group, the Newborn Hearing Screening (NBHS) Advisory Council, and the Early Hearing Detection and Intervention (EHDI) advisory group. The Title V Child Health Program manager leads the ECCS work group, and CMS/Title V takes the lead role in coordinating the newborn screening and newborn hearing councils. 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, including PRO and Education for Parents of Indian Children (EPICS), 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 and conferences and provides training for staff/families. CMS staff regularly attend the Family Leadership conferences hosted by PRO and EPICS, and this provides a forum for families to give feedback on the gaps in services and hardships they encounter in accessing health care services for CYSHCN.

Last year, Survey Monkey was used as a method for obtaining feedback on the block grant application. This year, however, this method was not employed due to the extensive feedback that the Title V program is getting through the needs assessment process. However, each year, the domain group leaders distribute the final block grant and/or Executive Summary to stakeholders and request input on the state selected priorities, the state performance measures, the evidence or informed-based strategy measures and the action plan for the application year. We want to assure that, as the Title V program, we are articulating plans which reflect our stakeholders' input.

All existing public input is compiled and summarized prior to grant submission. We post the block grant on a page of

the NMDOH Health website and on the agency-sponsored Facebook page where we can obtain feedback from the public. This year we have added a Title V email address specifically to be used for feedback on the grant activities, which we will post on the website and on social media.  We will continue to meet quarterly within the Family Health Bureau as an executive committee to assure we are continuously working with stakeholders and engaging with public input processes during the needs assessment cycle. This will allow us to address emerging issues and to follow up on or modify our action plans throughout the year.

### III.G. Technical Assistance

For this last reporting year, New Mexico's Title V Program has encountered some difficulties in implementing our five-year Action Plan. Throughout the narrative of the application, these difficulties have been described. For the Adolescent and Maternal domains, in each program, there have been structural changes that have created confusion on what programming activities will be most appropriate to speak to the previously selected NPMs. For adolescent health, we have had some clarity in using the NPM toolkits that are found on the Innovation Station. However, these do not yet exist for each NPM, which would be helpful in the future.

Through our experience last year with the MCH Workforce Development Center, we have members on the Title V team that learned a lot about what TA resources are available through the Center as well as those that work in conjunction with AMCHP, such as the MCH Navigator. Last year, it was suggested to our state to use the Wilder Collaboration Factors Inventory assessment tool as a way to determine how our collaborations are doing. This is not yet something that we have started, and some technical assistance around identifying which partnerships to evaluate and how best to do so would be a great introduction and way to move forward.

## IV. Title V-Medicaid IAA/MOU

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

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Program Purpose and Design Matrix_FY1820.pdf

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - PHD_Org Chart 7-2019.pdf

## VII. Appendix

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## Form 2
## MCH Budget/Expenditure Details

**State: New Mexico**

| | FY 20 Application Budgeted | |
|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 4,130,727 | |
| A. Preventive and Primary Care for Children | $ 1,540,907 | (37.3%) |
| B. Children with Special Health Care Needs | $ 1,711,772 | (41.4%) |
| C. Title V Administrative Costs | $ 282,557 | (6.9%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 3,535,236 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 5,883,664 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 8,513,300 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 14,396,964 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 3,087,900 | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 18,527,691 | |
| 9. OTHER FEDERAL FUNDS<br>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) | $ 46,475,877 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 65,003,568 | |

| OTHER FEDERAL FUNDS | FY 20 Application Budgeted |
|---|---|
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs | $ 150,000 |
| Department of Health and Human Services (DHHS) > 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) | $ 81,996 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 337,125 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 5,180,631 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC) | $ 40,014,430 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | $ 597,072 |

| | FY 18 Annual Report Budgeted | | FY 18 Annual Report Expended | |
|---|---|---|---|---|
| 1. FEDERAL ALLOCATION<br>(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year) | $ 4,063,782 | | $ 3,849,336 | |
| A. Preventive and Primary Care for Children | $ 1,662,889 | (40.9%) | $ 1,412,278 | (36.6%) |
| B. Children with Special Health Care Needs | $ 1,652,042 | (40.7%) | $ 1,708,658 | (44.3%) |
| C. Title V Administrative Costs | $ 251,522 | (6.2%) | $ 237,221 | (6.2%) |
| 2. Subtotal of Lines 1A-C<br>(This subtotal does not include Pregnant Women and All Others) | $ 3,566,453 | | $ 3,358,157 | |
| 3. STATE MCH FUNDS<br>(Item 18c of SF-424) | $ 6,019,300 | | $ 5,883,664 | |
| 4. LOCAL MCH FUNDS<br>(Item 18d of SF-424) | $ 0 | | $ 0 | |
| 5. OTHER FUNDS<br>(Item 18e of SF-424) | $ 0 | | $ 0 | |
| 6. PROGRAM INCOME<br>(Item 18f of SF-424) | $ 9,377,300 | | $ 12,906,507 | |
| 7. TOTAL STATE MATCH<br>(Lines 3 through 6) | $ 15,396,600 | | $ 18,790,171 | |
| A. Your State's FY 1989 Maintenance of Effort Amount<br>$ 3,087,900 | | | | |
| 8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL<br>(Total lines 1 and 7) | $ 19,460,382 | | $ 22,639,507 | |
| 9. OTHER FEDERAL FUNDS<br>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 | | $ 41,641,331 | |
| 11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL<br>(Partnership Subtotal + Other Federal MCH Funds Subtotal) | $ 68,796,105 | | $ 64,280,838 | |

| OTHER FEDERAL FUNDS | FY 18 Annual Report Budgeted | FY 18 Annual Report Expended |
|---|---|---|
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs | $ 129,000 | $ 70,298 |
| Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS) | $ 114,623 | $ 109,264 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) | $ 90,000 | $ 54,133 |
| Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention | $ 232,000 | $ 214,493 |
| Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning | $ 3,112,400 | $ 4,218,453 |
| US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC) | $ 45,657,700 | $ 36,451,166 |
| Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP) | | $ 523,524 |

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **1.FEDERAL ALLOCATION** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Project ID expires 9/30/19. Some programs are still spending down this project ID | |
| 2. | **Field Name:** | **Federal Allocation, A. Preventive and Primary Care for Children:** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Programs are still spending this project ID | |
| 3. | **Field Name:** | **2. Subtotal of Lines 1A-C** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Maternal health needed extra funds so more was spent in maternal than anticipated | |
| 4. | **Field Name:** | **Federal Allocation, B. Children with Special Health Care Needs:** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Other programs had funding unspent so CMS used it | |
| 5. | **Field Name:** | **Federal Allocation, C. Title V Administrative Costs:** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Programs are still spending this Project ID | |
| 6. | **Field Name:** | **3. STATE MCH FUNDS** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |

| | | |
|---|---|---|
| | **Field Note:**<br>When we budgeted we were anticipating a cut in GF | |
| 7. | **Field Name:** | **6. PROGRAM INCOME** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>Revenues were less than anticipated due to staff vacancies and change in MCOs | |
| 8. | **Field Name:** | **7. TOTAL STATE MATCH** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:**<br>State funds are match only; program income is all revenue | |

**Data Alerts: None**

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

**State: New Mexico**

### I. TYPES OF INDIVIDUALS SERVED

| IA. Federal MCH Block Grant | FY 20 Application Budgeted | FY 18 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 595,491 | $ 491,179 |
| 2. Infants < 1 year | $ 692,121 | $ 701,832 |
| 3. Children 1 through 21 Years | $ 848,786 | $ 710,446 |
| 4. CSHCN | $ 1,711,772 | $ 1,708,658 |
| 5. All Others | $ 0 | $ 0 |
| Federal Total of Individuals Served | $ 3,848,170 | $ 3,612,115 |

| IB. Non-Federal MCH Block Grant | FY 20 Application Budgeted | FY 18 Annual Report Expended |
|---|---|---|
| 1. Pregnant Women | $ 1,226,829 | $ 1,906,263 |
| 2. Infants < 1 year | $ 3,109,224 | $ 4,851,667 |
| 3. Children 1 through 21 Years | $ 2,064,106 | $ 2,401,621 |
| 4. CSHCN | $ 7,254,314 | $ 8,888,128 |
| 5. All Others | $ 0 | $ 0 |
| Non-Federal Total of Individuals Served | $ 13,654,473 | $ 18,047,679 |
| Federal State MCH Block Grant Partnership Total | $ 17,502,643 | $ 21,659,794 |

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **IA. Federal MCH Block Grant, 3. Children 1 through 21 years** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:** On form 2 preventive and primary care includes infants as well as children 1-21 so it is children birth to 21 total | |
| 2. | **Field Name:** | **IA. Federal MCH Block Grant, 3. Children 1 through 21 years** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Form 2 includes infants as well as children 1-21 | |
| 3. | **Field Name:** | **IB. Non-Federal MCH Block Grant, Non Federal Total of Individuals Served** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Equals Non-Federal Total on Form 2 minus FHB Admin (742491) | |

**Data Alerts:**

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

## Form 3b
## Budget and Expenditure Details by Types of Services

**State: New Mexico**

### II. TYPES OF SERVICES

| IIA. Federal MCH Block Grant | FY 20 Application Budgeted | FY 18 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 767,082 | $ 527,249 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 595,491 | $ 378,208 |
| B. Preventive and Primary Care Services for Children | $ 141,591 | $ 119,041 |
| C. Services for CSHCN | $ 30,000 | $ 30,000 |
| 2. Enabling Services | $ 2,064,580 | $ 2,160,587 |
| 3. Public Health Services and Systems | $ 1,299,065 | $ 1,161,500 |
| 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 | | $ 118,222 |
| Physician/Office Services | | $ 133,749 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 183,562 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 0 |
| Durable Medical Equipment and Supplies | | $ 11,720 |
| Laboratory Services | | $ 79,996 |
| Direct Services Line 4 Expended Total | | $ 527,249 |
| **Federal Total** | $ 4,130,727 | $ 3,849,336 |

| IIB. Non-Federal MCH Block Grant | FY 20 Application Budgeted | FY 18 Annual Report Expended |
|---|---|---|
| 1. Direct Services | $ 5,534,829 | $ 5,345,966 |
| A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One | $ 562,042 | $ 456,082 |
| B. Preventive and Primary Care Services for Children | $ 583,290 | $ 719,719 |
| C. Services for CSHCN | $ 4,389,497 | $ 4,170,165 |
| 2. Enabling Services | $ 4,596,703 | $ 3,067,888 |
| 3. Public Health Services and Systems | $ 3,522,941 | $ 7,478,535 |
| 4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service | | |
| Pharmacy | | $ 626,731 |
| Physician/Office Services | | $ 668,349 |
| Hospital Charges (Includes Inpatient and Outpatient Services) | | $ 852,331 |
| Dental Care (Does Not Include Orthodontic Services) | | $ 3,600 |
| Durable Medical Equipment and Supplies | | $ 10,537 |
| Laboratory Services | | $ 3,184,418 |
| Direct Services Line 4 Expended Total | | $ 5,345,966 |
| **Non-Federal Total** | $ 13,654,473 | $ 15,892,389 |

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **IIA. Federal MCH Block Grant, 3. Public Health Services and Systems** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:** Includes admin (unlike form 3a) | |
| 2. | **Field Name:** | **IIA. Federal MCH Block Grant, Federal Total Budgeted** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:** Needs to match total on Form 2 | |
| 3. | **Field Name:** | **IIB. Non-Federal MCH Block Grant, 1. C. Services for CSHCN** |
| | **Fiscal Year:** | **2020** |
| | **Column Name:** | **Application Budgeted** |
| | **Field Note:** Includes payment for medical care, clinics, OR lab (newborn screening tests) | |
| 4. | **Field Name:** | **IIA. Federal MCH Block Grant, 3. Public Health Services and Systems** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Annual Report Expended** |
| | **Field Note:** Includes admin (unlike form 3a) | |

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

**State: New Mexico**

**Total Births by Occurrence: 21,711** **Data Source Year: 2018**

**1. Core RUSP Conditions**

| Program Name | (A) Aggregate Total Number Receiving at Least One Screen | (B) Aggregate Total Number Presumptive Positive Screens | (C) Aggregate Total Number Confirmed Cases | (D) Aggregate Total Number Referred for Treatment |
|---|---|---|---|---|
| Core RUSP Conditions | 21,212 (97.7%) | 2,167 | 89 | 89 (100.0%) |

| Program Name(s) | | | | |
|---|---|---|---|---|
| 3-Hydroxy-3-Methyglutaric Aciduria | 3-Methylcrotonyl-Coa Carboxylase Deficiency | Argininosuccinic Aciduria | Biotinidase Deficiency | Carnitine Uptake Defect/Carnitine Transport Defect |
| Citrullinemia, Type I | Classic Galactosemia | Classic Phenylketonuria | Congenital Adrenal Hyperplasia | Critical Congenital Heart Disease |
| Cystic Fibrosis | Glutaric Acidemia Type I | Hearing Loss | Holocarboxylase Synthase Deficiency | Homocystinuria |
| Isovaleric Acidemia | Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency | Maple Syrup Urine Disease | Medium-Chain Acyl-Coa Dehydrogenase Deficiency | Methylmalonic Acidemia (Cobalamin Disorders) |
| Methylmalonic Acidemia (Methylmalonyl-Coa Mutase) | Primary Congenital Hypothyroidism | Propionic Acidemia | S, ßeta-Thalassemia | S,C Disease |
| S,S Disease (Sickle Cell Anemia) | Severe Combined Immunodeficiences | ß-Ketothiolase Deficiency | Trifunctional Protein Deficiency | Tyrosinemia, Type I |
| Very Long-Chain Acyl-Coa Dehydrogenase Deficiency | | | | |

**2. Other Newborn Screening Tests**

None

### 3. Screening Programs for Older Children & Women

None

### 4. Long-Term Follow-Up

New Mexico long-term follow up starts at the time of diagnosis and up to age 21. Any client diagnosed with a condition identified by a 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 throughout 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 six months, until the age of 21. After that, follow up is only as needed. The Newborn Screening Program wants to ensure that there are no barriers to healthcare. 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 there developmental milestones achieved and any barriers/challenges in housing, financially, with transportation or obtaining medication.

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Total Births by Occurrence** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Total Births by Occurrence Notes** |
| | **Field Note:**<br>2018 data. Data source: NM Vital Records | |
| 2. | **Field Name:** | **Data Source Year** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Data Source Year Notes** |
| | **Field Note:**<br>Provisional as of 5/22/19- Data source: NM Vital Records | |
| 3. | **Field Name:** | **Core RUSP Conditions - Receiving At Least One Screen** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>2018 data. Data source: DOH Children Medical Program. Data represented includes newborn hearing and genetic screening. | |
| 4. | **Field Name:** | **Core RUSP Conditions - Positive Screen** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>2018 data. Data source: DOH Childrens Medical Services. Data represented comes from the Oregon Public Health lab.<br>2017 data. Data source: Newborn hearing, CDC annual report | |
| 5. | **Field Name:** | **Core RUSP Conditions - Confirmed Cases** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Core RUSP Conditions** |
| | **Field Note:**<br>2018 data. Data source: DOH Childrens Medical Services | |
| 6. | **Field Name:** | **Core RUSP Conditions - Referred For Treatment** |

| | |
|---|---|
| **Fiscal Year:** | **2018** |
| **Column Name:** | **Core RUSP Conditions** |

**Field Note:**
2018 data. Data source: DOH Childrens Medical Services

**Data Alerts: None**

## Form 5
## Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

**State: New Mexico**

**Annual Report Year 2018**

### Form 5a – Count of Individuals Served by Title V
### (Direct & Enabling Services Only)

| | | Primary Source of Coverage | | | | |
|---|---|---|---|---|---|---|
| Types Of Individuals Served | (A) Title V Total Served | (B) Title XIX % | (C) Title XXI % | (D) Private / Other % | (E) None % | (F) Unknown % |
| 1. Pregnant Women | 2,106 | 0.0 | 0.0 | 0.0 | 100.0 | 0.0 |
| 2. Infants < 1 Year of Age | 2,215 | 56.0 | 0.0 | 37.0 | 7.0 | 0.0 |
| 3. Children 1 through 21 Years of Age | 11,630 | 54.0 | 0.0 | 42.0 | 4.0 | 0.0 |
| 3a. Children with Special Health Care Needs | 6,491 | 59.0 | 0.0 | 38.0 | 3.0 | 0.0 |
| 4. Others | 1,370 | 25.0 | 0.0 | 66.0 | 9.0 | 0.0 |
| Total | 17,321 | | | | | |

### Form 5b – Total Percentage of Populations Served by Title V
### (Direct, Enabling, and Public Health Services and Systems)

| Populations Served by Title V | Reference Data | Used Reference Data? | Denominator | Total % Served | Form 5b Count (Calculated) | Form 5a Count |
|---|---|---|---|---|---|---|
| 1. Pregnant Women | 23,767 | Yes | 23,767 | 100 | 23,767 | 2,106 |
| 2. Infants < 1 Year of Age | 22,343 | No | 23,755 | 100 | 23,755 | 2,215 |
| 3. Children 1 through 21 Years of Age | 574,321 | Yes | 574,321 | 28 | 160,810 | 11,630 |
| 3a. Children with Special Health Care Needs | 113,773 | Yes | 113,773 | 100 | 113,773 | 6,491 |
| 4. Others | 1,488,689 | Yes | 1,488,689 | 1 | 14,887 | 1,370 |

**Form Notes for Form 5:**

None

**Field Level Notes for Form 5a:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women Total Served** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:**<br>2018 data reported. Data source: Maternal Health Program High Risk Fund. Raw data was manually deduplicated. for Primary Source of Coverage: by definition, women are not eligible for Title V funds if they are eligible for any other source of health insurance. Also included in the count are those served by prenatal vitamin distribution and births attended by licensed midwives in NM. WIC and home visiting program data will not be included due to lack of direct Title V funding. | |
| 2. | **Field Name:** | **Infants Less Than One YearTotal Served** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:**<br>2018 data reported. Data source: DOH NM Genetic and Hearing Screening Program. This is the same number reported on Form 4 (b) which indicates those who attended a follow up visit after an abnormal screening. Primary source of coverage is represented by the reference data provided by HRSA. | |
| 3. | **Field Name:** | **Children 1 through 21 Years of Age** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:**<br>2018 data reported. Data is sourced from multiple programs as follows: DOH Injury Prevention(425)+ DOH Family Planning (4,345)+ DOH Child Health (166)+ DOH Adolescent Health (820)+ DOH Oral Health(5,874). All data reported is for the state FY 2018. Primary source of coverage is represented by the reference data provided by HRSA. | |
| 4. | **Field Name:** | **Children with Special Health Care Needs** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:**<br>2018 data reported. Data source: DOH Children's Medical Services. Number represents direct client count. Primary source of coverage is represented by the reference data provided by HRSA. | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:**<br>2018 data reported. Data represents those served over the age of 21. Data is sourced from multiple programs as follows: Child Health (203)+ Injury Prevention(425+550)+ Family Planning (192). Primary source of coverage is represented by the reference data provided by HRSA. | |

**Field Level Notes for Form 5b:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **Pregnant Women** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:** 100% of NM birth population through the perinatal regionalization and the Locate Survey and secondary is the number of infants screened. | |
| 2. | **Field Name:** | **InfantsLess Than One Year** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:** Data Source: NM-IBIS, 2018 | |
| 3. | **Field Name:** | **Children 1 Through 21 Years of Age** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:** Data represented is estimated as follows: WIC (22,900)+ Fam Plan (91,512) + Injury Prev (850+550) + Adolescent Health (820+16,365) + Child Health Prog (1,869)+ Oral Health (25,850). WIC data was unable to be deduplicated from other child domain services. This estimate came from the 2018 WIC annual report on the number of children served, ages 1-5. | |
| 4. | **Field Name:** | **Children With Special Health Care Needs** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:** CMS Program Data. This includes population work to improve the system of care for CYSHCN in the state via task forces, statewide initiatives to improve transition, access to specialty care and care coordination standards for CYSHCN. | |
| 5. | **Field Name:** | **Others** |
| | **Fiscal Year:** | **2018** |
| | **Field Note:** We are currently exploring how to best estimate this data. For this year, we used the number of those served directly, as reported in Form 5a, which came out to 0.0009% served. The one percent shown here is the smallest number we were able to enter. | |

**Data Alerts: None**

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

**State: New Mexico**

**Annual Report Year 2018**

### I. Unduplicated Count by Race/Ethnicity

| | (A) Total | (B) Non-Hispanic White | (C) Non-Hispanic Black or African American | (D) Hispanic | (E) Non-Hispanic American Indian or Native Alaskan | (F) Non-Hispanic Asian | (G) Non-Hispanic Native Hawaiian or Other Pacific Islander | (H) Non-Hispanic Multiple Race | (I) Other & Unknown |
|---|---|---|---|---|---|---|---|---|---|
| 1. Total Deliveries in State | 23,038 | 6,480 | 492 | 12,761 | 2,741 | 509 | 0 | 0 | 55 |
| Title V Served | 12,071 | 1,816 | 290 | 7,577 | 1,950 | 0 | 0 | 0 | 438 |
| Eligible for Title XIX | 14,503 | 2,948 | 337 | 8,437 | 2,281 | 0 | 0 | 0 | 500 |
| 2. Total Infants in State | 23,755 | 6,160 | 637 | 14,195 | 2,425 | 338 | 0 | 0 | 0 |
| Title V Served | 21,711 | 6,129 | 473 | 11,682 | 2,875 | 504 | 0 | 0 | 48 |
| Eligible for Title XIX | 17,432 | 6,660 | 314 | 8,403 | 1,517 | 227 | 0 | 279 | 32 |

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **1. Total Deliveries in State** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>Data Source: NM Vital Records, 2018 . Asian and Pacific Islander are collected jointly in NM, therefore the number reported for Non-Hispanic Asian, also includes the Non-Hispanic Native Hawaiian or Other Pacific Islander. Multiple race is also not collected by Vital Records in NM. | |
| 2. | **Field Name:** | **1. Title V Served** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>Data Source: NM PRAMS, 2017. Asian and Pacific Islander are collected jointly in NM, therefore the number reported for Non-Hispanic Asian, also includes the Non-Hispanic Native Hawaiian or Other Pacific Islander. Multiple race is also not collected by PRAMS | |
| 3. | **Field Name:** | **1. Eligible for Title XIX** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>Data Source: NM PRAMS, 2017. Asian and Pacific Islander are collected jointly in NM, therefore the number reported for Non-Hispanic Asian, also includes the Non-Hispanic Native Hawaiian or Other Pacific Islander. Multiple race is also not collected by PRAMS in NM. | |
| 4. | **Field Name:** | **2. Total Infants in State** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Total** |
| | **Field Note:**<br>Data Source: NM-IBIS, 2018. Asian and Pacific Islander are collected jointly in NM, therefore the number reported for Non-Hispanic Asian, also includes the Non-Hispanic Native Hawaiian or Other Pacific Islander. Multiple race is also not collected by Vital Records in NM. | |
| 5. | **Field Name:** | **2. Title V Served** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Total** |

**Field Note:**
Source: NM Vital Records, 2018 data. Asian and Pacific Islander are collected jointly in NM, therefore the number reported for Non-Hispanic Asian, also includes the Non-Hispanic Native Hawaiian or Other Pacific Islander. Multiple race is also not collected by Vital Records in NM. This is the same number as occurrent births reported in Form 4.

| | | |
|---|---|---|
| 6. | **Field Name:** | **2. Eligible for Title XIX** |
| | **Fiscal Year:** | **2018** |
| | **Column Name:** | **Total** |

**Field Note:**
2017 data. Data source(s): Census, American Community Survey. Estimated total comes from taking the population estimate for number of infants in NM (25,243) and applying the percentage of households in NM that are under 300% FPL (69.1). This assumes that the likelihood that a child lives in poverty is equal across the age groups 0 through 17 (ACS data). The counts for each race/ethnicity were determined by applying the percentage for each race/ethnicity to the total. Counts calculated from percentages were rounded up but were still 32 individuals lower than the calculated total. This is due to other collected racial categories that are not represented in the grant application. These individuals are represented in the 'other and unknown' category. We used the population estimated that ACS category which gives Hispanic or Latino and Race due to the importance for New Mexico.

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

**State: New Mexico**

| A. State MCH Toll-Free Telephone Lines | 2020 Application Year | 2018 Annual Report Year |
|---|---|---|
| 1. State MCH Toll-Free "Hotline" Telephone Number | (800) 691-9067 | (855) 662-7474 |
| 2. State MCH Toll-Free "Hotline" Name | Pull Together | New Mexico Crisis and Access Line |
| 3. Name of Contact Person for State MCH "Hotline" | Rachel Nowak | Optumhealth New Mexico |
| 4. Contact Person's Telephone Number | (505) 252-8744 | (505) 798-5640 |
| 5. Number of Calls Received on the State MCH "Hotline" | | 0 |

| B. Other Appropriate Methods | 2020 Application Year | 2018 Annual Report Year |
|---|---|---|
| 1. Other Toll-Free "Hotline" Names | NM Crisis and Access Line 1-855-NMCRISIS | |
| 2. Number of Calls on Other Toll-Free "Hotlines" | | |
| 3. State Title V Program Website Address | https://nmhealth.org/about/phd/fhb/mch/ | |
| 4. Number of Hits to the State Title V Program Website | | |
| 5. State Title V Social Media Websites | | |
| 6. Number of Hits to the State Title V Program Social Media Websites | | |

**Form Notes for Form 7:**

None

## Form 8
## State MCH and CSHCN Directors Contact Information

**State: New Mexico**

| 1. Title V Maternal and Child Health (MCH) Director | |
|---|---|
| Name | Janis Gonzales |
| Title | Title V Director/ FamilyHealth Bureau Chief |
| Address 1 | 2040 S. Pacheco St. NW |
| Address 2 | |
| City/State/Zip | Santa Fe / NM / 87505 |
| Telephone | (505) 476-8854 |
| Extension | |
| Email | janis.gonzales@state.nm.us |

| 2. Title V Children with Special Health Care Needs (CSHCN) Director | |
|---|---|
| Name | Susan Chacon |
| Title | Director, Childrens Medical Services |
| Address 1 | 2040 S. Pacheco St. NW |
| Address 2 | |
| City/State/Zip | Santa Fe / NM / 87505 |
| Telephone | (505) 476-8860 |
| Extension | |
| Email | susan.chacon@state.nm.us |

| 3. State Family or Youth Leader (Optional) | |
|---|---|
| Name | Cathy Salazar |
| Title | Healthcare Family Liaison |
| Address 1 | 1920 B Columbia Dr. SE |
| Address 2 | |
| City/State/Zip | Albuquerque / NM / 87106 |
| Telephone | (505) 247-0192 |
| Extension | |
| Email | csalazar@parentsreachingout.org |

**Form Notes for Form 8:**

None

## Form 9
## List of MCH Priority Needs

**State: New Mexico**

**Application Year 2020**

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

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

| No. | Priority Need | Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period) | Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure |
|---|---|---|---|
| 1. | To maintain and increase breastfeeding initiation and duration | New | |
| 2. | To increase the percentage of children receiving a developmental screen | New | |
| 3. | Increase access to care to a family-centered comprehensive medical home for children and adolescents | New | |
| 4. | To increase the amount of services available to assist adolescents to make successful transitions to adult health care services | New | |
| 5. | To reduce birth rates among teens 15-19 | New | A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application |
| 6. | To improve access and quality of comprehensive well exams for adolescents | New | |
| 7. | Improve access to care across the life span, from prenatal to adult well-woman care, including adequate insurance access and utilization. | New | |
| 8. | To increase access to resources and increase awareness on bullying prevention | New | |
| 9. | To improve safe sleep practices among home visiting participants and birthing facility medical staff | New | A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application |
| 10. | To decrease abuse and maltreatment on children | New | A state measure will be developed for this priority in the FY2015 Annual Report/FY2017 Application |

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

**Field Name:**

Priority Need 8

**Field Note:**
Was identified as an emerging need in 2016 cycle. It has been chosen as an NPM for the 2017_2019 submission. This will be continued for the 2018_2020 grant application.

## Form 10
## National Outcome Measures (NOMs)

**State: New Mexico**

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

The comment period to Medicaid is now closed. We were successful in submitting a comment on youth transition that was put into policy for the managed care organizations to reference. Section 5.7 in the Managed Care Policy Manual.

**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 |
|---|---|---|---|---|
| 2017 | 69.8 % | 0.3 % | 16,203 | 23,218 |
| 2016 | 69.6 % | 0.3 % | 16,669 | 23,943 |
| 2015 | 72.4 % | 0.3 % | 17,960 | 24,802 |
| 2014 | 71.5 % | 0.3 % | 17,633 | 24,674 |
| 2013 | 67.1 % | 0.3 % | 16,677 | 24,862 |
| 2012 | 68.8 % | 0.3 % | 17,154 | 24,946 |
| 2011 | 67.7 % | 0.3 % | 17,401 | 25,694 |
| 2010 | 68.9 % | 0.3 % | 17,935 | 26,046 |
| 2009 | 66.4 % | 0.3 % | 16,863 | 25,394 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

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

**Legends:**

Indicator has a numerator ≤10 and is not reportable

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

**NOM 2 - Notes:**

None

**Data Alerts: None**

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

**Federally available Data (FAD) for this measure is not available/reportable.**

| State Provided Data | |
|---|---|
| | **2018** |
| **Annual Indicator** | 28.0 |
| **Numerator** | |
| **Denominator** | |
| **Data Source** | NM Bureau of Vital Records and Health Statistics |
| **Data Source Year** | 2014-2017 |

**NOM 3 - Notes:**

In the absence of FAD and reportable data in MMRIA, New Mexico used the most current report from 2017 titled, New Mexico Selected Health Statistics Annual Report, 2017. This report is prepared by the State Center for Health Statistics, Bureau of Vital Records and Health Statistics in the Epidemiology and Response Division. New Mexico is in the first few years of developing a maternal mortality review and thus not able to report data at this time. The definition of maternal mortality for the purposes of the reported data is as follows: Maternal mortality includes deaths that were the result of, or aggravated by, pregnancy or pregnancy management, and occurred within 42 days of termination of pregnancy and excludes all external injury deaths.

**Data Alerts: None**

**NOM 4 - Percent of low birth weight deliveries (<2,500 grams)**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 9.5 % | 0.2 % | 2,250 | 23,743 |
| 2016 | 9.0 % | 0.2 % | 2,227 | 24,680 |
| 2015 | 8.7 % | 0.2 % | 2,244 | 25,767 |
| 2014 | 8.8 % | 0.2 % | 2,282 | 25,950 |
| 2013 | 8.9 % | 0.2 % | 2,333 | 26,283 |
| 2012 | 8.8 % | 0.2 % | 2,381 | 26,948 |
| 2011 | 8.8 % | 0.2 % | 2,385 | 27,227 |
| 2010 | 8.7 % | 0.2 % | 2,427 | 27,828 |
| 2009 | 8.3 % | 0.2 % | 2,416 | 28,969 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 4 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 10.3 % | 0.2 % | 2,435 | 23,756 |
| 2016 | 10.0 % | 0.2 % | 2,464 | 24,676 |
| 2015 | 9.5 % | 0.2 % | 2,462 | 25,803 |
| 2014 | 9.2 % | 0.2 % | 2,387 | 26,017 |
| 2013 | 9.3 % | 0.2 % | 2,439 | 26,255 |
| 2012 | 9.5 % | 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% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

**NOM 5 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 28.0 % | 0.3 % | 6,663 | 23,756 |
| 2016 | 27.6 % | 0.3 % | 6,814 | 24,676 |
| 2015 | 27.3 % | 0.3 % | 7,040 | 25,803 |
| 2014 | 26.9 % | 0.3 % | 6,986 | 26,017 |
| 2013 | 27.3 % | 0.3 % | 7,162 | 26,255 |
| 2012 | 26.9 % | 0.3 % | 7,254 | 26,983 |
| 2011 | 26.8 % | 0.3 % | 7,309 | 27,229 |
| 2010 | 27.0 % | 0.3 % | 7,492 | 27,747 |
| 2009 | 28.1 % | 0.3 % | 8,140 | 28,953 |

**Legends:**

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, 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 |
|---|---|---|---|---|
| 2017/Q2-2018/Q1 | 1.0 % | | | |
| 2017/Q1-2017/Q4 | 1.0 % | | | |
| 2016/Q4-2017/Q3 | 1.0 % | | | |
| 2016/Q3-2017/Q2 | 2.0 % | | | |
| 2016/Q2-2017/Q1 | 1.0 % | | | |
| 2016/Q1-2016/Q4 | 2.0 % | | | |
| 2015/Q4-2016/Q3 | 2.0 % | | | |
| 2015/Q3-2016/Q2 | 1.0 % | | | |
| 2015/Q2-2016/Q1 | 2.0 % | | | |
| 2015/Q1-2015/Q4 | 2.0 % | | | |
| 2014/Q4-2015/Q3 | 3.0 % | | | |
| 2014/Q3-2015/Q2 | 4.0 % | | | |
| 2014/Q2-2015/Q1 | 4.0 % | | | |
| 2014/Q1-2014/Q4 | 4.0 % | | | |
| 2013/Q4-2014/Q3 | 4.0 % | | | |
| 2013/Q3-2014/Q2 | 3.0 % | | | |
| 2013/Q2-2014/Q1 | 3.0 % | | | |

**Legends:**

Indicator results were based on a shorter time period than required for reporting

**NOM 7 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 5.5 | 0.5 | 136 | 24,743 |
| 2015 | 4.3 | 0.4 | 111 | 25,871 |
| 2014 | 5.1 | 0.4 | 134 | 26,117 |
| 2013 | 5.0 | 0.4 | 133 | 26,404 |
| 2012 | 5.8 | 0.5 | 157 | 27,130 |
| 2011 | 4.8 | 0.4 | 131 | 27,348 |
| 2010 | 4.8 | 0.4 | 133 | 27,908 |
| 2009 | 5.1 | 0.4 | 148 | 29,081 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 8 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 6.2 | 0.5 | 152 | 24,692 |
| 2015 | 5.1 | 0.4 | 131 | 25,816 |
| 2014 | 5.2 | 0.5 | 136 | 26,052 |
| 2013 | 5.3 | 0.5 | 139 | 26,354 |
| 2012 | 6.8 | 0.5 | 184 | 27,068 |
| 2011 | 5.6 | 0.5 | 152 | 27,289 |
| 2010 | 5.6 | 0.5 | 156 | 27,850 |
| 2009 | 5.3 | 0.4 | 154 | 29,000 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 9.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 4.3 | 0.4 | 107 | 24,692 |
| 2015 | 3.1 | 0.3 | 79 | 25,816 |
| 2014 | 3.5 | 0.4 | 92 | 26,052 |
| 2013 | 3.9 | 0.4 | 103 | 26,354 |
| 2012 | 4.7 | 0.4 | 126 | 27,068 |
| 2011 | 3.4 | 0.4 | 92 | 27,289 |
| 2010 | 3.4 | 0.4 | 95 | 27,850 |
| 2009 | 3.2 | 0.3 | 92 | 29,000 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 9.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 1.8 | 0.3 | 45 | 24,692 |
| 2015 | 2.0 | 0.3 | 52 | 25,816 |
| 2014 | 1.7 | 0.3 | 44 | 26,052 |
| 2013 | 1.4 | 0.2 | 36 | 26,354 |
| 2012 | 2.1 | 0.3 | 58 | 27,068 |
| 2011 | 2.2 | 0.3 | 60 | 27,289 |
| 2010 | 2.2 | 0.3 | 61 | 27,850 |
| 2009 | 2.1 | 0.3 | 62 | 29,000 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 9.3 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 186.3 | 27.5 | 46 | 24,692 |
| 2015 | 108.5 | 20.5 | 28 | 25,816 |
| 2014 | 180.4 | 26.3 | 47 | 26,052 |
| 2013 | 223.9 | 29.2 | 59 | 26,354 |
| 2012 | 247.5 | 30.3 | 67 | 27,068 |
| 2011 | 216.2 | 28.2 | 59 | 27,289 |
| 2010 | 161.6 | 24.1 | 45 | 27,850 |
| 2009 | 151.7 | 22.9 | 44 | 29,000 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 9.4 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 68.8 | 16.7 | 17 | 24,692 |
| 2015 | 116.2 | 21.2 | 30 | 25,816 |
| 2014 | 46.1 | 13.3 | 12 | 26,052 |
| 2013 | 60.7 | 15.2 | 16 | 26,354 |
| 2012 | 92.4 | 18.5 | 25 | 27,068 |
| 2011 | 77.0 | 16.8 | 21 | 27,289 |
| 2010 | 43.1 | 12.4 | 12 | 27,850 |
| 2009 | 86.2 | 17.3 | 25 | 29,000 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2015 | 4.5 % | 0.5 % | 1,044 | 23,133 |
| 2014 | 6.4 % | 0.7 % | 1,507 | 23,569 |
| 2013 | 5.5 % | 0.6 % | 1,310 | 24,003 |
| 2012 | 4.5 % | 0.8 % | 1,111 | 24,695 |
| 2011 | 6.6 % | 0.6 % | 1,668 | 25,192 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births**

**Data Source: HCUP - State Inpatient Databases (SID)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016 | 12.3 | 0.7 | 287 | 23,258 |
| 2015 | 9.4 | 0.7 | 171 | 18,157 |
| 2014 | 9.2 | 0.6 | 218 | 23,723 |
| 2013 | 8.4 | 0.6 | 203 | 24,283 |
| 2012 | 7.7 | 0.6 | 193 | 25,135 |
| 2011 | 5.8 | 0.5 | 148 | 25,553 |
| 2010 | 4.0 | 0.4 | 105 | 26,078 |
| 2009 | 3.5 | 0.4 | 94 | 26,896 |
| 2008 | 3.9 | 0.4 | 89 | 22,828 |

**Legends:**

Indicator has a numerator ≤10 and is not reportable

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

**NOM 11 - Notes:**

None

**Data Alerts: None**

**NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 12 - Notes:**

None

**Data Alerts: None**

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

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 13 - Notes:**

None

**Data Alerts: None**

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

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 13.9 % | 1.7 % | 64,498 | 465,483 |
| 2016 | 14.0 % | 1.9 % | 65,406 | 466,421 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 14 - Notes:**

None

**Data Alerts: None**

**NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000**

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 19.6 | 2.9 | 47 | 239,741 |
| 2016 | 21.8 | 3.0 | 53 | 242,659 |
| 2015 | 23.7 | 3.1 | 59 | 248,557 |
| 2014 | 17.0 | 2.6 | 43 | 252,620 |
| 2013 | 19.9 | 2.8 | 51 | 256,147 |
| 2012 | 22.0 | 2.9 | 57 | 259,441 |
| 2011 | 27.8 | 3.3 | 73 | 262,232 |
| 2010 | 21.1 | 2.9 | 55 | 260,110 |
| 2009 | 22.2 | 2.9 | 57 | 256,535 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 15 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 42.3 | 3.9 | 118 | 278,633 |
| 2016 | 43.2 | 4.0 | 120 | 277,524 |
| 2015 | 43.0 | 3.9 | 119 | 276,621 |
| 2014 | 43.9 | 4.0 | 122 | 278,105 |
| 2013 | 35.5 | 3.6 | 100 | 281,413 |
| 2012 | 43.3 | 3.9 | 123 | 284,233 |
| 2011 | 39.3 | 3.7 | 113 | 287,793 |
| 2010 | 49.7 | 4.1 | 145 | 291,552 |
| 2009 | 53.6 | 4.3 | 156 | 291,043 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 16.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2015_2017 | 14.4 | 1.9 | 60 | 415,693 |
| 2014_2016 | 17.1 | 2.0 | 71 | 415,064 |
| 2013_2015 | 13.7 | 1.8 | 57 | 416,705 |
| 2012_2014 | 17.1 | 2.0 | 72 | 420,608 |
| 2011_2013 | 14.5 | 1.8 | 62 | 427,695 |
| 2010_2012 | 17.8 | 2.0 | 78 | 437,214 |
| 2009_2011 | 19.1 | 2.1 | 85 | 446,029 |
| 2008_2010 | 22.8 | 2.3 | 103 | 451,937 |
| 2007_2009 | 24.9 | 2.4 | 113 | 453,253 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 16.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2015_2017 | 20.9 | 2.2 | 87 | 415,693 |
| 2014_2016 | 15.4 | 1.9 | 64 | 415,064 |
| 2013_2015 | 14.9 | 1.9 | 62 | 416,705 |
| 2012_2014 | 16.2 | 2.0 | 68 | 420,608 |
| 2011_2013 | 17.5 | 2.0 | 75 | 427,695 |
| 2010_2012 | 19.2 | 2.1 | 84 | 437,214 |
| 2009_2011 | 17.5 | 2.0 | 78 | 446,029 |
| 2008_2010 | 19.7 | 2.1 | 89 | 451,937 |
| 2007_2009 | 20.5 | 2.1 | 93 | 453,253 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 16.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 19.0 % | 1.7 % | 93,717 | 492,668 |
| 2016 | 19.7 % | 1.8 % | 98,104 | 497,964 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 17.1 - Notes:**

None

**Data Alerts: None**

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

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 21.9 % | 4.5 % | 20,499 | 93,717 |
| 2016 | 22.0 % | 4.6 % | 21,538 | 98,104 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 17.2 - Notes:**

None

**Data Alerts: None**

**NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 1.4 % | 0.4 % | 5,676 | 407,986 |
| 2016 | 2.3 % | 0.8 % | 9,182 | 404,196 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 17.3 - Notes:**

None

**Data Alerts: None**

**NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 7.1 % | 1.0 % | 28,732 | 404,190 |
| 2016 | 9.3 % | 1.4 % | 37,202 | 400,344 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling**

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 50.9 % | 5.9 % | 26,480 | 52,029 |
| 2016 | 59.4 % | 6.6 % | 35,427 | 59,639 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 18 - Notes:**

None

**Data Alerts: None**

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

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 91.2 % | 1.2 % | 448,900 | 492,110 |
| 2016 | 89.9 % | 1.5 % | 447,456 | 497,964 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 19 - Notes:**

None

**Data Alerts: None**

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

**Data Source: WIC**

**Multi-Year Trend**

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

**Legends:**

Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

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

**Data Source: Youth Risk Behavior Surveillance System (YRBSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 15.3 % | 0.8 % | 14,149 | 92,630 |
| 2015 | 15.6 % | 0.4 % | 14,599 | 93,868 |
| 2013 | 12.7 % | 1.2 % | 11,632 | 91,581 |
| 2011 | 12.8 % | 1.0 % | 11,765 | 91,720 |
| 2009 | 13.4 % | 1.2 % | 12,258 | 91,296 |
| 2007 | 10.8 % | 0.9 % | 9,775 | 90,260 |
| 2005 | 12.0 % | 1.1 % | 11,108 | 92,550 |

**Legends:**

Indicator has an unweighted denominator <100 and is not reportable

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

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 15.1 % | 2.6 % | 31,238 | 207,268 |
| 2016 | 13.1 % | 2.4 % | 25,652 | 195,211 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 20 - Notes:**

None

**Data Alerts: None**

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

**Data Source: American Community Survey (ACS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 4.3 % | 0.4 % | 21,037 | 487,786 |
| 2016 | 5.6 % | 0.6 % | 27,172 | 486,671 |
| 2015 | 4.4 % | 0.5 % | 22,133 | 498,999 |
| 2014 | 7.6 % | 0.6 % | 37,982 | 497,539 |
| 2013 | 9.0 % | 0.8 % | 45,457 | 506,345 |
| 2012 | 8.0 % | 0.8 % | 41,412 | 514,814 |
| 2011 | 9.1 % | 0.7 % | 47,170 | 518,003 |
| 2010 | 10.0 % | 0.7 % | 51,481 | 517,558 |
| 2009 | 12.0 % | 0.8 % | 61,415 | 513,468 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable 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 |
|---|---|---|---|---|
| 2017 | 71.9 % | 3.6 % | 27,068 | 37,623 |
| 2016 | 68.5 % | 3.4 % | 26,855 | 39,230 |
| 2015 | 70.1 % | 4.0 % | 27,390 | 39,050 |
| 2014 | 75.9 % | 3.5 % | 29,643 | 39,058 |
| 2013 | 65.7 % | 3.7 % | 25,879 | 39,405 |
| 2012 | 71.6 % | 3.4 % | 28,790 | 40,234 |
| 2011 | 69.8 % | 3.4 % | 29,615 | 42,427 |
| 2010 | 53.1 % | 3.4 % | 23,204 | 43,706 |
| 2009 | 45.8 % | 3.4 % | 19,433 | 42,442 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS) - Flu**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017_2018 | 62.3 % | 1.8 % | 289,707 | 465,016 |
| 2016_2017 | 63.8 % | 2.5 % | 295,923 | 464,048 |
| 2015_2016 | 68.9 % | 2.2 % | 329,679 | 478,767 |
| 2014_2015 | 65.4 % | 2.0 % | 318,477 | 486,893 |
| 2013_2014 | 66.6 % | 2.0 % | 325,864 | 489,437 |
| 2012_2013 | 66.9 % | 2.3 % | 326,700 | 488,661 |
| 2011_2012 | 60.8 % | 2.4 % | 291,085 | 478,706 |
| 2010_2011 | 57.2 % | 3.9 % | 271,893 | 475,337 |
| 2009_2010 | 51.8 % | 3.0 % | 254,462 | 491,239 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.2 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 66.9 % | 2.9 % | 91,805 | 137,300 |
| 2016 | 60.5 % | 3.1 % | 82,545 | 136,477 |
| 2015 | 60.4 % | 2.9 % | 83,952 | 139,101 |

**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 |
|---|---|---|---|---|
| 2017 | 85.5 % | 2.3 % | 117,448 | 137,300 |
| 2016 | 84.3 % | 2.3 % | 115,084 | 136,477 |
| 2015 | 85.9 % | 2.2 % | 119,455 | 139,101 |
| 2014 | 83.3 % | 2.7 % | 117,458 | 140,960 |
| 2013 | 85.6 % | 2.3 % | 122,630 | 143,185 |
| 2012 | 82.6 % | 2.9 % | 118,201 | 143,106 |
| 2011 | 81.3 % | 2.6 % | 116,512 | 143,243 |
| 2010 | 71.8 % | 2.9 % | 99,579 | 138,689 |
| 2009 | 63.5 % | 2.8 % | 88,052 | 138,699 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.4 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Immunization Survey (NIS) - Teen**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 78.0 % | 2.7 % | 107,161 | 137,300 |
| 2016 | 77.8 % | 2.6 % | 106,233 | 136,477 |
| 2015 | 72.5 % | 2.7 % | 100,907 | 139,101 |
| 2014 | 75.1 % | 2.8 % | 105,921 | 140,960 |
| 2013 | 70.9 % | 2.9 % | 101,451 | 143,185 |
| 2012 | 54.2 % | 3.6 % | 77,578 | 143,106 |
| 2011 | 64.8 % | 3.1 % | 92,755 | 143,243 |
| 2010 | 52.9 % | 3.2 % | 73,319 | 138,689 |
| 2009 | 51.2 % | 2.9 % | 71,032 | 138,699 |

**Legends:**

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 or that are inestimable might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

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

**Data Source: National Vital Statistics System (NVSS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 27.9 | 0.6 | 1,896 | 67,846 |
| 2016 | 29.8 | 0.7 | 2,019 | 67,667 |
| 2015 | 34.3 | 0.7 | 2,320 | 67,674 |
| 2014 | 37.5 | 0.7 | 2,543 | 67,756 |
| 2013 | 43.0 | 0.8 | 2,959 | 68,749 |
| 2012 | 47.0 | 0.8 | 3,275 | 69,721 |
| 2011 | 48.4 | 0.8 | 3,452 | 71,318 |
| 2010 | 53.2 | 0.9 | 3,872 | 72,827 |
| 2009 | 60.3 | 0.9 | 4,438 | 73,571 |

**Legends:**

Indicator has a numerator <10 and is not reportable

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

**NOM 23 - Notes:**

None

**Data Alerts: None**

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

**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)**

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2017 | 12.9 % | 1.0 % | 2,738 | 21,220 |
| 2016 | 14.4 % | 1.1 % | 3,182 | 22,066 |
| 2015 | 11.4 % | 0.9 % | 2,609 | 22,818 |
| 2014 | 11.4 % | 0.9 % | 2,695 | 23,640 |
| 2013 | 12.6 % | 0.9 % | 3,048 | 24,260 |
| 2012 | 14.1 % | 1.2 % | 3,479 | 24,737 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

**NOM 24 - Notes:**

None

**Data Alerts: None**

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

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

**Multi-Year Trend**

| Year | Annual Indicator | Standard Error | Numerator | Denominator |
|---|---|---|---|---|
| 2016_2017 | 4.2 % | 1.1 % | 20,505 | 491,796 |
| 2016 | 4.2 % | 1.1 % | 21,003 | 496,705 |

**Legends:**

Indicator has an unweighted denominator <30 and is not reportable

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

**NOM 25 - Notes:**

None

**Data Alerts: None**

## Form 10
## National Performance Measures (NPMs)

**State: New Mexico**

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: Behavioral Risk Factor Surveillance System (BRFSS)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | 58.7 | 62 | 62.3 |
| Annual Indicator | 61.1 | 60.6 | 54.5 |
| Numerator | 213,517 | 212,186 | 190,568 |
| Denominator | 349,603 | 349,927 | 349,904 |
| Data Source | BRFSS | BRFSS | BRFSS |
| Data Source Year | 2015 | 2016 | 2017 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 63.5 | 64.8 | 66.1 | 67.3 | 68.0 | 68.0 |

**Field Level Notes for Form 10 NPMs:**

None

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | 78.5 | 87 | 88.4 |
| Annual Indicator | 85.5 | 83.2 | 87.7 |
| Numerator | 21,270 | 20,438 | 21,834 |
| Denominator | 24,890 | 24,563 | 24,910 |
| Data Source | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 |

| State Provided Data | | | |
|---|---|---|---|
| | **2016** | **2017** | **2018** |
| Annual Objective | 78.5 | 87 | 88.4 |
| Annual Indicator | 91.1 | 88.9 | 89.2 |
| Numerator | 20,885 | 19,734 | 18,951 |
| Denominator | 22,926 | 22,196 | 21,242 |
| Data Source | NM PRAMS | NM PRAMS | NM PRAMS |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 89.8 | 91.2 | 92.6 | 94.0 | 95.0 | 96.0 |

**Field Level Notes for Form 10 NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NM PRAMS, breastfeeding initiation (2015 births) | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NM PRAMS, breastfeeding initiation (2016 births) | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NM PRAMS, breastfeeding initiation (2017 births) | |

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Immunization Survey (NIS)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | 25.6 | 27.2 | 28 |
| Annual Indicator | 26.6 | 24.0 | 27.6 |
| Numerator | 6,319 | 5,708 | 6,648 |
| Denominator | 23,784 | 23,807 | 24,076 |
| Data Source | NIS | NIS | NIS |
| Data Source Year | 2013 | 2014 | 2015 |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 28.8 | 30.4 | 32.0 | 33.8 | 34.0 | 34.5 |

**Field Level Notes for Form 10 NPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NIS | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NIS | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NIS | |

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 80.8 |
| Annual Indicator | | 80.5 | 82.9 |
| Numerator | | 140,946 | 137,803 |
| Denominator | | 175,148 | 166,150 |
| Data Source | | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 82.2 | 83.5 | 84.7 | 85.0 | 86.2 | 87.0 |

**Field Level Notes for Form 10 NPMs:**

None

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 41.1 |
| Annual Indicator | | 41.6 | 42.1 |
| Numerator | | 40,839 | 39,424 |
| Denominator | | 98,104 | 93,717 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 43.1 | 45.0 | 47.0 | 49.5 | 50.0 | 51.0 |

**Field Level Notes for Form 10 NPMs:**

None

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH) - CSHCN** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 40 |
| Annual Indicator | | 22.5 | 22.1 |
| Numerator | | 8,575 | 8,571 |
| Denominator | | 38,131 | 38,736 |
| Data Source | | NSCH-CSHCN | NSCH-CSHCN |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 41.4 | 42.8 | 44.2 | 45.6 | 46.4 | 47.0 |

**Field Level Notes for Form 10 NPMs:**

None

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

| Federally Available Data | | | |
|---|---|---|---|
| **Data Source: National Survey of Children's Health (NSCH)** | | | |
| | **2016** | **2017** | **2018** |
| Annual Objective | | | 85.9 |
| Annual Indicator | | 85.0 | 83.7 |
| Numerator | | 386,111 | 384,606 |
| Denominator | | 454,417 | 459,720 |
| Data Source | | NSCH | NSCH |
| Data Source Year | | 2016 | 2016_2017 |

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

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 87.5 | 89.2 | 90.0 | 90.0 | 90.5 | 91.0 |

**Field Level Notes for Form 10 NPMs:**

None

## Form 10
## State Performance Measures (SPMs)

**State: New Mexico**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | 80.3 | 80.9 |
| Annual Indicator | 75.4 | 78 | 79.2 |
| Numerator | 17,707 | 17,558 | 16,845 |
| Denominator | 23,487 | 22,517 | 21,271 |
| Data Source | NM PRAMS | NM PRAMS | NM PRAMS |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 81.5 | 83.1 | 85.7 | 86.5 | 87.2 | 87.2 |

**Field Level Notes for Form 10 SPMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NM PRAMS weighted estimates, 2016 births | |
| 2. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** NM PRAMS weighted estimate, 2017 births | |

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | 31.6 | 28.8 |
| Annual Indicator | 34.2 | 29.4 | 27.6 |
| Numerator | 2,307 | 2,000 | 1,889 |
| Denominator | 67,519 | 68,117 | 68,324 |
| Data Source | NM Vital Records | NM Vital Records | NM Vital Records |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 26.1 | 23.4 | 20.7 | 18.2 | 17.6 | 17.6 |

**Field Level Notes for Form 10 SPMs:**

None

**SPM 5 - Adequate Insurance Across the Lifespan**

| Measure Status: | Active |
|---|---|

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 90.0 | 92.0 | 94.0 | 96.0 | 98.0 | 98.0 |

**Field Level Notes for Form 10 SPMs:**

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

**Field Note:**
Objectives are based on insurance coverage for women ages 18-49 years, as reported in the NM BRFSS. The baseline for 2017 survey data is 85.6%.

## Form 10
## State Outcome Measures (SOMs)

**State: New Mexico**

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

| Measure Status: | Active | | | | | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 82.0 | 84.0 | 86.0 | 88.0 | 90.0 | 91.0 |

**Field Level Notes for Form 10 SOMs:**

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

**Field Note:**
Baseline data were derived from NM PRAMS, and the prevalence of infants usually placed in a crib, cradle or bassinet was 80.2% (2015 births).

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

**State: New Mexico**

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | | 75 |
| Annual Indicator | 0 | 0 | 47.7 |
| Numerator | 0 | 0 | 239 |
| Denominator | 100 | 100 | 501 |
| Data Source | UNM Cerner Hosptial Medical Records | UNM Cerner Hosptial Medical Records | UNM Cerner Hosptial Medical Records |
| Data Source Year | 2016 | 2017 | 2018 |
| Provisional or Final ? | Provisional | Provisional | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 60.0 | 65.0 | 70.0 | 75.0 | 80.0 | 80.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 70.0 | 80.0 | 90.0 | 93.0 | 95.0 | 95.0 |

**Field Level Notes for Form 10 ESMs:**

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

**Field Note:**
This is a border CoIIN project with local partners in the border region of New Mexico. In March 2019, the primary lead, Healthy Start, lost funding and left the project. This means that the baseline data is changing due to redesign. Partners started the redesign in Summer 2019. The Border CoIIN formally ends in Fall 2020.

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

| Measure Status: | Active | | | | | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 10.0 | 25.0 | 30.0 | 35.0 | 40.0 | 45.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | 29 | 30 |
| Annual Indicator | 27.2 | 28.2 | 27 |
| Numerator | 5,679 | 5,574 | 4,924 |
| Denominator | 20,855 | 19,734 | 18,240 |
| Data Source | NM PRAMS | NM PRAMS | NM PRAMS |
| Data Source Year | 2015 | 2016 | 2017 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 31.3 | 33.0 | 35.0 | 37.0 | 39.0 | 35.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2016** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** | |
| | Definition: percent of women with live birth reporting 8 baby-friendly-related indicators, in NM PRAMS | |
| 2. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** | |
| | Denominator slightly lower than resident in-state birth population due to survey design (2016 births). | |
| 3. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** | |
| | NM PRAMS. 2017 births | |

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 50.0 | 75.0 | 100.0 | 125.0 | 150.0 | 175.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 1.0 | 2.0 | 3.0 | 4.0 | 5.0 | 6.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | Active | | | | | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 70.0 | 95.0 | 110.0 | 135.0 | 150.0 | 175.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | Active |
|---|---|

| State Provided Data | | | |
|---|---|---|---|
| | 2016 | 2017 | 2018 |
| Annual Objective | | | 10 |
| Annual Indicator | 4 | 4 | 0 |
| Numerator | | | |
| Denominator | | | |
| Data Source | CMS Training Roll | CMS | CMS |
| Data Source Year | 2016 | 2016 | 2018 |
| Provisional or Final ? | Final | Final | Final |

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 5.0 | 8.0 | 11.0 | 14.0 | 17.0 | 20.0 |

**Field Level Notes for Form 10 ESMs:**

| | | |
|---|---|---|
| 1. | **Field Name:** | **2017** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** The project focus changed due to a contract ending with Envision at the end of 2017. An RFP was issued to begin a new project and due to delays in this process and obtaining a contract with NMQIP this new project was also delayed.This is the reason for the there is no 2017 data and that providers were trained in 2018. Please refer to the narrative for more explanation. | |
| 2. | **Field Name:** | **2018** |
| | **Column Name:** | **State Provided Data** |
| | **Field Note:** An RFP was issued to resume the QI work, and there were numerous delays, so the contract was not awarded until May 2019. It is a three-year contract so work has now begun. For more information- see the 2018 narrative report for medical home. | |

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

| Measure Status: | Active |
|---|---|

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 4.0 | 5.0 | 7.0 | 9.0 | 11.0 | 13.0 |

**Field Level Notes for Form 10 ESMs:**

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

**Field Note:**
We expect an increase in events due to the support of the NM AAP chapter and early childhood stakeholders.

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

**Field Level Notes for Form 10 ESMs:**

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

**Field Note:**
The open comment period to Medicaid is over. This ESM is complete and will be deactivated.

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

| Measure Status: | Inactive - Completed | |
|---|---|---|
| **State Provided Data** | | |
| | **2017** | **2018** |
| Annual Objective | 2 | 2 |
| Annual Indicator | 2 | 1 |
| Numerator | | |
| Denominator | | |
| Data Source | Family Health Bureau - Title V | Medicaid |
| Data Source Year | 2017 | 2018 |
| Provisional or Final ? | Final | Final |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 2.0 | 2.0 | 3.0 | 4.0 | 5.0 | 6.0 |

**Field Level Notes for Form 10 ESMs:**

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

**Field Note:**
An RFP was issued in 2018, and there were delays in contracting. This QI project will begin in May 2019. This is the reason that the annual objective is not changing between 2019 and 2020. More detail is explained in the 2018 Annual Report on Transition.

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 1.0 | 2.0 | 3.0 | 4.0 | 5.0 | 5.0 |

**Field Level Notes for Form 10 ESMs:**

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

**Field Note:**
An RFP was issued in 2018, and due to delays in contracting work did not begin until May 2019.

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

| Measure Status: | Active |
|---|---|

| Annual Objectives | | | | | | |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
| Annual Objective | 43.1 | 44.1 | 45.1 | 47.0 | 48.0 | 49.1 |

**Field Level Notes for Form 10 ESMs:**

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

**Field Note:**
Data source, NM PRAMS (2017 births)

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 18.0 | 23.0 | 28.0 | 33.0 | 38.0 | 40.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 9.0 | 11.0 | 13.0 | 15.0 | 17.0 | 17.0 |

**Field Level Notes for Form 10 ESMs:**

None

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

| Measure Status: | | | | | Active | |
|---|---|---|---|---|---|---|
| **Annual Objectives** | | | | | | |
| | **2019** | **2020** | **2021** | **2022** | **2023** | **2024** |
| Annual Objective | 9,353.0 | 14,353.0 | 19,353.0 | 24,353.0 | 29,353.0 | 29,353.0 |

**Field Level Notes for Form 10 ESMs:**

None

## Form 10
## State Performance Measure (SPM) Detail Sheets

**State: New Mexico**

**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<br>**Denominator:** Number of live births<br>**Unit Type:** Percentage<br>**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 4 - Teen Birth Rate, Girls ages 15 to 19 years**
**Population Domain(s) – Women/Maternal Health, Adolescent Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To reduce birth rates among adolescent females 15 to 19 years |
| **Definition:** | **Numerator:** Births to adolescent females aged 15 to 19 years<br>**Denominator:** Number of adolescent females in population, ages 15 to 19 years<br>**Unit Type:** Rate<br>**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<br><br>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.<br><br>This rate includes New Mexico RESIDENT births only.<br><br>Birth records are filed electronically by hospitals. Medical records staff use standard mother and facility worksheets and medical charts to complete the birth registration.<br><br>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.<br><br>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.<br><br>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).<br><br>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.<br><br>Teen parenthood is most common in rural areas. In the 26 rural counties in NM, the teen birth rate was 51.1/1,000, whereas the teen birth rate in the seven urban counties, the teen birth rate was 33.8/1,000 |

**SPM 5 - Adequate Insurance Across the Lifespan**
**Population Domain(s) – Women/Maternal Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To improve access to healthcare across the lifespan via adequate insurance options for MCH populations across New Mexico |
| **Definition:** | **Numerator:** (n=912) Number of adult women ages 18-49 with health insurance coverage<br>**Denominator:** (1031) Number of adult women ages 18-49<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | AHS-1 Increase proportion of persons with health insurance<br>AHS-6 Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care or prescription medicines |
| **Data Sources and Data Issues:** | NM Behavioral Risk Factor Surveillance System (BRFSS), NM-IBIS |
| **Significance:** | New Mexico struggles with access to and timely utilization of health services due to chronic poverty, rural and frontier geography and health professional shortage areas. Adequate insurance is an important part of perinatal and childhood healthcare access we seek to address through programs and partnerships in Title V, which many times involves working with different systems to provide coverage. NM ranks second in the nation, along with Florida, for the highest percentage of children without health insurance. Through an aggressive outreach and enrollment campaign, the number of children eligible for and enrolled in the State Children's Health Insurance Program (SCHIP) and Medicaid are increasing steadily.<br>The New Mexico state high-risk prenatal care fund (HRF) provides a safety net for families with otherwise inadequate subsidies or eligibility for Medicaid may be served in this program. Partner programs take a systems approach to making birthing options available to the Medicaid population, not just those with private insurance. Between 62 and 74% of New Mexico's birth population is covered by Medicaid, but Medicaid does not permit for billing lactation consultants or birth doulas. And, although home births by licensed midwives are billable to Medicaid, there have been significant problems with reimbursement to the midwives through Managed Care Organizations.To address the above problem, planning began in 2017 with the Human Services Department/Medicaid Division for a formal training with the licensed midwives (LMs) and the Managed Care Organizations. |

## Form 10
## State Outcome Measure (SOM) Detail Sheets

**State: New Mexico**

**SOM 1 - Percent of Infants who were usually placed to sleep in a crib or bassinet**
**Population Domain(s) – Perinatal/Infant Health**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the percentage of infants who were usually placed to sleep in a crib or bassinet |
| **Definition:** | **Numerator:** number of women reporting infants that were usually placed to sleep in a crib or bassinet<br>**Denominator:** number of resident occurent births in PRAMS<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Healthy People 2020 Objective:** | MICH-20 Increase the proportion of infants who are put to sleep on their backs with a target of 75.8% |
| **Data Sources and Data Issues:** | PRAMS<br>The percent of women whose infant slept in a crib was not mutually exclusive with those who slept in a bed with another person. |
| **Significance:** | AAP recommendation to prevent sudden, unexpected death for infants |

## Form 10
## Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

**State: New Mexico**

**ESM 1.1 - Percent of completed postpartum visits by maternal clients followed at the Title V Maternity and Family Planning Clinic in metro Albuquerque.**
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

| | |
|---|---|
| **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:** Attended post-partum visits within the MF& P clinics in the UNMH Healthcare system<br>**Denominator:** The number of post partum visits scheduled<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | UNMH Cerner Database |
| **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 1.3 - Out of those who tested positive for pregnancy at the three pilot sites (Teen Resource Center, NMDOH Public Health Office and La Clinica de Familia), the percentage of women who received and completed a first trimester prenatal visit.**
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase by 10% from baseline the number of pregnant women who seek prenatal care in the first trimester from three sites in the Dona Ana County area. |
| **Definition:** | **Numerator:** # of pregnant women who received prenatal care within their 1st trimester<br>**Denominator:** # of pregnant women who were identified as pregnant in the specified clinics in the same time period as the numerator<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NMDOH Electronic Health Record System, Teen Resource Center data, and LCDF visit data |
| **Significance:** | Early prenatal care is associated with improved birth weight and decreased risk of preterm delivery, both of which are important contributors to infant mortality. It increases the opportunity for mothers and families to access other supports (health, social, legal, environmental, etc.) that can impact the health of both mother and baby across the life course. It is a proxy indicator for access to health care in general, and finally, it is a National Healthy People 2020 goal. |

**ESM 1.4 - Percentage of primary providers that have received training and/or consultation in assessing and treating behavioral health needs.**
**NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of New Mexico health care providers who receive evidence-based training in the assessment and management of behavioral health disorders in prenatal patients. |
| **Definition:** | **Numerator:** # of prenatal care providers who have completed training<br>**Denominator:** # of prenatal providers in the state<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NMDOH Bureau of Primary Care; NM Medicaid Provider Enrollment Data; UNM Project ECHO data |
| **Significance:** | Women in New Mexico are a particularly high-risk group. Nineteen percent of New Mexican women report symptoms of postpartum depression and that number increases to 24% in teen mothers. Additionally, in a Center for Disease Control comparison study of 17 states, New Mexico had the highest rate of self-reported symptoms of postpartum depression. In addition, many of these women live in disadvantaged environments, which are associated with increased risk for maternal distress. In 2016, the New Mexico Department of Health published a report on concentrated disadvantage and the effects on pregnancy. Concentrated disadvantage is a measure of social wellbeing of a neighborhood including availability of services and opportunities to access health care. Alarmingly, of New Mexico's 499 census tracts, 15.8% were categorized as high concentrated disadvantage and 36.9% fell into medium concentrated disadvantage. Thus, over half of New Mexico's census tracts are classified as medium to high concentrated disadvantage.<br>Finally, a report by the New Mexico Health Care Workforce Committee (2017) gave estimates on numbers of primary care physicians, certified nurse practitioners and certified nurse specialists (CNPs/CNSs), physicians assistants (PAs), obstetrician and gynecology physicians, certified nurse-midwives and licensed midwives in the state. A related analysis of these data revealed that due to the location of these providers, many areas of the state are Health Professional Shortage Areas (HPSA). Forty percent of New Mexico women live in a primary care Health Professional Shortage Area. Critically, 55% of New Mexico women live in a mental health HPSA.<br>If this project is successful, it will provide an innovative care and provider support models that overcomes barriers to accessing symptom management resources for perinatal mental health disorders in this high-risk population leading to healthy maternal-infant dyads and families. |

**ESM 4.1 - Percentage of mothers who report a baby-friendly experience at a New Mexico birthing facility**
**NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of birth facilities that have achieved baby-friendly status |
| **Definition:** | **Numerator:** Number of PRAMS respondent mothers who report experiencing 8 baby friendly steps at the hospital where they gave birth<br>**Denominator:** Number of PRAMS respondent mothers who gave birth at a birthing facility and started breastfeeding<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | The New Mexico Pregnancy Risk Assessment Monitoring System (PRAMS) |
| **Significance:** | The advantages of breastfeeding are indisputable, and Baby-Friendly hospitals provide an opportunity and for mothers to initiate breastfeeding by encouraging and recognizing hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. It designates birthing facilities who successfully implement the Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes. The New Mexico PRAMS survey includes 8 questions that correspond to baby friendly experience, so this ESM will allow New Mexico to assess the mother's self-reported experience with the percentage of births at baby friendly facilities thereby utilizing PRAMS to measure the correspondence between self-reported baby-friendly experience and the number of births in New Mexico. |

**ESM 10.4 - Number of youth and adults who are trained using the Youth Health Literacy Toolkit.**
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase, each year, the number of youth and adults (health educators, clinic staff etc.) that recieve education on youth health literacy in New Mexico. |
| **Definition:** | **Numerator:** Number of youth and adults who attend the Youth Health Literacy Workshop<br>**Denominator:** The number of sites that would be appropriate to hold a Youth Health Literacy Workshop in New Mexico<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | NM DOH Office of School & Adolescent Health |
| **Significance:** | Training youth and adults such as health educators and teachers in Youth Health Literacy Toolkit, would help to improve adolescent health. Adults are trained to take the information back to their school and/or community to train other youth. This toolkit covers the following topic areas 1)the 7 areas of health, 2) why young people do and don't go to the doctor, 3) what to do before, during and after a doctors appointment, 4) the HEADSSS Model and the importance of preventative annual well exams, 5) Confidentiality and 6) Self-Care. According to Pediatrics Perspectives: Promotion Health Literacy for Children & Adolescents "only 12% of American adults have proficient health literacy, defined as a set of skills needed to effectively function in the health care system. 1 This is troubling given that health literacy is a stronger predictor of health than age, income, employment status, educational level, or race. 2 A growing body of research also shows that low health literacy is associated with worse child health outcomes, 3 higher health care costs, and elevated mortality rates." (Source: http://pediatrics.aappublications.org/content/pediatrics/early/2016/11/08/peds.2016-1937.full.pdf )<br>An annual projection of your measurement for the next 5 years (through 2023): 2017 50 people, 2018 75 people, 2019 100 people Increase one class of 25 people each year. |

**ESM 10.5 - The number of clinics that respond that they have increased their youth friendliness practices by at least two points according to the pre and post surveys given after the Know Your Health Toolkit presentations. NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the adoption of youth friendly practices and environments in clinical settings that serve adolescents. |
| **Definition:** | **Numerator:** The number of clinics that self-report an increase of 'youth-friendliness' by at least 2 points<br>**Denominator:** The total number of clinics that take the survey<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NM DOH Office of School & Adolescent Health |
| **Significance:** | The Know Your Health Toolkit promotes Best Practices for Youth Friendly Clinical Services discussed on the Advocates for Youth publication such as ensuring youth confidentiality and respectful treatment from all staff within the clinic (Source: http://www.advocatesforyouth.org/publications/publications-a-z/1347--best-practices-for-youth-friendly-clinical-services ). |

**ESM 10.6 - Number of people attending Know Your Health Toolkit presentations**
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To annually increase the number of people receiving training on youth friendly practices through the Know Your Health Toolkit presentations |
| **Definition:** | **Numerator:** The number of individuals who attended a Know Your Health Toolkit presentation in New Mexico<br>**Denominator:** Adolescents and those who serve the health care needs of adolescents in New Mexico<br>**Unit Type:** Count<br>**Unit Number:** 1,000 |
| **Data Sources and Data Issues:** | NM DOH Office of School & Adolescent Health |
| **Significance:** | The more we share information about the Know Your Health Toolkit the more people will utilize it and also share other resources that could be included in the toolkit as we continue to update it. |

**ESM 11.1 - The number of medical providers who have participated in a Quality Improvement initiative to improve coordination of care for CYSHCN.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Increase the percentage of families who have access to patient and family centered care coordination that respects the culture and primary language of the family to assist in integrating physical, oral and behavioral health issues into the care plan. |
| **Definition:** | **Numerator:** The number of providers participating in QI around care coordination.<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | The CMS QI initiative roll. |
| **Significance:** | Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Pediatric clinicians in New Mexico who have effective policies and procedures in place to provide effective integration of physical health, oral and behavioral health care and have an effective method for cross-provider communication are needed to increase the percentage of children with a medical home. The QI initiative will increase the likelihood that pediatric providers utilize the appropriate policies and procedures. |

**ESM 11.3 - The number of outreach events to promote the Medical Home Portal**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of outreach events |
| **Definition:** | **Numerator:** The number of outreach events completed to promote the Medical home portal in the upcoming year<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NM DOH Childrens Medical Services Program |
| **Significance:** | The Medical Home Portal is a project of the Department of Pediatrics, University of Utah Health. Since its inception in 2001, funding for the Portal has come from a variety of foundations, grants, contracts, and gifts from many organizations, none of which involve any commercial stipulations or expectations. One of the numerous premises behind the Portal is that physicians and families sharing information and working together as partners in the Medical Home Model will improve outcomes for CYSHCN.<br>The Portal's Vision: All children and youth with special health care needs (CYSHCN) and their families achieve the best possible outcomes for their health, well-being, and success<br>The Portal's Mission: To assist and support professionals and families in working together (the Medical Home model) to care and advocate for CYSHCN by providing reliable and useful information about their conditions and caring for them and knowledge of valuable local and national services and resources<br>The Portal's Long-Range Goal: To improve outcomes for CYSHCN and their families by enhancing the availability and quality of healthcare, related services, and coordination of care |

**ESM 11.4 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal that were accepted into policy.**
**NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home**

| | |
|---|---|
| **Measure Status:** | Active |
| **ESM Subgroup(s):** | CSHCN |
| **Goal:** | To get at least one recommendation accepted into a policy change per year |
| **Definition:** | **Numerator:** The number of accepted recommendations into policy<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 10 |
| **Data Sources and Data Issues:** | NM DOH Childrens Medical Services Program |
| **Significance:** | Care coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and long-term care services and support and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes. Improvements to care coordination will Increase collaboration between the Title V CYSHCN program care coordinators, the Managed Care organizations who also provide care coordination and Family leaders representative of the diverse cultures in the State to strengthen the best practice model for children with special needs and their families across the state. |

**ESM 12.2 - The number of recommendations that Title V program submitted to Medicaid on the Medicaid 1115 renewal regarding transition to adult health care that were accepted into policy.**
**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**

| | |
|---|---|
| **Measure Status:** | Inactive - Completed |
| **Goal:** | To implement recommendations that result in policy changes in Medicaid and for the Managed Care organization that strengthen the system of care for CYSHCN. |
| **Definition:** | **Numerator:** The number of recommendations accepted into policy<br>**Denominator:** NA<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | The number of recommendations accepted into policy to Medicaid will counted. |
| **Significance:** | Care coordination remains central to the effort of ensuring the right care, at the right time, and in the right place. Improvements to care coordination include targeting members with complex needs and/or higher costs through initiatives that promote integration of physical health, behavioral health, and long-term care services and support and by leveraging partnerships with programs that are person-centered and deliver improved health outcomes. Improvements to care coordination will Increase collaboration between the Title V CYSHCN program care coordinators, the Managed Care organizations who also provide care coordination and Family leaders representative of the diverse cultures in the State to strengthen the best practice model for children with special needs and their families across the state. |

**ESM 12.3 - The number of pediatric providers participating in at least one quality improvement project on transition**
**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of pediatric providers who are using QI related to transition |
| **Definition:** | **Numerator:** The number of pediatric providers that participate in one or more QI projects about transition.<br>**Denominator:** The number of possible providers that can engage in QI around transition<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Childrens Medical Service Program |
| **Significance:** | QI initiatives are used as one strategy by professional organizations to help ease the transition from pediatric-based care to adult-based care. The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. "Transition planning between youth, family and provider has been associated with improvements in satisfaction, continuity of care, and greater adherence to care". Reference: Gabriel et al, 2017; McDanagh et al, 2007; Wojciechoski et al, 2002 |

**ESM 12.4 - The number of trainings to pediatric providers, families and youth that educate them on transition to adult health care.**
**NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of trainings provided |
| **Definition:** | **Numerator:** The number of trainings presented<br>**Denominator:** N/A<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | Childrens Medical Services Program |
| **Significance:** | Continuing education for providers is important, if not mandated by professional medical associations, if not by the employer. The reason is that it is important to stay current on best practices. Specific training provides practitioners with and in-depth understanding of the importance of health care transition. Providing trainings to families, patients and providers creates a greater likelihood that transition is handled correctly in order to maintain continuity of care and medical adherence. |

**ESM 13.2.1 - Percentage of pregnant women having a dental visit during pregnancy**
**NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | Through dental education with WIC participants, the goal is to see more women attending a dental visit, of any kind, during pregnancy so as to avoid gum disease development. |
| **Definition:** | **Numerator:** number of women in WIC attending a dental visit during pregnancy<br>**Denominator:** number of pregnant women served by the WIC program<br>**Unit Type:** Percentage<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NM PRAMS and NM DOH Oral Health Surveillance Data |
| **Significance:** | Pregnancy can affect the dental health of a woman due to rising hormone levels. These changes raise the risk of women developing dental health problems which can, in turn affect the health of the baby in utero. The risks to the baby can include pre-term birth and low birth weight (March of Dimes, 2018). Getting a checkup during pregnancy is safe and important for good oral health of pregnant women and their children. Seeing a provider can take care of cleanings and provide procedures like cavity fillings before the baby is born, a dental visit can help with any pregnancy-related dental symptoms a woman might be experiencing. The American Dental Association, the American Congress of Obstetricians and Gynecologists and the American Academy of Pediatrics all encourage women to get dental care while pregnant. |

**ESM 13.2.2 - Number of oral health promotion activities conducted within the year to promote the importance of oral and general health.**
**NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | The goal is to increase the exposure that children and pregnant women in New Mexico have to education on the importance of dental health. |
| **Definition:** | **Numerator:** Number of dental health promotion activities done through the NM DOH Office of Oral Health<br>**Denominator:** 100<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NM DOH Office of Oral Health |
| **Significance:** | Being informed about health issues relating to pregnancy will help women to make informed choices about their health and the health of their children. Oral health education teaches skills for good oral hygiene in order to prevent oral diseases and other dental problems. Oral health is important to the overall health and the well-being of infants, children, adolescents and adults. Oral health promotion covers a range of health promotion and disease prevention concerns, including dental caries; periodontal (gums) health; proper development and alignment of facial bones, jaws, and teeth; other oral diseases and conditions; and trauma or injury to the mouth and teeth. Promoting oral health includes integrating chronic diseases as they relate to general health. The oral health promotion campaign will be designed to target New Mexico residents. |

**ESM 13.2.3 - Number of oral health providers that provide dental sealants and fluoride varnish applications to low income and uninsured and pregnant women**
**NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To increase the number of providers who are serving low income and uninsured pregnant women |
| **Definition:** | **Numerator:** Number of oral health providers that provide dental sealants and fluoride varnish applications to low income and uninsured and pregnant women<br>**Denominator:** Number of dental providers who serve low income and uninsured pregnant women<br>**Unit Type:** Count<br>**Unit Number:** 100 |
| **Data Sources and Data Issues:** | NM DOH Office of Oral Health |
| **Significance:** | The New Mexico Departments Health Improvement Plan calls for an increase of preventive services for children (dental sealants/fluoride varnish) a preventive strategy to reduce the incidence of tooth decay and other risk factors. Additional providers in New Mexico will reduce the potential of tooth decay by offering additional preventive services to children especially those residing in rural/frontier Health Professional Service Areas. The New Mexico Office of Oral Health “School Based Preventive Services” Program has been designated as a “Best Practice” by the Association of State and Territorial Dental Directors. |

**ESM 13.2.4 - Number of students who have received oral health education through the programs facilitated by the NM Office of Oral Health**
**NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year**

| | |
|---|---|
| **Measure Status:** | Active |
| **Goal:** | To ultimately increase the number of adolescents that attend a dental visit in the past year by providing health education on oral health directly to adolescents. |
| **Definition:** | **Numerator:** The number of students in attendance at health education presentations given through the NM Office of Oral Health<br>**Denominator:** Total number of students that could receive an oral health training by the NM Office of Oral Health<br>**Unit Type:** Count<br>**Unit Number:** 100,000 |
| **Data Sources and Data Issues:** | NM DOH Office of Oral Health Program |
| **Significance:** | To improve the oral health status of children they should understand the importance of good oral hygiene, seeing a dental provider, eating healthy and reduce those risk factors that develop poor oral health. Educating children and adults will improve their oral health literacy; and implement good oral health and eating habits and impacting the use of tobacco and other risk factors. |

## Form 11
## Other State Data

### State: New Mexico

The Form 11 data are available for review via the link below.

Form 11 Data